Blue PPO Options

Summary of Benefits – Plan 10 B

This is a summary only that lists copayments, deductible, out-of-pocket limit options, member coinsurance percentages, and provides a brief description of Blue PPO Options Health Plan benefits.

Blue PPO Options Benefits – There is no lifetime maximum benefit. However, certain services have maximum annual limits. See below.	**Member's Share of Covered Charges**	
	Preferred Provider	**Nonpreferred Provider**[1]
Copayment and Coinsurance – Plan 10-B		
Office Visit (OV) Copayment	$10	25%
Inpatient Hospital/Facility Copayment	$250	
Emergency Room/Outpatient Facility Copayment	$50	
Calendar Year Deductibles – Family deductible is an aggregate of three times the individual deductible. [1]	N/A	$500
Annual Out-of-Pocket Limits (per member) – Copays and Preferred Provider coinsurance amounts apply to Preferred Provider limit. Nonpreferred Provider coinsurance only applies to Nonpreferred Provider limit. No family out-of-pocket limit is available.	$1,500	$2,500
Office Services (nonroutine/nonpreventive)		
Office Visit/Office Surgery[1] (including casts, splints, dressings, medication checks, and intake evaluations.)	$10 copay/visit	25%
Allergy Care: Injections, Tests, Serum	50% coinsurance	Not Covered
Lab Tests, X-Rays, EKGs, Other Diagnostic Tests	No copay [4]	25% [4]
Routine/Preventive Office Services		
Adult Physicals and Gynecological Exams (ages 18 and older), Related Testing (includes routine Pap tests, mammograms, colonoscopies, cholesterol tests, urinalysis, etc.), and Immunizations	$10 copay/visit (no copay for services other than exam)	Not Covered
Well-Child Care; Routine Vision or Hearing Screenings (only through age 17); Routine Testing, Immunizations	$10 copay/visit (no copay for services other than exam)	25%
Acupuncture Treatment (max. **$1,500**/year)	$10 copay/visit	Not Covered
Ambulance Services: Ground and Emergency Air	$50 per trip (copay waived if between facilities or results in an admission)	
Ambulance Services: Nonemergency Air Transfer	$50 per trip [4]	25% [4]
Cardiac and Pulmonary Rehabilitation, Outpatient	$10 copay/visit [4]	Not Covered
Dental/Facial Accident, Oral Surgery, TMJ/CMJ Services	Copays based on place of treatment and type of service [4]	25% [4]
Emergency Room/Emergency Observation Treatment	$50 copay (no charge for physician)[3]	
Hearing Aids and Related Services: Hearing aids for members under age 21 are paid at 100% of covered charges (deductible waived) 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**/yr)	$10 copay/physician visit [4]	25% [4]
Hospice Services (lifetime max. **$10,000**)	No copay [4]	25% [4]
Hospital/Facility Services (See "Short-Term Rehabilitation" for physical rehabilitation/skilled nursing facility admissions. See "Psychotherapeutic Services" for mental health or chemical dependency. See "Transplant Services," if applicable.)		
Inpatient Medical/Surgical and **Maternity-Related** Room and Board and Covered Ancillaries	$250 copay/admission [4,5] (no charge for physician)	25% [4,5]
Routine Inpatient Nursery Care for Covered Newborns	No copays if mother covered	25%
Outpatient/Ambulatory Surgical Center Treatment, including therapies, colonoscopies, and surgical procedures	$50 copay (no charge for physician services) [4]	25% [4]

Blue PPO Options Benefits – There is no lifetime maximum benefit. However, certain services have maximum annual limits. See below.	**Member's Share of Covered Charges**	
	In-Network Preferred Provider	**Out-of-Network Nonpreferred Provider[1]**
Lab, X-Ray, and Other Diagnostic Tests	No copay [4]	25% [4]
Maternity Services (including routine and complicated deliveries and services; also see "Hospital/Other Facility Services")	$10 copay for initial visit; all other services = copay based on place of treatment and type of service	25%
Prescription Drugs, Insulin, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods	See your separately issued Drug Plan Rider.	
Prosthetics and Orthotics	15% coinsurance [4]	Not Covered
Psychotherapeutic Services, Inpatient and Outpatient (Includes mental health services; maximum benefit of up to **$3,500**/year for outpatient services and **30 days/visits** per year for inpatient services.)	Copays based on place of treatment and type of service [4,5]	Not Covered
Psychotherapeutic Services, Inpatient and Outpatient (Includes chemical dependency rehabilitation; maximum benefit of up to **$3,500**/year for outpatient services and **30 days/visits** per year for inpatient services. Chemical dependency also limited to services received within a maximum of **two 12-month benefit periods**.)	Copays based on place of treatment and type of service [4,5]	Not Covered
Short-Term Rehabilitation: Occupational, Physical, and Speech Therapy; including Physical Rehabilitation and Skilled Nursing Facility **Inpatient Rehabilitation** (max. **30 days**/year) **Outpatient and Office Rehabilitation** (max. **$3,500**/year)	Copays based on place of treatment and type of service [4,5]	Not Covered
Smoking/Tobacco Cessation Counseling (90 minutes total or 2 group sessions per calendar year)	$10 copay/visit	Not Covered
Spinal Manipulation Services (max. **$1,500**/year)	$10 copay/visit	Not Covered
Supplies and Durable Medical Equipment	15% coinsurance [4]	Not Covered
Surgery, Inpatient or Outpatient, Physician	No copay [4]	25% [4]
Therapy: Chemotherapy, Dialysis, and Radiation (Office)	No copay [4]	25% [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.)	Copays based on place of treatment and type of service [4,5]	Not Covered
Urgent Care Facility	$10 copay/visit	25%

FOOTNOTES:

1 The deductible must be met each calendar year before benefit payments are made for Nonpreferred Provider services.

2 After a member reaches the applicable out-of-pocket limit, BCBSNM pays 100 percent of most of that member's covered Preferred Provider 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. (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 Nonpreferred Provider level when member receives services from Nonpreferred Providers.

4 Certain services are not covered if prior approval is not obtained from BCBSNM. See a Member 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 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 charge you the difference.

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.