Archdiocese of Santa Fe
EPO Plan

Blue Cross and Blue Shield of New Mexico

Highlights deductible and out-of-pocket limit amounts; copayments; member coinsurance percentage amounts; and provides a brief description of Archdiocese of Santa Fe health care plan benefits.

Benefit Summary – This plan does **not** cover services received from nonpreferred providers, except in an emergency.		**Member's Share of Covered Charges from a Preferred Provider**
Calendar Year Deductible – (January – December) (Only covered charges for services subject to percentage "coinsurance" amounts apply toward deductible.)[1]		$500 ($1,500/family)
Calendar Year Out-of-Pocket Limit - (January - December) (Includes: Deductible, Coinsurance and Copayments only; not prescription drugs, penalty amounts or noncovered charges)[2]		$2,500 ($7,500/family)
Lifetime Maximum Benefit		Unlimited; certain services have calendar year or benefit period limitations, as listed below.
Primary Preferred Provider (PPP) Office Services *		
Office Visit**, Medication Management ** Virtual Visit (MDLIVE provider)		$20 $20
Office Surgery (including cast, splints, and dressings)		$20
Mental Health/Chemical Dependency Services (office visit only) Virtual Visit (MDLIVE provider)		$20 $20
Specialty Physician Office Services		
Office Visit**, Medication Management**, Office Evaluations**		$35
Office Surgery (including cast, splints, and dressings)		$35
Preventive Care (Outpatient/office adult medical care/routine exams; well-child care; vision and hearing screening; mammogram, routine colonoscopy, lab, X-ray, and immunizations)		No Charge
Acupuncture/Spinal Manipulation (max. **25 visits**/year/combined)		$35
Allergy Services (testing and injections)	**Primary Provider**	$20
	Specialist	$35
Allergy Serum		50%
Ambulance Services		$75 per trip/ground or $150 per trip/air[3]
Autism Spectrum Disorders Applied Behavioral Analysis[3]; Occupational, Physical, and Speech Therapy		$20
Cardiac and Pulmonary Rehabilitation (outpatient)		$35
Dental/Facial Accidents, Oral Surgery, TMJ/CMJ Services		Based on place of treatment and type of service[3,4]
Durable Medical Equipment, Supplies, Prosthetics, and Orthotics		20%[5]
Emergency and Urgent Care Services Emergency Room (includes all related ER services) Observation Room (including pregnancy) Urgent Care Facility		 $120 $120 $35
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 (prescribed home nursing care, physician, and therapy care – max. **100 visits/**year)		20%
Hospice - **inpatient**		20%[4]
Hospice - home		No Charge after deductible[3]

* A Primary Preferred Provider (PPP) 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.

** If therapy is received or diagnostic tests are performed during the visit, please see additional services listed on this summary. In such cases, you will pay both the office visit copay – if an office exam is billed – and the amount due for the therapy or diagnostic test.

Benefit Summary – 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 and Physician Care such as Physician Visits, Surgeon, Anesthesiologist, Lab, X-Ray, Other Diagnostic Tests, Residential Treatment Center (RTC), Medical/Surgical, and Mental Health/Chemical Dependency (including partial hospitalization)	20%[4]
Maternity – initial visit to diagnose pregnancy Maternity – prenatal and post-delivery exams, inpatient delivery Newborn Care – must be enrolled within 31 days of birth	Office copay for initial visit 20%[4] 20%[4]
Lab Tests, X-Rays, EKGs, CT Scans[3], PET Scans[3] and Other Diagnostic Services (including tests done in office, outpatient facility, freestanding facility, ambulatory surgery facility, or any other place of treatment)	No Charge
MRI (outpatient facility, freestanding facility, ambulatory surgery facility, or any other place of treatment)[3]	$50 copay per test
Outpatient Facility/Surgeon/Physician (including surgical procedures related to pregnancy and family planning; nonroutine colonoscopies)	20%
Short-Term Rehabilitation: **Inpatient Rehabilitation/Skilled Nursing Facility** **Outpatient/Office, Occupational, Physical and Speech Therapy** (max. **60 days/visits/**year for all services combined)	20%[4] $20 copay
Therapy: Chemotherapy, Dialysis, and Radiation Therapy	$100[3]
Transplant Services (Must use facilities that contract with BCBSNM or through 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]

Prescription Drugs, Insulin, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods				
Copayments are not applied to medical out-of-pocket; there is a separate Prescription out-of-pocket listed below. Certain drugs, special medical foods, and enteral nutritional products require preauthorization or benefits will be denied.	**Generic Drug**	**Brand-Name Drug**		
		If a generic equivalent is available and you or your doctor order the brand-name drug, you pay:	**If there is no generic equivalent available:**	
			On Drug List	**Not on Drug List**
Retail Pharmacy Program (up to a 30-day supply or 120 units, whichever is less)	$10	$10 plus difference in covered charge between the brand-name and the generic equivalent	$35	$75
Specialty Pharmacy Drug	**15%** of covered charge up to a maximum copayment of **$125** per prescription			
Mail-Order Service (up to a 90-day supply or 360 units, whichever is less)	2.5 times retail pharmacy copayment (Specialty pharmacy drugs are not available through Mail-Order Service)			
Nonprescription enteral nutritional products and special medical foods	**50%** of covered charges[3]			
Prescription Drug Out-of-Pocket Limit	**$1,500/Individual or $3,000/Family**			

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. Deductibles, copayments, and coinsurance percentages 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.

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