

# BlueNet<sup>®</sup> 500/2000

## Summary of Plan Benefits



Blue Cross and Blue Shield  
of New Mexico

**This is a summary only** that lists the individual and family deductible and out-of-pocket limit amounts; lists applicable member coinsurance percentage amount options; and provides a brief description of BlueNet health care plan benefits. Your member ID card will show the chosen deductible and office visit copayment amount.

<b>Benefit Summary</b> – This plan does <b>not</b> cover services received from nonpreferred providers, except in an emergency.		<b>Member's Share of Covered Charges From a Preferred Provider</b>			
<b>Annual Deductible</b> (Except for diagnostic lab and x-ray – which are not subject to a deductible -- only covered charges for services subject to percentage “coinsurance” amounts apply towards deductible.) <sup>1</sup>		\$500 (\$1,500/family)			
<b>Annual Out-of-Pocket Limit</b> (Coinsurance and copayments only apply; deductible, penalty amounts, and noncovered charges do not.) <sup>2</sup>		\$2,000 (\$6,000/family)			
<b>Lifetime Maximum Benefit</b>		Unlimited; certain services have calendar year or benefit period limitations, as listed below.			
<b>Plan Options</b>		<b>Option A</b>	<b>Option B</b>	<b>Option C</b>	<b>Option D</b>
<b>Primary Provider Services</b> *		\$15	\$20	\$25	\$30
Office Visit**, Medication Management **		\$15	\$20	\$25	\$30
Office Surgery (including casts, splints, and dressings)		\$15 <sup>3</sup>	\$20 <sup>3</sup>	\$25 <sup>3</sup>	\$30 <sup>3</sup>
Preventive Care (Adult medical care/routine exams; well child care; vision/hearing screening for members age 17 and under)		\$15	\$20	\$25	\$30
<b>Specialty Physician Services</b>		\$30	\$35	\$40	\$45
Office Visit**, Medication Management**, Office Evaluations**		\$30	\$35	\$40	\$45
Office Surgery (including casts, splints, and dressings)		\$30 <sup>3</sup>	\$35 <sup>3</sup>	\$40 <sup>3</sup>	\$45 <sup>3</sup>
<b>Lab Tests, X-Rays, EKGs, MRIs, &amp; Other Diagnostic Services</b> (including tests done in office, outpatient facility, freestanding facility, ambulatory surgery facility, or any other place of treatment)		20% No deductible	20% No deductible	30% No deductible	30% No deductible
<b>Allergy Services</b> (testing and injections)	<b>Primary Provider</b>	\$15	\$20	\$25	\$30
	<b>Specialist</b>	\$30	\$35	\$40	\$45
<b>Allergy Serum</b>		50%			
<b>Ambulance Services</b>		\$75 per trip/ground or \$150 per trip/air			
<b>Emergency and Urgent Care Services</b>					
Emergency Room (includes all related ER services)		\$120	\$120	\$240	\$240
Observation Room (including pregnancy)		\$120	\$120	\$240	\$240
Urgent Care Facility		\$35	\$35	\$70	\$70
<b>Dental/Facial Accidents, Oral Surgery, TMJ/CMJ Services</b>		Usual copays or coinsurance based on place of treatment and type of service <sup>3,4</sup>			
<b>Hearing Aids and Related Services:</b> Hearing aids for members under age 21 are paid at 100% of covered charges up to a maximum of \$2,200 per ear during any 3-year period; exams and testing are subject to usual cost-sharing provisions. These services are not covered for members age 21 and older.					
<b>Hospice – inpatient</b>		20% <sup>4</sup>		30% <sup>4</sup>	
<b>Hospice – home</b>		No charge			

\* A Primary Provider is a 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.

**See footnotes on back.**

<b>Benefit Summary</b> – Except in an emergency, services received from nonpreferred providers are not covered under this plan.	<b>Member's Share of Covered Charges</b>			
<b>Plan Options</b>	<b>Option A</b>	<b>Option B</b>	<b>Option C</b>	<b>Option D</b>
<b>Home Health Care</b> (prescribed home nursing care, physician, and therapy care – <b>100 visits</b> per calendar year)	20% <sup>4</sup>		30% <sup>4</sup>	
<b>Inpatient Hospital/Facility Services</b> (See “Short-Term Rehabilitation” for physical rehabilitation and skilled nursing facility admissions and “Transplant Services,” “Psychotherapy,” or “Chemical Dependency,” if applicable.)				
Room and Board and Physician Care such as Physician Visits, Surgeon, and Anesthesiologist, Lab, X-Ray, and other Diagnostic Tests	20% <sup>4</sup>		30% <sup>4</sup>	
Maternity – initial visit to diagnose pregnancy Maternity – prenatal & post delivery exams, inpatient delivery Newborn Care – must be enrolled within 31 days of birth.	Office copay for initial visit 20% <sup>4</sup>		Office copay for initial visit 30% <sup>4</sup>	
<b>Prescription Drugs, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods, Smoking/Tobacco Cessation</b>	See your separately issued Prescription Drug Plan Rider.			
<b>Psychotherapy: Mental Health Rehabilitation</b>				
Inpatient Rehab (max. <b>30 days</b> per calendar year) <sup>4</sup> Outpatient/Office Rehab (limit <b>\$3,500</b> per calendar year) <sup>3</sup>	20% <sup>3,4</sup>		30% <sup>3,4</sup>	
<b>Chemical Dependency (Alcoholism/Drug Abuse) Rehabilitation:</b> Limited to services received during two 12-month benefit periods. Inpatient Rehab (max. <b>30 days</b> per calendar year) <sup>4</sup> Outpatient/Office Rehab (limit <b>\$3,500</b> per calendar year) <sup>3</sup>	20% <sup>3,4</sup>		30% <sup>3,4</sup>	
<b>Short-Term Rehabilitation:</b> Occupational, Physical, and Speech Therapy; and Spinal Manipulation, including Skilled Nursing Facility Inpatient Rehabilitation (max. <b>30 days</b> /calendar year) <sup>4</sup> Outpatient/Office Rehabilitation (limit <b>\$3,500</b> /calendar year) <sup>3</sup>	20% <sup>3,4</sup>		30% <sup>3,4</sup>	
<b>Smoking/Tobacco Cessation Counseling</b> (90 minutes total or two group sessions per calendar year)	20%		30%	
<b>Supplies, Equipment, Prosthetics, and Orthotics</b> (equipment and supplies over \$500 require prior approval)	20% <sup>3,5</sup>		30% <sup>3,5</sup>	
<b>Surgery, Outpatient Facility</b> (including surgical procedures related to pregnancy and family planning)	20% <sup>3</sup>		30% <sup>3</sup>	
<b>Surgery, Outpatient Physician/Surgeon</b> (including surgical procedures related to pregnancy and family planning)	20% <sup>3</sup>		30% <sup>3</sup>	
<b>Therapy: Chemotherapy, Dialysis, and Radiation Therapy</b>	\$100/Visit <sup>3</sup>			
<b>Transplant Services</b> (Must use facilities that contract with BCBSNM or through the national BCBSNM transplant network.)				
Cornea, Kidney, Bone Marrow	Usual copays or coinsurance based on place of treatment and type of service			
Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney: <b>\$10,000</b> maximum for travel, food, and lodging (travel + <b>\$125</b> per diem)				

**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, and outpatient diagnostic testing are not subject to a deductible.)

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 prior approval is not obtained from BCBSNM (or Mesa Mental Health). See a benefit booklet for details.

4 Admission review is required for inpatient admissions. You pay a \$400 penalty for covered facility services if approval is not obtained. Some services, such as transplants, require additional approval. If you do not receive approval 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.