BlueNet® "H"

Summary of Benefits & Plan Options

Blue Cross and Blue Shield of New Mexico

This is a summary only that lists copayment and coinsurance amounts and provides a brief description of BlueNet "H" EPO 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**
Annual Out-of-Pocket Limit (Copayments and coinsurance amounts only apply; penalty amounts, and noncovered charges do not.) [1]		$2,500 ($7,500/family) [1]
Lifetime Maximum Benefit		Unlimited; certain services have calendar year or benefit period limitations, as listed below.
Primary Provider (PPP) Services *		$15
Office Visit, Medication Management		$15
Office Surgery (including casts, splints, and dressings)		$15 [2]
Specialty Physician Services		$30
Office Visit, Medication Management, Office Evaluations		$30
Office Surgery (including casts, splints, and dressings)		$30 [2]
Preventive Care Services (Adult medical care/routine exams; well child care; mammograms; preventive/ routine colonoscopies (office and outpatient facility); vision/hearing screening for members age 17 and under)	**Primary**	$15
	Specialist	$30
Lab Tests, X-Rays & Other Basic Diagnostic Services (including tests done in office, outpatient facility, freestanding facility, or any other place of treatment)		No Charge
MRI, PET Scan, CT Scan		$50 [2]
Allergy Services (testing, injections and serum)	**Primary**	$15
	Specialist	$30
Acupuncture and Chiropractic Services (max. **$1,500**/year)		$30
Ambulance Services		$75 per trip/ground or $150 per trip/air [2]
Emergency and Urgent Care Services Emergency Room (includes all related ER services) Observation Room (including pregnancy) Urgent Care Facility		 $100 $100 $45
Dental/Facial Accidents, Oral Surgery, TMJ/CMJ Services		Usual copays or coinsurance based on place of treatment and type of service
Hearing Aids and Related Services: Hearing aids for members under age 21 are paid at 100% of covered charges up to a maximum of **$2,200** 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.		
Hospice – Inpatient and Home (lifetime max. **$10,000**)		No charge [2, 3]
Home Health Care (prescribed home nursing care, physician, and therapy care – **100 visits**/year)		No charge [2]

* A "PPP" (or Primary Preferred Provider) 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.

See footnotes on back.

Benefit Summary – Except in an emergency, services received from nonpreferred providers are not covered under this plan.	**Member's Share of Covered Charges**
Inpatient Hospital/Facility Services (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	$500/admit [3]
Maternity – initial visit to diagnose pregnancy Maternity – prenatal & post delivery exams, inpatient delivery Newborn Care – must be enrolled within 31 days of birth.	OV copay $500/admit [3] $500/admit [3]
Outpatient Facility (including surgical procedures related to pregnancy and family planning, nonroutine colonoscopies)	$150/visit [2]
Outpatient Physician/Surgeon (including surgical procedures related to pregnancy and family planning, and nonroutine colonoscopies)	No Charge [2]
Prescription Drugs, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods, Smoking/Tobacco Cessation	See Drug Plan Rider for details.
Psychotherapy: Mental Health Rehabilitation **Inpatient, Outpatient/Office Rehab** (max. **60 days/visits/**year for all services combined)	$500/admit [3] OV copay [2]
Chemical Dependency (Alcoholism/Drug Abuse) Rehabilitation: Limited to services received during two 12-month benefit periods. **Inpatient (**max. **30 days/**year) **Outpatient/Office Rehab** (max. **$3,500**/year)	$500/admit [3] OV copay [2]
Short-Term Rehabilitation: Occupational, Physical, and Speech Therapy; including Skilled Nursing Facility **Inpatient, Outpatient/Office Rehab** (max. **60 days/visits/**year for all services combined)	$500/admit [3] OV copay [2]
Smoking/Tobacco Cessation Counseling (90 minutes total or two group sessions/year)	OV Copay
Supplies, Equipment, Prosthetics, and Orthotics (equipment and supplies over $500 require prior approval)	50%[2,4]
Therapy: Chemotherapy, Dialysis, and Radiation Therapy	No Charge [2]
Transplant Services (Must use facilities that contract with BCBSNM or through the national BCBS transplant network.)	
Cornea, Kidney, Bone Marrow	Usual copays based on place of treatment and type of service [2,3]
Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney: **$10,000** maximum for travel, food, and lodging (travel + **$125** per diem)	

FOOTNOTES:

1 There is no deductible to meet. After a member (or family) reaches the out-of-pocket limit during a calendar year, BCBSNM pays 100 percent of that member's (or family's) covered charges for the remainder of the calendar year.

2 Certain services are not covered if prior approval is not obtained from BCBSNM (or Mesa Mental Health). See a benefit booklet for details.

3 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.

4 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. Copayment and/or coinsurance amounts 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.

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.