

Blue PPO

Summary of Benefits and Plan Options



Blue Cross and Blue Shield of New Mexico

This is a summary only that lists the deductible, out-of-pocket limit, and prescription drug copayment options, member coinsurance amounts, and provides a brief description of Blue PPO Plan benefits.

Blue PPO Benefits — There is no lifetime maximum benefit. However, certain services have maximum annual limits. See below.	Member's Share of Covered Charges	
	Preferred Provider ¹	Nonpreferred Provider ¹
Calendar Year Deductible Options (per individual) – Check your ID card for the amount chosen by your group. (Family deductible is three times individual amount chosen. ¹)	\$250 \$500 \$1,000 \$2,000	\$500 \$1,000 \$2,000 \$4,000
Annual Out-of-Pocket Limit Options – Check your ID card for the amount chosen by your group. (Includes coinsurance only – NOT deductible, copayments, penalty amounts, or noncovered charges.) ²	\$2,000 (\$5,000/family) OR \$4,000 (\$10,000/family)	\$4,000 (\$10,000/family) OR \$8,000 (\$20,000/family)
PPO Primary 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	20%	40%
Office Surgery (including casts, splints, and dressings)	20% ⁴	40% ⁴
Lab Tests, X-Rays, EKGs, Other Diagnostic Tests	20% ⁴	40% ⁴
Immunizations, Allergy Injections, Tests, Serum	20%	40%
Routine Vision or Hearing Screenings (only through age 17)	20%	40%
Acupuncture Treatment (max. \$1,500/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, Outpatient	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
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.		
Home Health Care/Home I.V. Services (max. 100 visits/year)	20% ⁴	40% ⁴
Hospice Services (lifetime max. \$10,000)	20% ⁴	40% ⁴
Inpatient Hospital/Facility Services (See “Short-Term Rehabilitation” for physical rehabilitation and skilled nursing facility admissions. See “Psychotherapeutic Services” for inpatient treatments related to mental health or chemical dependency. See “Transplant Services,” if applicable.)		
Medical/Surgical and Maternity-Related Room and Board and Covered Ancillaries	20% ⁵	40% ⁵
Routine Nursery Care for Covered Newborns	20%	40%
Lab, X-Ray, and Other Diagnostic Tests	20% ⁴	40% ⁴
Maternity Services , including Routine Inpatient Pediatrician Care for Covered Newborns (also see “Inpatient Hospital/Facility Services”)	20% ⁵ (plus \$20 copay for first office visit if to a PPP)	40% ⁵

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.

See footnotes on back.

Blue PPO Benefits — There is no lifetime maximum benefit. However, certain services have maximum annual limits. See below.	Member's Share of Covered Charges	
	Preferred Provider ¹	Nonpreferred Provider ¹
Prescription Drugs, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods, & Smoking/Tobacco Cessation	See your separately issued Prescription Drug Plan Rider	
Prosthetics and Orthotics	20% ^{4,6} (Unlimited benefit)	40% ^{4,6} (Max. benefit of \$1,000/year)
Psychotherapeutic Services, Inpatient and Outpatient (Includes mental health services and chemical dependency rehabilitation. Prior authorization is required. Chemical dependency also limited to services received within a maximum of two 12-month benefit periods.)	20% ^{4,5}	No benefit
Short-Term Rehabilitation, Inpatient and Outpatient (Includes services in a rehabilitation facility or skilled nursing facility, and outpatient physical, occupational, and speech therapy services. Prior authorization is required.)	20% ^{4,5}	No benefit
Spinal Manipulation Services (max. \$1,500/year)	20%	No benefit
Supplies and Durable Medical Equipment	20% ^{4,6} (Unlimited benefit)	40% ^{4,6} (Max. benefit of \$1,000/year)
Surgery, Inpatient or Outpatient (For transplants, see "Transplant Services," below)	20% ^{4,5}	40% ^{4,5}
Smoking/Tobacco Cessation Counseling (90 minutes total or 2 group sessions per calendar year)	20% ⁴	No benefit
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		
Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney (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

FOOTNOTES:

1 The deductible must be met before benefit payments are made (excluding hearing aids, PPP office visits, for which you pay a \$20 copayment, but including all other services billed during a PPP office visit and excluding specified transplant services). **Note:** A "PPP" is any preferred provider with a specialty of Family Practice, Internal Medicine, General Practice, Gynecology, Pediatrics, or Obstetrics/ Gynecology. Deductible amounts do not cross-apply in the Preferred Provider and Nonpreferred Provider benefit levels. See the Blue PPO Member's Benefit Booklet for details.

2 After a member reaches the applicable out-of-pocket limit, BCBSNM pays 100 percent of most of that member's covered Preferred or Nonpreferred Provider charges, whichever is applicable, for the rest of the calendar year. Out-of-pocket amounts do not cross-apply in the Preferred Provider and Nonpreferred Provider benefit levels. Copayments are not applied to the out-of-pocket limit and are not waived once the out-of-pocket limit is met. Specified transplant services are subject to a separate out-of-pocket limit.

3 Initial treatment of a medical emergency is paid at the Preferred Provider level. Follow-up treatment and treatment that is not for an emergency is paid at the Nonpreferred Provider level.

4 Certain services are not covered if prior approval is not obtained from BCBSNM. See a Member's Benefit Booklet for a list of services requiring prior approval.

5 Admission review is required for inpatient admissions. You pay a \$300 penalty for covered medical/surgical facility services if approval is not obtained. Some services, such as transplants and physical rehabilitation require additional approval. If you do not receive approval for these individually identified procedures and services, benefits for any related admissions will be denied. The \$300 penalty will not apply in such cases. See a Member's Benefit Booklet for details.

6 Rental benefits for medical equipment and other items will not exceed the 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.