BlueNet® EPO 2000/7000

Summary of Benefits – Option C (SG/GFD)

Blue Cross and Blue Shield of New Mexico

Summary only – lists copayments, deductible and out-of-pocket limit amounts; member coinsurance percentage amounts; 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.

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 Deductible (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.) [1]		$2,000 ($6,000 family)
Annual Out-of-Pocket Limit (Coinsurance and copayments only apply; deductible, penalty amounts, and noncovered charges do not.) [2]		$7,000 ($21,000/family)
Lifetime Maximum Benefit		Unlimited; certain services have calendar year or benefit period limitations, as listed below.
Primary Preferred Provider (PPP) Office Services *		$40
Office Visit**, Medication Management **		$40
Office Surgery (including casts, splints, and dressings)		$40 [3]
Specialty Physician Office Services		$55
Office Visit**, Medication Management**, Office Evaluations**		$55
Office Surgery (including casts, splints, and dressings)		$55 [3]
Preventive Care Services (Adult medical care/routine exams; well child care; vision/hearing screening for members age 17 and under)	**Primary**	$40
	Specialist	$55
Routine Screening Colonoscopy and **Mammogram** (office and outpatient facility)		No Charge
Acupuncture/Spinal Manipulation (max. **$1,500**/year)		$55
Allergy Services (testing and injections)	**Primary**	$40
	Specialist	$55
Allergy Serum		50%
Ambulance Services		$75 per trip/ground or $150 per trip/air [3]
Autism Spectrum Disorders for Children (max. **$36,000** each calendar year for applied behavioral analysis when part of a **preauthorized** treatment plan; up to **$200,000** in a lifetime)		Usual copays or coinsurance based on place of treatment and type of service [3]
Cardiac and Pulmonary Rehabilitation (outpatient)		$55[3]
Dental/Facial Accidents, Oral Surgery, TMJ/CMJ Services		Usual copays or coinsurance based on place of treatment and type of service [3,4]
Emergency and Urgent Care Services Emergency Room (includes all related ER services) Observation Room (including pregnancy) Urgent Care Facility		 $300 $300 $100
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 (prescribed home nursing care, physician, and therapy care – **100 visits/**year)		30%[3]

* A 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.

** 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.

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**
Hospice – inpatient	30%[4]
Hospice – home	No Charge[3]
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, Anesthesiologist, Lab, X-Ray, Other Diagnostic Tests	30%[4]
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 30%[4] 30%[4]
Lab Tests, X-Rays, EKGs, MRIs, & Other Diagnostic Services (including tests done in office, outpatient facility, freestanding facility, ambulatory surgery facility, or any other place of treatment)	30% [3] No deductible
Outpatient Facility (including surgical procedures related to pregnancy and family planning, nonroutine colonoscopies)	30%[3]
Outpatient Physician/Surgeon (including surgical procedures related to pregnancy and family planning, nonroutine colonoscopies)	30%[3]
Prescription Drugs, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods, Smoking/Tobacco Cessation	See your separately issued Prescription Drug Plan Rider.
Psychotherapy: Mental Health Rehabilitation Inpatient, Outpatient/Office Rehab (max. **60 days/visits/**year for all services combined)	30%[3,4]
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. **35 visits**/year)	30%[3,4]
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)	30%[3,4]
Smoking/Tobacco Cessation Counseling (max. 90 minutes total or two group sessions/year)	30%
Supplies, Equipment, Prosthetics, and Orthotics (equipment and supplies over $500 require preauthorization)	30%[3,5]
Therapy: Chemotherapy, Dialysis, and Radiation Therapy	$100/Visit [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 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, or outpatient diagnostic testing.

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 preauthorization is not obtained from BCBSNM. See a benefit booklet for details.

4 Preauthorization is required for inpatient admissions. You pay a $400 penalty for covered facility services if preauthorization is not obtained. 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.

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.