

Archdiocese of Santa Fe

EPO Plan



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**, Virtual Visit, Medication Management **	\$20	
Office Surgery (including cast, splints, and dressings)	\$20	
Mental Health/Chemical Dependency Services (outpatient/office/virtual visit)	\$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	Usual copays or coinsurance based on place of treatment ³ and type of service	
Cardiac and Pulmonary Rehabilitation (outpatient)	\$35	
Dental/Facial Accidents, Oral Surgery, TMJ/CMJ Services	Usual copays or coinsurance 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 2 hearing aids 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 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.

Blue Cross and Blue Shield of New Mexico (BCBSNM) is a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

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 Scans³, PET Scans³ 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 and Outpatient/Office Occupational, Physical and Speech Therapy; Including Inpatient Rehabilitation/Skilled Nursing Facility (max. 60 days/visits/year for all services combined)		20% ⁴		
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		Usual copays or coinsurance based on place of treatment and type of service ^{3,4}		
Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney (\$10,000 maximum for travel and lodging per diem)				
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:

- 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.
- 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.
- Certain services are not covered if preauthorization is not obtained from BCBSNM. See a benefit booklet for details.
- 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.
- 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.