HMO Blue® OPTIONS Plan 10
Summary of Benefits and Member Costs

Blue Cross and Blue Shield of New Mexico

BENEFIT HIGHLIGHTS	HMO OPTION (IN-NETWORK)	OUT-OF-NETWORK OPTION
Annual Deductible (per member) **Family Deductible** (aggregate)	None N/A	$500 Three times the individual amount
Annual Out-of-Pocket Maximum (Note: There is no family out-of-pocket max)	Twice annual premium	$2,500
Lifetime Maximum Benefit	Unlimited (some services are specifically limited)	$1,000,000 per member

This is a summary only that provides the copayments and brief descriptions of HMO Blue OPTIONS plan benefits. For more complete information, see an HMO Blue Member's Benefit Book (H340) and OPTIONS Rider (H342).

If you visit an HMO-participating health care provider, you receive HMO Option benefits (In-Network) for covered services. If you visit a provider that is not in the HMO-participating network of providers, you receive the Out-of-Network Option level of benefits for covered services. **Some services are covered only if you use an HMO-participating provider.**

Benefits and Member Costs for HMO Option (In-Network) and Out-of-Network Option Levels

BENEFIT	TYPE OF SERVICE	HMO OPTION (IN-NETWORK) COPAY	ADDITIONAL INFORMATION	OUT-OF-NETWORK OPTION COST*
Ambulance	Ground Ambulance Air Ambulance**	$0 $0	Prior authorization required for nonemergency air ambulance. All emergency services paid at the HMO Option level.	30% 30%
Emergency Services	Emergency Room Urgent Care Facility/Office	$50 per visit $25 per visit	Emergency care (as defined in the benefit booklet) from Out-of-Network providers will be paid at the HMO Option level.	30% 30%
Hearing Aids & 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 and Home I.V. Care**	Including Nurse and Physician Visits, Medical Supplies, Therapy	$0	Intravenous medications require prior authorization.	Not covered
Hospice Care**	Including Nurse and Physician Visits, Medical Supplies, Therapy	$0	**$10,000** lifetime benefit maximum.	30%
Hospital Services, Acute Care (Medical/Surgical, including Detox)	Hospitalization**	$250 per admission	No copayment under the HMO Option required for related physician services.	30%
	Surgery, Hospital Outpatient	$50 per visit	Includes invasive diagnostic procedures.	30%
	Routine Nursery Care for Covered Newborns	$0	Extended stay under the HMO Option requires admission copayment.	30%
Reproductive Services and Family Planning	Physician Delivery, Pre- & Postnatal Care Hospital Admission	$10 per visit $250 per admission	Under the HMO Option, office visit copay required for initial maternity visit only; thereafter, admission copayment applies upon delivery.	30%

**Member's share of out-of-network covered services after deductible is met. Member also pays difference between the BCBSNM covered charge and the provider's billed charge.*

***These services require prior authorization from BCBSNM (or Mesa Mental Health) or benefits will be reduced or denied. See a benefit booklet for full limitations and requirements.*

BENEFIT	TYPE OF SERVICE	HMO OPTION (IN-NETWORK) COPAY	ADDITIONAL INFORMATION	OUT-OF-NETWORK OPTION COST*
Diagnostic Tests** (Noninvasive)	Laboratory and X-Ray, MRI, CAT Scan, EKG, Other Tests, Psychological Testing	$0	Prior authorization required for PET scans, genetic testing, home sleep studies, cardiac CT scans, psychological testing.	30%
Physician Services	Office Visit (nonroutine/nonpreventive), including medical supplies, medication checks**, and intake evaluations** (also see other headings such as "Rehabilitative Therapy" or "Medical Therapy")			
	Primary Care/Specialist Care	$10 per visit	Some office services require prior authorization. See a benefit book.	30%
	Therapeutic Injections	$0	Some require prior authorization.	30%
	Allergy Injections	$0	Copayment for office visit only.	Not covered
	Inpatient Medical Care	$0	No additional copayment required under the HMO Option.	30%
	Surgery — in office	$10 per visit	Includes invasive diagnostic procedures.	30%
	Preventive Services Adult (age 18 and over) routine physicals and tests; health education/counseling	$10 per visit	No maximum benefit limit. Copayment taken on office visit charge only; all other services = $0 copayment.	Not covered
	Well-child (through age 17) and well-baby care; immunizations; vision and hearing screenings.	$10 per visit	No maximum benefit limit. Under the HMO Option, copayment taken on office visit charge only; all other services = $0 copayment.	30%
Rehabilitative Therapy (including Skilled Nursing Facility**)	Physical**, Occupational**, and Speech** Therapy; Acupuncture and Chiropractic Services; Cardiac** and Pulmonary** Rehab Psychotherapy (including for substance abuse)** - Inpatient Services - Outpatient/Office Services	 $250 per admission $10 per visit	Inpatient and outpatient physical, occupational, and speech therapy services are covered; prior authorization is required. Chiropractic and acupuncture services are each limited to **20 visits** per calendar year. Psychotherapeutic services are covered; prior authorization is required. Chemical dependency benefits are not provided for more than two 12-month benefit periods.	Not covered
Medical Therapy — Office or Outpatient	Chemotherapy**, Radiation Therapy, Kidney Dialysis**, Electroshock Therapy**, Narcosynthesis**	$0	High-dose chemotherapy, electroshock therapy, narcosynthesis, and home dialysis require prior authorization.	30%
Smoking/Tobacco Cessation Counseling	Counseling	$10 per visit	Benefits limited to 90 minutes total or 2 group sessions per calendar year.	Not covered
Durable Medical Equipment	Orthopedic Appliances/DME, Prosthetics, Oxygen and Equipment	$0	Prior authorization required for specified items and all items costing $500 or more. Rental benefit will not exceed purchase price of new unit.	30%
Organ Transplants** All transplants must be received at a facility that contracts with BCBSNM as an HMO-participating provider or the national BCBS transplant network.	Cornea, Kidney, Bone Marrow	Usual Copayments	Paid same as any other service (copayments based on type of service and place of treatment).	Not covered
	Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney Transplants	Usual Copayments	Copayments based on type of service and place of treatment. **$10,000** max for travel, food, and lodging (travel **+ $125** per diem).	Not covered

Prescription Drugs, Diabetic Supplies, Enteral Nutritional Products, and Special Medical Foods, Smoking/Tobacco Cessation - See the separately issued Prescription Drug Plan rider.

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If you disagree with the payment or denial of a claim or portion of a claim, call Customer Service at the number below. If you are still dissatisfied, you may file a formal complaint. Call Customer Service if you would like a copy of the complete complaint and grievance procedures, or visit our Web site at www.bcbsnm.com.

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