

# Plans 5, 10, 15/HMO Blue® OPTIONS Plan Summary of Benefits and Member Costs



Blue Cross and Blue Shield  
of New Mexico

This is a summary only that provides the copayment options 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)*.

## Highlights of Costs

BENEFIT HIGHLIGHTS	HMO OPTION (IN-NETWORK) PLANS			OUT-OF-NETWORK OPTION
<b>Member Copayment Options</b>	<b>Plan 5</b>	<b>Plan 10</b>	<b>Plan 15</b>	Under all three plans, member pays 30% of the BCBSNM covered charge for covered services, subject to deductible and out-of-pocket limit. Member must also pay difference between covered charge and billed charge. Some benefits are <b>not available</b> under the Out-of-Network Option.
Office Visit Copayment/Visit	\$5	\$10	\$15	
Outpatient Copayment/Visit	\$50	\$50	\$100	
Admission Copayment	\$100	\$250	\$500	
<b>Prescription Drugs, Diabetic Supplies, Enteral Nutritional Products, and Special Medical Foods, Smoking/Tobacco Cessation</b> - See the separately issued Prescription Drug Plan rider.				
<b>Annual Deductible</b> (per member)	None			\$250, \$500, \$1000 (based on plan chosen)
<b>Family Deductible</b> (aggregate)	N/A			Three times the individual amount
<b>Annual Out-of-Pocket Maximum</b> (Note: There is no family out-of-pocket max)	Twice annual premium			\$2000, \$2500, \$3000 (based on plan chosen)
<b>Lifetime Maximum Benefit</b>	Unlimited (some services are specifically limited)			\$1,000,000 per member

If you visit an HMO-participating provider, you receive HMO Option benefits (In-Network) for covered services. If you visit a provider that is not in the BCBSNM network of HMO providers, you receive Out-of-Network Option 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*
<b>Ambulance</b>	Ground Ambulance	\$0	Prior authorization required for nonemergency air ambulance. All emergency services paid at the HMO Option level.	30%
	Air Ambulance**	\$0		30%
<b>Emergency Services</b>	Emergency Room	Outpatient Copay	Emergency care (as defined in the benefit booklet) from Out-of-Network providers will be paid at the HMO Option level.	30%
	Urgent Care Facility/Office	\$25 per visit		30%
<b>Hearing Aids and Related Services</b>	Hearing aids for members under age 21 are paid at 100% of covered charges up to a maximum of <b>\$2,200</b> 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.			
<b>Home Health and Home I.V. Care**</b>	Including Nurse and Physician Visits, Medical Supplies, Therapy	\$0	Intravenous medications require prior authorization.	Not covered
<b>Hospice Care**</b>	Including Nurse and Physician Visits, Medical Supplies, Therapy	\$0	<b>\$10,000</b> lifetime benefit maximum.	30%
<b>Hospital Services, Acute Care</b> (Medical/Surgical, including Detox)	Hospitalization**	Admission Copay	Under the HMO Option, no copayment required for related physician services.	30%
	Surgery, Hospital Outpatient	Outpatient Copay	Includes invasive diagnostic procedures.	30%
	Routine Nursery Care for Covered Newborns	\$0	Extended stay under the HMO Option requires admission copayment.	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*
<b>Diagnostic Tests**</b> (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%
<b>Reproductive Services and Family Planning</b>	Physician Delivery, Pre- & Postnatal Care Hospital Admission	Office Visit Copay Admission Copay	Under the HMO Option, office visit copay required for initial maternity visit only; thereafter, admission copayment applies upon delivery.	30%
<b>Physician Services</b>	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	Office Visit Copay	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	Office Visit Copay	Includes invasive diagnostic procedures.	30%
	Preventive Services			
	Adult (age 18 and over) routine physicals and tests; health education/counseling	Office Visit Copay	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.	Office Visit Copay	No maximum benefit limit. Under the HMO Option, copayment taken on office visit charge only; all other services = \$0 copayment.	30%
<b>Rehabilitative Therapy</b> (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	Admission Copay Office Visit Copay	Inpatient and outpatient physical, occupational, and speech therapy services are covered; prior authorization is required. Chiropractic and acupuncture services are each limited to <b>20 visits</b> 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
<b>Medical Therapy — Office or Outpatient</b>	Chemotherapy**, Radiation Therapy, Kidney Dialysis**, Electroshock Therapy**, Narcosynthesis**	\$0	High-dose chemotherapy, electroshock therapy, narcosynthesis, and home dialysis require prior authorization.	30%
<b>Smoking Cessation Counseling</b>	Counseling	Office Visit Copay	Benefits limited to 90 minutes total or 2 group sessions per calendar year.	Not covered
<b>Durable Medical Equipment</b>	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%
<b>Organ Transplants**</b> 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. <b>\$10,000</b> max for travel, food, and lodging (travel + <b>\$125</b> per diem).	Not covered

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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](http://www.bcbsnm.com).**

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