Dona Ana County

HSA Plan

Administered by:

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 Dona Ana County HSA Plan benefits.

PPO Benefits – There is no lifetime maximum benefit. However, certain services have maximum annual limits.	**Member's Share of Covered Charges**	
	Preferred Provider[1]	**Nonpreferred Provider[1]**
Contract Year Deductible[1]	$1600	$4,000
Family Contract Year Deductible: Aggregate – All family members' services apply to the Family Deductible. Once the entire Family Deductible is met, then all family members' services apply coinsurance benefits.[1]	$4800	$12,000
Annual Out-of-Pocket Limit (Includes deductible, coinsurance, and prescription drugs only – NOT penalty amounts or noncovered charges.)[2]	$6,500/Individual Coverage $13,000/Family Coverage	$9,000/Individual Coverage $18,000/Family Coverage
Office Services (nonroutine)		
Office Visit/Exams/Consultations Virtual Visits (MDLIVE providers)	20% coinsurance 20% coinsurance	50% coinsurance Not Covered
Allergy Injections, Tests, Serum	20% coinsurance	50% coinsurance
Office Surgery (including casts, splints, and dressings)	20% coinsurance	50% coinsurance
Mental Health and Chemical Dependency (outpatient/office) Virtual Visits (MDLIVE providers)	No charge after deductible No charge after deductible	50% coinsurance Not Covered
Preventive Services Routine Adult Physicals and Gynecological Exams, Related Testing (includes routine Pap tests, mammograms, cholesterol tests, urinalysis, etc.), Routine colonoscopies (outpatient/office), Immunizations, Well-Child Care; and Routine Vision or Hearing Screenings	No Charge (deductible waived)	50% coinsurance
Acupuncture / Spinal Manipulation (max. **25 visits**/year/combined)	20% coinsurance	50% coinsurance
Ambulance Services: Ground and Emergency Air Transport	20% coinsurance[3]	
Ambulance Services: Nonemergency Air Transfer	20% coinsurance[4]	50% coinsurance[4]
Autism Spectrum Disorders Applied Behavioral Analysis,[4] and Occupational, Physical, and Speech Therapy	20% coinsurance	50% coinsurance
Cardiac and Pulmonary Rehabilitation, Outpatient	20% coinsurance	50% coinsurance
Dental/Facial Accident, Oral Surgery, and TMJ/CMJ Services	20% coinsurance[4]	50% coinsurance[4]
Emergency Room Treatment	20% coinsurance after PPO deductible[3]	
Hearing Aids and Related Services for Adults and Children: Hearing aids are paid at 100% of covered charges, after deductible, 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)	20% coinsurance	50% coinsurance
Hospice Services	20% coinsurance[4,5]	50% coinsurance[4,5]
Inpatient Hospital/Facility and Physician Services		
Medical/Surgical, Maternity-Related Room and Board and Covered Ancillaries Mental Health/Chemical Dependency (including partial hospitalization), Residential Treatment Center	20% coinsurance[5] No charge after deductible[5]	50% coinsurance[5]
Routine Nursery Care for Covered Newborns	20% coinsurance[5]	50% coinsurance[5]
Lab, X-Ray, and Other Diagnostic Tests	20% coinsurance	50% coinsurance
MRIs, CT Scans, PET Scans	20% coinsurance[4]	50% coinsurance[4]
Maternity Services (pre- and post-natal, delivery, and newborn charges)	20% coinsurance[5]	50% coinsurance[5]
Short-Term Rehabilitation: Occupational, Physical, and Speech Therapy; including Physical Rehabilitation and Skilled Nursing Facility **Inpatient Rehabilitation / Skilled Nursing Facility** (max. **30 days**/year/combined)[5] **Outpatient Therapies** (max. **35 visits**/year/combined)	20% coinsurance[5]	50% coinsurance[5]
Supplies, Durable Medical Equipment, Prosthetics, Orthotics	20% coinsurance[6]	50% coinsurance[6]
Outpatient Facility/Surgeon/Physician (surgical procedures, pregnancy-related services, and non-routine colonoscopies)	20% coinsurance	50% coinsurance

PPO Benefits – There is no lifetime maximum benefit. However, certain services have maximum annual limits.	**Member's Share of Covered Charges**	
	Preferred Provider[1]	**Nonpreferred Provider[1]**
Therapy: Chemotherapy, Dialysis, and Radiation	20% coinsurance	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	20% coinsurance[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)		No Benefit
Urgent Care Facility	20% coinsurance	50% coinsurance
Prescription Drugs, Insulin, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods	**Generic Drug**	**Brand-Name Drug**
Prescription Drugs are subject to medical plan deductible and out-of-pocket maximum.	20% coinsurance	20% coinsurance
Retail Pharmacy (up to a 30-day supply) Includes nonprescription enteral nutritional products and special medical foods.)[4,7]		
Mail-Order Pharmacy (up to a 90-day supply)	20% coinsurance	20% coinsurance
Specialty Pharmacy Program (up to a 30-day supply. Includes nonprescription enteral nutritional products and special medical foods.)[4,7]	20% coinsurance	
Nonprescription Enteral Nutritional Products and Special Medical Foods (up to a 30-day supply/30-day period, needs preauthorization.)[4,7]	50% coinsurance	
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 (deductible waived)	

FOOTNOTES:

1 The Individual or Family Coverage deductible (as applicable) must be met before benefit payments are made, including for services covered under the drug plan.

2 After a member or family reaches the applicable out-of-pocket limit, BCBSNM pays 100 percent of that member's or family's Preferred Provider or Nonpreferred Provider covered charges, whichever is applicable. Amounts paid under the drug plan are subject to the Preferred Provider limit. Preferred Provider/prescription drug coinsurance and copayment amounts do not cross-apply to the Nonpreferred Provider out-of-pocket limit amount, or vice versa.

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 Benefit Booklet for a list of services requiring preauthorization.

5 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. See a Benefit Booklet for details

6 Rental benefits will not exceed the purchase price of a new unit.

7 Prescription drugs and other items covered only under the drug plan (e.g., diabetic supplies) must be purchased at a pharmacy that participates in the Retail Pharmacy or Mail Order Service programs. (BCBSNM has contracted with a separate program for administration of your drug plan benefits.)

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.

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.