

Blue PPO Options

Summary of Benefits and Plan Options



Blue Cross and Blue Shield
of New Mexico

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 Options	Plan 10	Plan 15	Plan 20	Plan 30	Plan 10	Plan 15	Plan 20	Plan 30
Office Visit (OV) Copayment	\$10 A&B	\$15	\$20	\$30	25%	25%	30%	30%
Inpatient Hospital/Facility Copayment	\$100-A \$250-B	\$250	\$500	\$1,000				
Emergency Room/Outpatient Facility Copayment	\$50	\$50	\$50	\$250				
Calendar Year Deductibles – Family deductible is an aggregate of three times the individual deductible. ¹	N/A				\$250-A \$500-B	\$500	\$1,000	\$2,000
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.	\$1,000-A \$1,500-B	\$1,500	\$2,000	\$2,500	\$2,000-A \$2,500-B	\$2,500	\$3,000	\$5,000
Office Services (nonroutine/nonpreventive)								
Office Visit/Office Surgery ¹ (including casts, splints, dressings, medication checks, and intake evaluations.)	OV copay/visit				Out-of-Net coinsurance			
Allergy Care: Injections, Tests, Serum	50% coinsurance				Not Covered			
Lab Tests, X-Rays, EKGs, Other Diagnostic Tests	No copay ⁴				Out-of-Net coinsurance 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	OV 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	OV copay/visit (no copay for services other than exam)				Out-of-Net coinsurance			
Acupuncture Treatment (max. \$1500/year)	OV 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				Out-of-Net coinsurance ⁴			
Cardiac and Pulmonary Rehabilitation, Outpatient	OV copay/visit ⁴				Not Covered			
Dental/Facial Accident, Oral Surgery, TMJ/CMJ Services	Copays based on place of treatment and type of service ⁴				Out-of-Net coinsurance ⁴			
Emergency Room/Emergency Observation Treatment	Emergency Room 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)	OV copay/physician visit ⁴				Out-of-Net coinsurance ⁴			
Hospice Services (lifetime max. \$10,000)	No copay ⁴				Out-of-Net coinsurance 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	Inpatient copay/admission ^{4,5} (no charge for physician)				Out-of-Net coinsurance ^{4,5}			
Routine Inpatient Nursery Care for Covered Newborns	No copays if mother covered				Out-of-Net coinsurance			
Outpatient/Ambulatory Surgical Center Treatment , including therapies, colonoscopies, and surgical procedures	Outpatient copay (no charge for physician services) ⁴				Out-of-Net coinsurance ⁴			

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	In-Network Preferred Provider	Out-of-Network Nonpreferred Provider¹
Lab, X-Ray, and Other Diagnostic Tests	No copay ⁴	Out-of-Net coinsurance ⁴
Maternity Services (including routine and complicated deliveries and services; also see "Hospital/Other Facility Services")	OV copay for initial visit; all other services = copay based on place of treatment and type of service	Out-of-Net coinsurance
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)	OV copay/visit	Not Covered
Spinal Manipulation Services (max. \$1,500/year)	OV copay/visit	Not Covered
Supplies and Durable Medical Equipment	15% coinsurance ⁴	Not Covered
Surgery, Inpatient or Outpatient, Physician	No copay ⁴	Out-of-Net coinsurance ⁴
Therapy: Chemotherapy, Dialysis, and Radiation (Office)	No copay ⁴	Out-of-Net coinsurance 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	Copays based on place of treatment and type of service ^{4,5}	Not Covered
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.)		
Urgent Care Facility	OV copay/visit	Out-of-Net coinsurance

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.