BlueChoice® $20

Summary of Benefits and Plan Options

$20 PPP Office Visit Copayment, 20% In-Network Coinsurance, 40% Out-of-Network Coinsurance

This is a summary only that lists the deductible options, coinsurance, and out-of-pocket features, and provides a very brief description of BlueChoice $20 Plan benefits. Your ID card will show the PPO deductible amount selected. For more complete information, see the *BlueChoice Member's Benefit Booklet (M494).*

BlueChoice Benefits – There is no lifetime maximum benefit. However, certain services have maximum annual limits. See below.	**Member Share of Covered Charges**	
	Preferred Provider (PPO)[1]	**Nonpreferred Provider**[1]
Calendar Year Deductible Options (per individual) – New members should refer to their ID card to verify the individual PPO deductible amount chosen. Family deductible is three times individual amount chosen.[1]	$ 250 $ 500 $1,000 $2,000	(Based on PPO amount chosen) $ 500 $1,000 $2,000 $4,000
Annual Out-of-Pocket Limit – Includes only coinsurance - does not include deductible, copayments, penalty amounts, or noncovered charges.[2]	$2,000 ($5,000/family)	$4,000 ($10,000/family)
Primary Preferred Provider (PPP) Office Visit/Exam Copayment (including Physicals): All other services received during the office visit to the PPP are subject to deductible and coinsurance as listed below.	$20 per office visit (deductible waived)	Not applicable
Other Office Services: Includes all other services received during a PPP office visit and services of non-PPP providers (including routine exams and physicals).	20%	40%
Non-PPP Office Visit; Office Surgery (including casts, splints, and dressings)	20%	40%
Allergy Injections, Tests, Serum; Immunizations	20%	40%
Lab Tests, X-Rays, EKGs, Other Diagnostic Tests	20%[4]	40%[4]
Routine Vision or Hearing Examinations (screening only through age 17)	20%	40%
Accident Treatment (BCBSNM pays 100% of covered charges for first $500/year for services received within 90 days of accident; thereafter, services paid as any other service.)	20%	40%[3]
Acupuncture Treatment (max. **$1500**/year)	20%	No benefit
Ambulance Services: Ground and Emergency Air Transport	20%	
Ambulance Services: Nonemergency Air Transfer	20%[4]	40%[4]
Cardiac and Pulmonary Rehabilitation	20%[4]	No benefit
Dental/Facial Accidents, Oral Surgery, and TMJ/CMJ Services	20%[4]	40%[4]
Emergency Room Treatment and Urgent Care Facility	20%	40%[3]
Home Health Care/Home I.V. Services/Hospice (max. **100 visits**/year)	20%[4]	40%[4]
Inpatient Services (See "Short-Term Rehabilitation" for physical rehabilitation and skilled nursing facility services. Also, see "Transplant Services," if applicable.)		
Room and Board and Physician Care such as Physician Visits, Surgeon, and Anesthesiologist	20%[5]	40%[5]
Routine Nursery Care for Covered Newborn Infants	20%	40%

* **Note:** A "PPP" is any preferred provider with a specialty of Family Practice, Internal Medicine, General Practice, Gynecology, Pediatrics, or OB/GYN.

See footnotes on back.

BlueChoice Benefits (continued) – There is no lifetime maximum benefit. However, certain services have maximum annual limits. See below.	**Member Share of Covered Charges**	
	Preferred Provider (PPO)[1]	**Nonpreferred Provider**[1]
Lab, X-Ray, and Other Diagnostic Tests	20%[4]	40%[4]
Prescription Drugs, Insulin, Diabetic Supplies, Nutritional Products, Special Medical Foods	See your separately issued Prescription Drug Plan Rider.	
Prosthetics and Orthotics	20%[4,6] (Unlimited benefit)	40%[4,6] (Max. **$1000**/year)
Short-Term Rehabilitation: Occupational, Physical, and Speech Therapy; including Physical Rehabilitation/Skilled Nursing Facility **Inpatient Rehabilitation** (max. **30 days**/year) **Outpatient and Office Rehabilitation** (max. **$3,500**/year)	20%[4,5]	No benefit
Spinal Manipulation (max. **$1,500**/year)	20%	No benefit
Supplies and Durable Medical Equipment	20%[4,6] (Unlimited benefit)	40%[4,6] (Max. **$1000**/year)
Surgery, Inpatient or Outpatient (For transplants, see "Transplant Services," below)	20%[4,5]	40%[4,5]
Therapy: Chemotherapy, Dialysis, and Radiation	20%[4]	40%[4]
Transplant Services (Must be received at a facility that contracts with BCBSNM or with our national transplant network.)		
Cornea, Kidney, and Bone Marrow	20%[4,5]	No benefit
Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney (Services are subject to a separate $5,000 out-of-pocket limit per transplant type. Additional benefit maximums also apply. Calendar year deductible does not apply.)	20%[4,5]	No benefit

ADDITIONAL FEATURES AND LIMITATIONS:

Age limit for children: Children are covered only through age 24.

Charges for PPP office visits: The member's copayment is $20 per office visit to a Primary Preferred Provider (PPP) in our Preferred network of physicians. An annual deductible, plus a percentage of charges, applies to lab work, x-rays, and other covered services.

Choose who is covered: Coverage is offered just for kids, just for adults, or for the whole family.

Choose your providers: Members choose from our national network of Primary Preferred Providers (PPPs) and preferred specialists for lowest out-of-pocket costs. Or members may see other providers for covered services and receive less extensive benefits. (Some benefits are not available if services are received from nonpreferred providers.)

Services not covered: There are no benefits for maternity or pregnancy-related services, mental health services, or alcoholism and substance abuse treatment. Transplants must be received at facilities that contract with BCBSNM or through our national transplant network and must be prior-approved in order to be covered.

FOOTNOTES:

1 The member's initial covered charges that are incurred in a calendar year are applied to the calendar year deductible; the deductible must be met before benefit payments are made (excluding services for which you pay **only** a fixed-dollar copayment, such as for PPP office visits). Preferred Provider deductible amounts do not cross-apply to the Nonpreferred Provider deductible amount, or vice versa.

2 After a member reaches the applicable out-of-pocket limit, BCBSNM pays 100 percent of that member's Preferred or Nonpreferred Provider covered charges, whichever is applicable. Fixed-dollar office visit copayments are not applied to the out-of-pocket limit, and will not be waived after the limit is met. Preferred Provider coinsurance 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 prior approval is not obtained from BCBSNM. See a Benefit Booklet for a complete list of services requiring prior approval.

5 Admission review is required for admissions; you pay a $300 penalty for covered facility services if not obtained. See a Benefit Booklet for details.

6 Rental benefits for medical equipment and other items will not exceed purchase price of a new unit.

IMPORTANT: Deductibles, copayments, and coinsurance percentages are applied to BCBSNM's covered charges, which may be less than billed charges. Preferred providers will not charge you the difference between the covered charge and the billed charge for covered services; nonpreferred providers may.

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