BluePPO Evolution[SM]

Summary of Benefits & Plan Options

Blue Cross and Blue Shield of New Mexico

This is a summary only that lists the deductible and out-of-pocket limit options, lists member coinsurance percentage amounts, and provides a brief description of BluePPO Evolution Health Care Plan benefits.

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 aggregate of three times individual amount chosen.[1]	$250 $500 $1,000 $2,000 $5,000	$500 $1,000 $2,000 $4,000 $10,000
Annual Out-of-Pocket Limit Options – Includes coinsurance only; NOT deductible, copayments, penalty amounts, or noncovered charges.[2]	$2,000 ($5,000 family)	$4,000 ($10,000 family)
Office Services: If listed on this summary, other services received during the office visit to the PPO Primary Provider (PPP*) or to the PPO Specialist • such as physical therapy, acupuncture, etc. • are subject to deductible and coinsurance as listed below.		
Primary Provider* Office Visit & Initial visit to diagnose pregnancy	$20 copay/visit	40%
Specialist Office Visit & Initial office visit to diagnose pregnancy	$35 copay/visit	40%
Office Surgery (including casts, splints, and dressings)	Office Visit (OV) Copay [4]	40% [4]
Allergy Injections, Tests, Serum	Office Visit (OV) Copay	40%
Preventive Services Routine Adult Physicals and Gynecological Exams (ages 18 and older), Related Testing (includes routine Pap tests, mammograms, cholesterol tests, urinalysis, etc.), and Immunizations Well-Child Care; Routine Vision or Hearing Screenings (only through age 17); Routine Testing, and Immunizations	Plan pays 100% (deductible waived) up to $500, thereafter, services are subject to deductible and 20% coinsurance	40%
Preventive/Routine Colonoscopies (office and outpatient facility)	Plan pays 100% (deductible waived, no max.)	40%
Acupuncture Treatment (benefit max. **$1,500**/year)	20%	40%
Ambulance Services: Ground and Emergency Air Transport	20%[3]	
Ambulance Services: Nonemergency Air Transfer	20%[4]	40%[4]
Cardiac and Pulmonary Rehabilitation	20%[4]	40%[4]
Dental/Facial Accident, Oral Surgery, and TMJ/CMJ Services	Member share based on place of treatment & type of service [4]	40%[4]
Emergency Room Treatment	20% [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 (benefit max. **100 visits**/year)	20%[4]	40%[4]
Hospice Services (lifetime max. **$10,000**)	20%[4]	40%[4]
Lab, X-Ray, and Other Basic Diagnostic Tests	Plan pays 100%[4] (deductible waived)	40%[4]
MRI, CT Scans, PET Scans	20%[4]	40%[4]

* 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. A "PPP" is a Primary Provider in the preferred provider network.

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.

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]
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]
Maternity Services (also see "Inpatient Hospital/Facility Services")	20%[5]	40%[5]
Routine Nursery/Pediatrician Care for Covered Newborns	20%[5]	40%[5]
Outpatient Facility/Physician (including surgical procedures related to pregnancy and family planning, nonroutine colonoscopies)	20%[4,5]	40%[4,5]
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] (benefit max. **$1,000**/year)
Psychotherapeutic Services, Inpatient and Outpatient (Includes mental health services and chemical dependency rehabilitation; benefit maximum of up to **$3,500**/year for outpatient services and **30 days** per year for inpatient services. Chemical dependency also limited to services received within a maximum of **two 12-month** benefit periods.)	20%[4,5]	40%[4]
Short-Term Rehabilitation: Occupational, Physical, and Speech Therapy; including Physical Rehabilitation and Skilled Nursing Facility **Inpatient Rehabilitation** (benefit max. **30 days**/year) **Outpatient and Office Rehabilitation** (benefit max. **$3,500**/year)	20%[4,5]	40%[4]
Smoking/Tobacco Cessation Counseling (90 minutes total or 2 group sessions per calendar year)	20%	No benefit
Spinal Manipulation Services (benefit max. **$1,500**/year)	20%	40%
Supplies and Durable Medical Equipment	20%[4,6] (Unlimited benefit)	40%[4,6] (benefit max. **$1,000**/year)
Therapy: Chemotherapy, Dialysis, and Radiation	20%[4]	40%[4]
Transplant Services (Must be received at a facility that contracts with BCBSNM or with the national BCBS 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
Urgent Care Facility	20%	40%

FOOTNOTES:

1 The deductible must be met before benefit payments are made for most services. Deductible amounts do not cross-apply in the Preferred Provider and Nonpreferred Provider benefit levels.

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. Out-of-pocket amounts do not cross-apply in the Preferred Provider and Nonpreferred Provider benefit levels. (Specified transplant services are subject to a separate out-of-pocket limit.)

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