

HMO Blue[®] Plan 25

Summary of Benefits and Copayments

This is a brief summary of HMO Blue Plan's benefits and copayments. For more complete information and for exclusions and limitations, see an *HMO Blue Benefit Booklet* (H340).



Blue Cross and Blue Shield
of New Mexico

Your Copayments, Annual Out-of-Pocket Limit, Lifetime Benefit

Annual Out-of-Pocket Limit	Twice annual premium (There is no family out-of-pocket limit.)	
Lifetime Maximum Benefit	Unlimited (some services are specifically limited)	
Type of Service	Copayments	Additional Information
PHYSICIAN SERVICES (See "Rehabilitation Therapy," on the reverse side, for physical, occupational, and speech therapy, and psychotherapy.)		
Office Visit, including Medical Supplies, Medication Checks*, and Intake Evaluations*		Medication checks for mental health/chemical dependency and intake evaluations require prior authorization from Mesa Mental Health.
Primary Care	\$25	You may visit any HMO-participating provider without a referral. However, if you must visit a nonparticipating provider for nonemergency services, you must have prior authorization or services will be denied.
Specialist Care	\$25	
Therapeutic and Allergy Injections	No Charge	Some require prior authorization.
Inpatient Medical Care	No Charge	Facility receives copayment.
Preventive Services Adult Routine Physicals & Related Tests; Health Education and Counseling; Well-Child Care; Immunizations; Vision and Hearing Screening (through age 17)	\$25	Copayment for office visit charge only; all other services = no charge.
Surgery — in office	\$25	Includes invasive diagnostic procedures.
ACUPUNCTURE TREATMENT	\$25	Maximum benefit of 20 visits/calendar year.
CHIROPRACTIC SERVICES	\$25	Maximum benefit of 20 visits/calendar year.
CARDIAC/PULMONARY REHAB, OUTPATIENT*	\$25	Prior authorization is required.
URGENT CARE FACILITY	\$35	Call 1-800-810-BLUE (2583) if you are outside the service area.*
AMBULANCE	No Charge	Prior authorization is required for nonemergency air ambulance.
EMERGENCY ROOM/OBSERVATION	\$125	Prior authorization is not required for emergencies (as defined).
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.		

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

* NOTE: Services marked with an asterisk (*) require prior authorization from BCBSNM or Mesa Mental Health. Some services may not be approved for payment.

What is a Primary Care Physician (PCP)?

Your PCP is your personal physician who coordinates all your health care. Although you no longer have to obtain a PCP referral before arranging to receive covered services from another HMO-participating provider, please contact your PCP whenever you have a health need. Because your PCP knows you and your medical history, your PCP is best qualified to coordinate all your medical care, including visits to specialists. **You must choose a PCP upon enrollment.**

What is prior authorization?

It is an approval received from BCBSNM **before** delivery of certain types of services. For certain services to be covered you or your provider must obtain authorization from BCBSNM before you receive those services.

When do I need authorization?

Authorization is required for all inpatient admissions, a few specified services (listed in your benefit booklet), and if you want to go outside the HMO-participating provider network. **Important:** BCBSNM must authorize all nonemergency services of a nonparticipating provider. If services are authorized, you may be responsible for amounts above the covered charge. If authorization is not obtained, benefits will be denied for the services.

Type of Service	Copayments	Additional Information
HOSPITAL SERVICES, ACUTE CARE (See "Rehabilitation Therapy," below, for physical, occupational, and speech therapy, skilled nursing facility, psychotherapeutic services, and substance abuse rehabilitation. Also see "Transplant Services," if applicable.)		
Hospitalization*	\$1000	No copayment required for related physician services.
Surgery — Hospital Outpatient	\$500	Surgery includes invasive diagnostic procedures.
Newborn Care: Routine Care	No Charge	An additional copayment is required if the newborn remains in the hospital longer than his/her mother.
Extended Stay	\$1000	
MATERNITY/FAMILY PLANNING		
Pre- and Postnatal Care; Physician Delivery	\$25	Office copayment required for initial maternity visit only; thereafter admission copayment applies upon delivery.
Hospital Admission	\$1000	
REHABILITATION THERAPY: Inpatient (Including Skilled Nursing Facility), Outpatient, and Office*		
Physical, Occupational, Speech Therapy* Inpatient/Skilled Nursing Facility Services Outpatient Services	\$1000 \$25	Inpatient, outpatient, and office services are covered. Prior authorization is required.
Psychotherapeutic Services, Including Chemical Dependency Rehabilitation* Inpatient Hospital/Treatment Facility Outpatient Services	\$1000 \$25	
MEDICAL THERAPY — Office or Outpatient Chemotherapy, Electroshock* or Radiation Therapy, Kidney Dialysis*, Narcosynthesis*	No Charge	High-dose chemotherapy, electroshock therapy, home dialysis, and narcosynthesis require prior authorization.
SMOKING/TOBACCO CESSATION COUNSELING	\$25	Benefits limited to 90 minutes total or 2 group sessions per calendar year.
DIAGNOSTIC TESTING Laboratory and X-Ray, MRI, MRA, CAT Scan, Sleep Studies, Psychological Testing*	No Charge	Prior authorization required for PET and cardiac CT scans, psychological testing, and home sleep studies.
MEDICAL EQUIPMENT/PROSTHETICS* Orthopedic Appliances/DME, Prosthetics, Oxygen and Equipment	No Charge	Prior authorization required. No maximum benefit limit, except that rental benefits will not exceed the purchase price of a new unit. Note: Certain diabetic supplies are covered only under the drug plan rider.
HOME HEALTH, HOSPICE, HOME I.V. * Including Nurse and Physician Visits, Medical Supplies, and Therapy	No Charge	\$10,000 lifetime benefit for hospice care. Intravenous medications and enteral nutritional products require prior authorization.
TRANSPLANT SERVICES* (Must use a facility that contracts with BCBSNM as an HMO-participating provider or through the national BCBS transplant network.)		
Cornea, Kidney, Bone Marrow	Usual copayments based on place of treatment and type of service	Paid same as any other service. \$10,000 maximum for travel, food, and lodging (travel + \$125 per diem)* for heart, heart-lung, liver, lung, and pancreas-kidney.
Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney		
PRESCRIPTION DRUGS, DIABETIC SUPPLIES, SPECIAL MEDICAL FOODS, SMOKING/TOBACCO CESSATION — See separately issued drug plan rider.		

Benefit Booklet

Please refer to your *Member's Benefit Booklet* for exclusions, limitations, and more benefit information.

Reminder:

You do NOT need a PCP referral before seeking covered services from an HMO-participating provider. However, if you are **admitted** to a hospital, receive **certain services** (listed in your benefit booklet) or visit a **nonparticipating** provider without first obtaining **prior authorization** from BCBSNM, **the services will not be covered**. Check your provider directory or visit the BCBSNM Web site at www.bcbsnm.com for a list of HMO-participating providers.

Complaints & Grievances:

If you disagree with the payment or denial of a claim or portion of a claim, call Customer Service at 1-800-423-1630. If you are still not satisfied, you may file a complaint. Call Customer Service if you would like a copy of the complete complaint and grievance procedures.

Customer Service:

Call toll-free Monday – Friday from 6 a.m. – 10 p.m. and 8 a.m. – 5 p.m. on Saturdays and most holidays: (800) 423-1630
Web site: www.bcbsnm.com