# Blue Preferred EPO℠ 0040

## $500 Deductible Plan

Blue Cross and Blue Shield of New Mexico

**Highlights** copayments, deductible, out-of-pocket limits, member coinsurance percentage amounts; and provides a brief description of Blue Preferred EPO health care plan benefits.

| **EPO Benefits** – This plan does **not** cover services received from nonpreferred providers, except for urgent/emergency services. | | **Member's Share of Covered Charges When Using Blue Preferred Providers** |
|---|---|---|
| **Annual Deductible** (Only services subject to a percentage "coinsurance" amount apply toward deductible; except Lab and X-ray.)[1] | | $500<br>($1,000/family) |
| **Annual Out-of-Pocket Limit** (Deductible, Coinsurance, and Copayments apply; penalty amounts and noncovered charges do not.)[2] | | $2,500<br>($5,000/family) |
| **Primary Care Provider (PCP) Office Services *** | | |
| Office Visit,** Medication Management,**<br>Virtual Visit (MDLIVE providers) | | $20 copay/visit<br>$0 copay/visit |
| Office Surgery (including casts, splints, and dressings) | | $20 copay/visit |
| **Mental Health/Chemical Dependency Services** (office visit only)<br>Virtual Visit (MDLIVE providers) | | $20 copay/visit<br>$0 copay/visit |
| **Specialty Physician Office Services** | | |
| Office Visit,** Medication Management,** Office Evaluations** | | $35 copay/visit |
| Office Surgery (including casts, splints, and dressings) | | $35 copay/visit |
| **Preventive Care**<br>Routine Adult Physicals and Gynecological Exams, Well-Child Care; Routine Vision or Hearing Screenings, Related Testing (includes routine Pap tests, cholesterol tests, urinalysis, etc.), Routine Colonoscopies (outpatient/office), and Immunizations | | No Charge<br>(deductible waived) |
| **Acupuncture/Spinal Manipulation** (max. **25 visits**/year/combined) | | $35 copay/visit |
| **Allergy Services** (testing and injections) | **Primary Provider** | $20 copay/visit |
| | **Specialist** | $35 copay/visit |
| **Allergy Serum** | | 50% coinsurance |
| **Ambulance Services** | | 20% coinsurance[3] |
| **Autism Spectrum Disorders**<br>Applied Behavioral Analysis,[3] and Occupational, Physical, and Speech Therapy | | $20 copay/visit |
| **Cardiac and Pulmonary Rehabilitation** (outpatient) | | 20% coinsurance |
| **Chemotherapy, Dialysis, and Radiation Therapy** | | 20% coinsurance |
| **Dental/Facial Accidents, Oral Surgery, TMJ/CMJ Services** | | 20% coinsurance[3] |
| **Durable Medical Equipment, Supplies, Prosthetics, and Orthotics** | | 20% coinsurance[5] |
| **Emergency and Urgent Care Services**<br>Emergency Room (includes all related ER services)<br>Observation Room (including pregnancy)<br>Urgent Care Facility | | <br>$200 copay/visit<br>$200 copay/visit<br>$75 copay/visit |
| **Hearing Aids and Related Services:** Hearing aids for members under age 21 are paid at 100% of covered charges up to a maximum of **1 hearing aid per hearing-impaired ear every 3 years**; exams and testing are subject to usual cost-sharing provisions. These services are not covered for members age 21 and older. | | |
| **Home Health Care** (prescribed home nursing care, physician, and therapy care – max. **100 visits**/year) | | 20% coinsurance |
| **Hospice** | | 20% coinsurance[3,4] |
| **Inpatient Hospital/Facility Services** | | |
| Room and Board and Physician Care such as Physician Visits, Surgeon, Anesthesiologist, Lab, X-Ray, Other Diagnostic Tests for: Medical/Surgical, Mental Health/Chemical Dependency (including partial hospitalization), Residential Treatment Center and Maternity Related and Delivery | | 20% coinsurance[4] |
| **Maternity Services** | | |
| Routine Nursery/Pediatrician Care for Covered Newborns | | 20% coinsurance<br>(deductible waived) |
| Extended Newborn Stay | | 20% coinsurance[4] |
| **Lab Tests, X-Rays, and Other Diagnostic Services** (including tests done in office, outpatient facility, freestanding facility, ambulatory surgery facility, or any other place of treatment) | | 20% coinsurance<br>(deductible waived) |

* A Primary Care Provider (PCP) is a physician or other professional provider in one of the following categories of practice: Family or General Practice, Internal Medicine, Pediatrics, Obstetrics and Gynecology, and Gynecology Only.

** If therapy is received or diagnostic tests are performed during the visit, please see additional services listed on this summary. In such cases, you will pay both the office visit copay – if an office exam is billed – and the amount due for the therapy or diagnostic test.

| **EPO Benefits** – This plan does **not** cover services received from nonpreferred providers, except for urgent/emergency services. | **Member's Share of Covered Charges When Using Blue Preferred Providers** |
|---|---|
| **MRI, CT Scans, PET Scans** (including tests done in office, outpatient facility, freestanding facility, ambulatory surgery facility, or any other place of treatment) | $250 copay/test[3] |
| **Outpatient Facility/Surgeon/Physician** (including surgical procedures related to pregnancy and family planning; and nonroutine colonoscopies) | 20% coinsurance |
| **Outpatient Infusion Therapy (for routine maintenance drugs)**<br>Administered by Professional Provider in Home, Office or Infusion Suite<br>Outpatient Facility | <br>$50 copay/visit[3]<br>$500 copay/visit[3] |
| **Prescription Drugs, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods, Smoking/Tobacco Cessation** | See your separately issued Prescription Drug Plan Rider |
| **Short-Term Rehabilitation**: Occupational, Physical, and Speech Therapy, including Skilled Nursing Facility and Inpatient Rehabilitation<br>**Skilled Nursing Facility** (max. **60 days**/year)[4]<br>**Outpatient Physical, Speech and Occupational Therapies** (max. **30 visits**/year/combined) | <br>20% coinsurance<br>$20 copay/visit |
| **Transplant Services** (Must use facilities that contract with BCBSNM or with the national BCBS transplant network.) | |
| Cornea, Kidney, Bone Marrow | Usual copays or coinsurance based on place of treatment and type of service[3,4] |
| Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney: **$10,000** maximum for travel and lodging per diem | |

**Footnotes:**

[1] Each member's initial covered charges (for most services that are subject to a percentage "coinsurance" amount unless stated otherwise) are applied to the deductible. The deductible must be met before benefit payments are made for such services.
**Note:** A deductible is not required for preventive care, lab, X-ray, imaging, and covered services that are subject to a fixed-dollar copayment.

[2] After a member (or family) reaches the out-of-pocket limit during a single calendar year, BCBSNM pays 100 percent of that member's (or family's) covered charges for the remainder of the calendar year.

[3] Certain services are not covered if preauthorization is not obtained from BCBSNM. See a benefit booklet for details.

[4] Preauthorization is required for inpatient admissions. Some services, such as transplants, require additional preauthorization. If you do not receive preauthorization for these individually-identified procedures and services, benefits for any related admissions will be denied.

[5] 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.

**This is a summary only – please refer to the Summary of Benefits and Coverage (SBC) document and Benefit Booklet for more details.**