New Mexico State University (NMSU)

Plan Highlights – PPO Plan Effective 1/1/2023

Blue Cross and Blue Shield of New Mexico

Highlights the deductible, out-of-pocket limits, member coinsurance percentage amounts, and provides a brief description of NMSU's 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]**
Annual Deductible[1] – Deductible does not apply to services with copays or "no charge."	$1,250 ($3,750/family)	$5,000 ($10,000/family)
Annual Out-of-Pocket Limit – Includes coinsurance only; NOT deductible, copayments, penalty amounts, or noncovered charges.[2]	$4,500 ($10,800/family)	$15,000 ($30,000/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, are subject to deductible and coinsurance as listed below.		
Primary Preferred Provider* Office Visit and initial office visit to diagnose pregnancy	$35 copay/visit (deductible waived for OV only)	40%
Virtual Visit (MDLive providers)	$35 copay/visit	Not Covered
Mental Health/Chemical Dependency services (office visit only)	No Charge	40%
Virtual Visit – Mental Health (MDLive providers)	No Charge	Not Covered
Specialist Office Visit and initial office visit to diagnose pregnancy	$55 copay/visit (deductible waived for OV only)	40%
Office Surgery (including casts, splints, and dressings)	30%[4]	40%[4]
Allergy Injections, Tests, Serum	30%	40%
Preventive Services Routine Adult Physicals and Gynecological Exams; Well-Child Care; Mammograms; Routine Colonoscopies (office/outpatient); Preventive Testing (includes routine Pap tests, cholesterol tests, urinalysis, etc.); Immunizations; and Routine Vision or Hearing Screenings	No Charge	40%
Acupuncture Treatment (benefit max. **20 visits**/year)	30%	40%
Ambulance Services: Ground and Emergency Air Transport	25%[3]	
Ambulance Services: Nonemergency Air Transfer	30%[4]	40%[4]
Autism Spectrum Disorders Applied Behavioral Analysis[4] Occupational, Physical, and Speech Therapy	$35 copay/visit	40%
Cardiac and Pulmonary Rehabilitation	30%	40%
Dental/Facial Accident, Oral Surgery, and TMJ/CMJ Services	Member share based on place of treatment & type of service[4]	40%[4]
Durable Medical Equipment and Supplies	30%	40%[4] (limits apply)
Emergency Room Treatment	$250 copay/visit; then 30%	
Hearing Aids and Related Services: Hearing aids for members under age 21 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. These services are not covered for members age 21 and older.		
Home Health Care/Home I.V. Services (benefit max. **100 visits**/year)	30%[4]	40%[4]
Hospice Services	30%[4,5]	40%[4,5]
Lab, X-Ray, MRI, CT Scan, PET Scan and Basic Diagnostic Tests	30%[4]	40%[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 (See "Short-Term Rehabilitation" for physical rehabilitation and skilled nursing facility admissions and "Transplant Services," if applicable.)		
Medical/Surgical, Maternity-Related Room and Board, and Covered Ancillaries Mental Health/Chemical Dependency	$300 copay/admit; then 30%[5] No Charge (deductible waived)[5]	40%[5]
Maternity Services (also see "Inpatient Hospital/Facility Services")	$300 copay/admit; then 30%[5]	40%[5]
Routine Nursery/Pediatrician Care for Covered Newborns	$300 copay/admit; then 30%[5]	40%[5]
Outpatient Facility/Physician (including surgical procedures related to pregnancy and family planning; and nonroutine colonoscopies)	$300 copay/procedure; then 30%[4]	40%[4]
Prosthetics and Orthotics	30%	40%[4] (limits apply)
Short-Term Rehabilitation: Outpatient – Occupational, Physical, and Speech Therapy	$35 copay/visit	40%
Skilled Nursing Facility (max. **60 days**/year) **Inpatient Rehabilitation**	30%[5]	40%[5]
Spinal Manipulation Services (max. **20 visits**/year)	30%	40%
Therapy: Chemotherapy, Dialysis, Radiation Therapy	30%[4]	40%[4]
Transplant Services (Must use facilities that contract with BCBSNM or through the national BCBS transplant network.)		
Cornea, Kidney, Bone Marrow	Based on place of treatment and type of service[4,5]	
Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney (Subject to a separate **$5,000** out-of-pocket limit per transplant type. Calendar year deductible does not apply.)	30%[4,5]	Not Covered
Urgent Care Facility	30%	40%

FOOTNOTES:

[1] All benefit payments are based on the covered charge as determined by BCBSNM. The deductible must be met before benefit payments are made for most services, except services with a copayment, hearing aids, and certain preventive services. 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. A list of services requiring preauthorization is in Section 4.

[5] Preauthorization is required for inpatient admissions. Some services, such as transplants and 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 NMSU Prescription Drug Benefit Summary on next page.

NMSU Prescription Drugs, Insulin, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods Summary				
Note: Deductible does not apply and copayments and coinsurance are not applied to out-of-pocket. Certain drugs, special medical foods, and enteral nutritional products require preauthorization or benefits will be denied.[4,7] The Performance Drug List is a list of preferred drugs that are available to members at lower copayment levels. Drugs not on the list are still covered, but at a higher copayment. The BCBSNM Pharmacy and Therapeutics Committee (made up of physicians & pharmacists) evaluate drugs for their therapeutic uniqueness, safety, and cost to select drugs to be included on the Performance Drug List. The Performance Drug List is available on the BCBSNM web site at www.bcbsnm.com. Your copayment for prescription drugs is based on whether the drug you receive is a generic or a brand-name drug **AND** whether the drug is on the Performance Drug List.	**Type of Prescription**	**Percentage of covered charge you pay (coinsurance), if the percentage is between the minimum and maximum copayments:**	**Minimum Copayment**	**Maximum Copayment**
Retail/Specialty Pharmacy Program (up to a 30-day supply)	Generic Drug on Drug List	$15[7]	$15[7]	$15[7]
	Brand-Name Drug on Drug List	30%[7]	$30[7]	$50[7]
	Not on Drug List	40%[7]	$50[7]	$85[7]
	Specialty Pharmacy	25%[7]	$130[7]	$275[7]
Mail-Order Plan (up to a 90-day supply)	Generic Drug on Drug List	$30[7]	$30[7]	$30[7]
	Brand-Name Drug on Drug List	30%[7]	$60[7]	$100[7]
	Not on Drug List	40%[7]	$100[7]	$170[7]
Nonprescription Enteral Nutritional Products and Special Medical Foods (up to a 30-day supply per 30-day period; requires preauthorization)		50%[4,7]		

[7] Prescription drugs must be purchased at a pharmacy that participates in the Retail Pharmacy, Specialty Pharmacy, or Mail Order Services programs. (BCBSNM has contracted with a separate program for administration of your prescription drug benefits.) Note: Under this prescription program, if you prefer a brand-name drug that has a generic equivalent or if you or your provider orders a brand-name drug when a generic is available, you will pay the difference in cost between the generic and brand-name drug, in addition to the generic drug copayment.