



Summary of Benefits and Plan Options

This summary provides you with the deductible, copayment, coinsurance, out-of-pocket amounts, and very brief descriptions of your New Mexico Federal High Risk Pool benefits.

NM State High Risk Pool Benefits	The deductible you choose defines the percentage of covered charges* that the FHRP will pay after deductible is met			
	80% Plans			100% Plans
Deductible Options (Per Enrollee): Unless otherwise indicated, the calendar year deductible must be met before benefit payments are made. For families of three or more, the annual deductible for all family members combined is twice the Individual amount chosen.	\$500	\$1000	\$2000	\$5000, \$7500 or \$10,000
Medical Out-of-Pocket Limit (Per Enrollee): Includes coinsurance and deductible amounts only. After the out-of-pocket limit is met, the Pool pays 100% of your covered charges for the rest of the calendar year. For families of three or more, the annual out-of-pocket limit is twice the individual amount chosen.	\$2500	\$3500	\$5000	N/A – The Pool pays 100% of covered charges after the deductible is met
Lifetime Maximum	There is no overall lifetime maximum payment limit. There are specific maximums for certain procedures.			
Covered Services	After Deductible, the Pool Pays*:			
	80% Plans		100% Plans	
Acupuncture (max. benefit \$1,500/calendar year)	80%		100%	
Ambulance	80% ¹		100% ¹	
Autism Spectrum Disorders (max. \$36,000 each calendar year; up to \$200,000 in a lifetime for all services combined; covered services include physical, speech and occupational therapy and applied behavioral analysis when part of a prior-approved treatment plan.)	80% ¹		100% ¹	
Chemical Dependency Services: Alcoholism and Drug Abuse (Lifetime maximum of two 12-month benefit periods) Inpatient Services (max. 30 days/visits per calendar year) Outpatient/Office Services (max. 30 visits per calendar year)	80% ^{1,2}		100% ^{1,2}	
Dental/Facial Accidents, Oral Surgery, TMJ Services	80% ^{1,2}		100% ^{1,2}	
Diabetic Services Self-Management Education (max. benefit \$800/calendar year and a lifetime maximum benefit payment of \$2,500) Diabetic Supplies and Equipment	80% ³		100% ³	
Diagnostic Services: Lab and X-Ray (Including Routine Pap Tests and Mammograms)	80% ¹		100% ¹	
Outpatient Preadmission Testing (within 10 days of admission)	100% ³		100% ³	
Equipment, Supplies, Prosthetics, Orthotics, Appliances	80% ¹		100% ¹	
Hearing Aids and Related Services	80% ¹		100% ¹	
Home Health Care/Home I.V. Services (max. 100 visits/calendar year)	80% ¹		100% ¹	
Hospice Care (limited to two six-month benefit periods)	80% ^{1,3}		100% ^{1,3}	
Hospital/Facility Services (including medical detoxification and mental health conditions) Note: Also see "Therapy and Rehabilitation," "Skilled Nursing Facility," "Chemical Dependency," "Routine Maternity " or "Pregnancy complications."				
Room and Board (including special care units), Other Hospital Services, and Physician Care such as Physician Visits, surgeon, Obstetrician, and Anesthesiologist	80% ²		100% ²	
Emergency Room, Observation, and Outpatient Services	80%		100%	
Newborn Care for Covered Newborn Infants (Application must be made within 31 days of birth)	80% ²		100% ²	
Physician Medical Visits (Inpatient, Outpatient, Emergency Room, Urgent Care Facility and Office)				
Physician Care or Provider Visit, Exam, Consultation	80%		100%	
Allergy Injections/Testing: Therapeutic Injections	80%		100%	
Mental Health Services, Inpatient and Outpatient	80% ^{1,2}		100% ^{1,2}	

See footnotes on next page



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New Mexico State High Risk Pool

Covered Services	After Deductible, the Pool Pays*:	
	80% Plans	100% Plans
Preventive Services		
Well Baby Care, Routine Child Care, Immunizations and Routine Vision or Hearing Screening (through age 17): Maximum benefit of \$500 per child/calendar year: thereafter, covered services are subject to usual deductible and coinsurance	100% ³	100% ³
Routine Adult Exams and Tests, such as Pap Tests, Mammograms, Prostate Exams, Colonoscopy: Other Routine Testing (over age 17): Maximum benefit of \$500 per member/calendar year: thereafter covered services are subject to usual deductible and coinsurance	100% ³	100% ³
Routine Maternity/Elective Termination of Pregnancy: Includes routine delivery, pre- and post-natal care, anesthesia, assistant, diagnostic tests, elective abortion (Subject to the pre-existing conditions exclusion <i>Section 4</i> , unless you are a HIPAA-eligible individual or had prior routine maternity coverage per <i>Section 3</i> .)	80% ^{1,2}	100% ^{1,2}
Pregnancy Complications	80% ^{1,2}	100% ^{1,2}
Therapy and Rehabilitation: Cardiac and Pulmonary Rehabilitation Chemotherapy, Dialysis, and Radiation Therapy Occupational, Physical and Speech Therapy, Outpatient Joint Manipulation/Alignment (max. benefit \$1500/calendar year) Physical rehabilitation, Inpatient (max. 30 days/calendar years)	80% ^{1,2}	100% ^{1,2}
Skilled Nursing Facility Care (Max. 100 days/calendar year)	80% ²	100% ²
Smoking/Tobacco Cessation Counseling (up to 90 minutes total provider contact time OR two multi-session group counseling programs per calendar year from approved providers)	80% ^{1,2}	100% ^{1,2}
Surgery, Inpatient and Outpatient (including reconstructive surgery, mastectomy coverage, and morbid obesity surgery)	80% ²	100% ^{1,2}
Transplant Services (Must be received at a participating transplant facility, Lifetime max. benefit per member of \$5,000,000. Additional maximums apply: see Section 3.)	80% ^{1,2}	100% ^{1,2}

Prescription Drugs, Insulin, Diabetic Supplies, Special Medical Foods

Out-of-pocket limit and deductible provision do not apply. Oral contraceptives are covered. Special medical foods and certain drugs require prior approval or benefits will be denied. Prescription drugs for smoking/tobacco use cessation are limited to **two 90-day** courses of drug therapy when prior-approved by the BCBSNM.⁴ In order to receive benefits for specialty pharmacy drugs, you are required to purchase such drugs from a specialty pharmacy provider that contracts with the Administrator.

Drug Plan Program and Supply Limitations*	Generic Drug	Brand Name Drug (NO generic equivalent)	Brand Name Drug (with generic equivalent)
Retail and Specialty Pharmacy Programs: During each one-month period, up to a 30-day supply or 180 units (e.g. pills), whichever is less.	\$10	\$30% or \$10, whichever is greater, up to a maximum copayment of \$250	\$10 plus difference in cost between generic drug and brand-name purchased
Mail-Order Plan: During each three-month period, up to a 90-day supply or 540 units (e.g. pills), whichever is less	\$30	30% or \$30, whichever is greater, up to a maximum copayment of \$750)	\$30 plus difference in cost between generic drug and brand-name purchased

* For commercially packaged items (such as an inhaler, a tube of ointment, or a blister pack of tablets), you will pay the applicable copayment or percentage amount for a 30-day supply – usually one packaged item – under the retail pharmacy and specialty pharmacy programs. You will pay three times that amount for up to a 90-day supply of the same item purchased through the mail-order program.

1-For some services, no benefits are available if prior approval is not obtained from the Administrator. See Section 2 for a list of services requiring prior approval. **Services for autism spectrum disorders and transplants must be received from a participating provider in order to be covered.**

2-Admission review is required for inpatient admissions: benefits for facility services are reduced by 20 percent if admission review is not obtained before the member is admitted (or within 48 hours of admission in an emergency or for pregnancy-related admissions).

3-Not subject to deductible

4-Prescription drugs, insulin, diabetic supplies, and special medical foods must be purchased at a pharmacy that participates in the Retail and/or Specialty Pharmacy or Mail Service Programs. If a generic equivalent is available and you or your provider request the brand-name, you must pay the generic drug copayment in addition to the difference in total covered drug costs between the brand-name and generic drug.

NOTE: Billed charges and covered charges are not the same. The “covered charge” is the amount that NMMIP determines is fair and reasonable for a particular covered service. It is often less than the billed charge. NMMIP will pay the provider 80% of covered charges after you have paid your share (e.g. deductible, coinsurance, copayment, penalty amount) or 100% of covered charges for preventive services. If you choose a participating provider, you will only have to pay up to the covered charge amount. If you choose a nonparticipating provider, you will have to pay the difference.

Customer Service: (800) 432-0750