Administered by:

BlueCross BlueShield of New Mexico

Gila Regional Medical Center

Plan Highlights – Base Plus $1,000

Highlight sheet – lists copayments, coinsurance percentage amounts and provides a brief description of Gila Regional Medical Center's health care plan benefits.

EPO Plan Benefits – 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]		$1,000 ($3,000 family)
Annual Out-of-Pocket Limit (Deductible, copayments and coinsurance amounts apply; prescription drug charges, penalty amounts, and noncovered charges do not.)[2]		$3,000 ($6,000 family)
Primary Preferred Provider (PPP) Office Services*		
Office Visit, Medication Management Virtual Visit (MDLIVE providers)		$30 copay/visit $30 copay/visit
Office Surgery (including casts, splints, and dressings)		$30 copay/visit
Mental Health and Chemical Dependency (office visit only) Virtual Visit (MDLIVE providers)		$30 copay/visit $30 copay/visit
Specialty Physician Office Services		
Office Visit, Medication Management, Office Evaluations		$45 copay/visit
Office Surgery (including casts, splints, and dressings)		$45 copay/visit
Preventive Care Services (Adult medical care/routine exams; well child care; vision/hearing screening, routine mammogram, routine colonoscopy, and immunizations)		No charge
Acupuncture/Spinal Manipulation Services (max. **25 visits**/year/combined)		$45 copay/visit
Allergy Services (testing, injections)	**Primary**	$30 copay/visit
	Specialist	$45 copay/visit
Allergy Serum		50%
Ambulance Services		$75 per trip/ground or $150 per trip/air[3]
Autism Spectrum Disorders Applied Behavioral Analysis[3], and Occupational, Physical, and Speech Therapy		$30 copay/visit
Cardiac and Pulmonary Rehabilitation (outpatient)		$45 copay/visit
Dental/Facial Accidents, Oral Surgery, TMJ/CMJ Services		Based on place of treatment and type of service
Emergency and Urgent Care Services Emergency Room (includes all related ER services) Observation Room (including pregnancy) Urgent Care Facility		 $240 copay/visit $240 copay/visit $150 copay/visit
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.		
Hospice - Inpatient		30% coinsurance[4]
Hospice - Home		No charge[3]
Home Health Care (prescribed home nursing care, physician, and therapy care – **100 visits**/year)		30% coinsurance

* A "PPP" (or Primary Preferred Provider) 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.

EPO Plan Benefits – 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				
Room and Board, Physician Care such as Physician Visits, Surgeon, and Anesthesiologist, Lab, X-Ray, Other Diagnostic Tests, Medical/Surgical, and Mental Health and/or Chemical Dependency (including partial hospitalization), and Residential Treatment Center		30% coinsurance[4]		
Maternity – initial visit to diagnose pregnancy Maternity – prenatal and post-delivery exams, inpatient delivery, and Routine Newborn Care (must be enrolled within 31 days of birth) Extended Stay Newborn Care (must be enrolled within 31 days of birth)		Office copay/initial visit 30% coinsurance[4] 30% coinsurance[4]		
Lab Tests, X-Rays and Other Basic Diagnostic Services (including tests done in office, outpatient facility, freestanding facility, or any other place of treatment)		No charge		
MRI, PET Scan, CT Scan		$50 copay per test[3]		
Outpatient Facility/Physician/Surgeon (including surgical procedures related to pregnancy and family planning, and nonroutine colonoscopies)		30% coinsurance		
Short-Term Rehabilitation: Inpatient Rehabilitation/Skilled Nursing Facility Outpatient/Office Occupational, Physical, and Speech Therapy (max. **60 days/visits/year** for all services combined)		30% coinsurance[4] $30 copay/visit		
Supplies, Durable Medical Equipment, Prosthetics, and Orthotics		30% coinsurance[5]		
Therapy: Chemotherapy, Dialysis, and Radiation Therapy		$100 copay/visit		
Transplant Services (Must use facilities that contract with BCBSNM or with the national BCBS transplant network.)				
Cornea, Kidney, Bone Marrow Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney: **$10,000** maximum for travel and lodging per diem		Based on place of treatment and type of service[3,4]		
Type of Prescription (must be on Drug List)	**Copay Level**	**Your Copay**		
Retail Pharmacy (up to a 30-day supply) **Mail-Order Pharmacy** (up to a 90-day supply)		**Preferred Pharmacy Retail**	**Nonpreferred Pharmacy Retail**	**Mail-Order Pharmacy**
Generic Drug	**Tier 1**	$10	$15	$25
Preferred Brand-Name Drug	**Tier 2**	$35	$45	$87.50
Nonpreferred Brand-Name Drug	**Tier 3**	$75	$85	$187.50
Specialty Pharmacy Provider	**Tier 4**	**15%** up to a maximum copayment of $250		
Nonprescription Enteral Nutritional Products and Special Medical Foods (brand-name or generic): Products must be **prior-approved**.		**50 percent** of covered charges (Limited to a 30-day supply during any 30-day period)		
Prescription Drug Plan Out-of-Pocket Limit	**All Tiers**	**$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.				
Preferred Participating Pharmacies: Walgreens; Walmart; Sam's; Albertsons (Savon Drugs/Savon Pharmacy); **Health Mart Atlas** and **Leader Drug** (groups of independent pharmacies in NM).				

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. 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. Copayment and/or coinsurance amounts 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.

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

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