Blue Preferred Plus[SM] 0000

$1,000 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 Plus Health Care Plan benefits.

Point of Service (POS) Benefits – There is no lifetime maximum benefit. However, certain services have maximum annual limits. See below.	**Member's Share of Covered Charges**		
	Blue Preferred (BP) Provider[1]	**PPO Provider[1]**	**NonPPO Provider[1]**
Annual Deductible[1] – Deductible does not apply to services with copays or "No Charge."	$1,000 ($2,000/Family)	$2,000 ($4,000/Family)	$3,000 ($6,000/Family)
Annual Out-of-Pocket Limit (Includes deductible, coinsurance, and copayments; NOT penalty amounts or noncovered charges.[2]	$4,000 ($8,000/Family)	$5,000 ($10,000/Family)	$12,000 ($24,000/Family)
Primary Preferred Provider (PPP)*			
Office Visit/Exam and initial office visit to diagnose pregnancy	$20 copay/visit	$30 copay/visit	50%
Virtual Visit (MDLIVE providers)	$20 copay/visit	$20 copay/visit	Not Covered
Mental Health and Chemical Dependency			
(office visit only)	$20 copay/visit	$30 copay/visit	50%
Virtual Visit (MDLIVE providers)	$20 copay/visit	$20 copay/visit	Not Covered
Specialist Office Visit and initial office visit to diagnose pregnancy	$40 copay/visit	$50 copay/visit	50%
Office Surgery (including casts, splints, and dressings)	$20 or $40 copay/visit	$30 or $50 copay/visit	50%
Allergy Injections, Tests, Serum	$20 or $40 copay/visit	$30 or $50 copay/visit	50%
Preventive Services 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 (deductible waived)		50%
Acupuncture Treatment (max. **25 visits**/year)	$40 copay/visit	$50 copay/visit	50%
Ambulance Services: Ground and Emergency Air Transport (must be medically necessary)	10%		
Autism Spectrum Disorders Applied Behavioral Analysis,[4] and Occupational, Physical, and Speech Therapy	$20 copay/visit	$30 copay/visit	50%
Cardiac and Pulmonary Rehabilitation (outpatient)	$40 copay/visit	$50 copay/visit	50%
Chiropractic/Spinal Manipulation Services (max. **25 visits**/year)	$40 copay/visit	$50 copay/visit	50%
Dental/Facial Accident, Oral Surgery, and TMJ/CMJ Services	10%[4]	40%[4]	50%[4]
Emergency Room Treatment	$200 copay/visit[3]		
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/Home I.V. Services (max. **100 visits**/year)	10%	40%	50%
Hospice Services	10%[4,5]	40%[4,5]	50%[4,5]
Lab, X-Ray, and Other Basic Diagnostic Tests	No Charge (deductible waived)		50%
MRI, CT Scans, PET Scans	$150 copay/test[4]	$300 copay/test[4]	50%[4]

* A Primary Preferred Provider (PPP) 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. A "PPP" is a Primary Preferred Provider in the Blue Preferred and PPO Provider networks.

Point of Service (POS) Benefits – There is no lifetime maximum benefit. However, certain services have maximum annual limits. See below.	**Member's Share of Covered Charges**		
	Blue Preferred (BP) Provider[1]	**PPO Provider[1]**	**NonPPO Provider[1]**
Inpatient Hospital/Facility Services			
Room and Board, and Covered Ancillaries for: Medical/Surgical, Mental Health/Chemical Dependency (including Partial Hospitalization), Residential Treatment Center (RTC), and Maternity-Related and Delivery	10%[5]	40%[5]	50%[5]
Maternity Services			
Routine Nursery/Pediatrician Care for Covered Newborns - Facility	10%[5] (deductible waived)	40%[5] (deductible waived)	50%[5]
Extended Newborn Stay	10%[5]	40%[5]	50%[5]
Outpatient Facility/Surgeon/Physician (including surgical procedures related to pregnancy and family planning; and nonroutine colonoscopies)	10%	40%	50%
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 (max. **30 visits**/year/combined)	$20 copay/visit	$30 copay/visit	50%
Skilled Nursing Facility and Inpatient Rehabilitation (Skilled Nursing Facility max. **30 days**/year)	10%[5]	40%[5]	50%[5]
Supplies, Durable Medical Equipment, Prosthetics, Orthotics	10%[6]	40%[6]	50%[6]
Therapy: Chemotherapy, Dialysis, and Radiation	10%	40%	50%
Transplant Services (Must be received at a facility that contracts with BCBSNM or with the national BCBS transplant network.)			
Cornea, Kidney, and Bone Marrow	Usual copays or coinsurance based on place of treatment and type of service[4, 5]		
Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney (**$10,000** maximum for travel and lodging per diem)	10%[4, 5]	40%[4, 5]	Not covered
Urgent Care Facility	$75 copay/visit		

Footnotes:

[1] The deductible must be met before benefit payments are made for services with coinsurance. Deductible amounts do cross-apply between the Blue Preferred and PPO Provider levels; the NonPPO Provider does not.

[2] After a member reaches the applicable out-of-pocket limit, BCBSNM pays 100 percent of most of that member's covered Blue Preferred, PPO or NonPPO Provider charges, whichever is applicable. Out-of-pocket amounts do cross-apply between the Blue Preferred and PPO Provider levels; the NonPPO Provider does not.

[3] Initial treatment of a medical emergency is paid at the Blue Preferred Provider level. Follow-up treatment and treatment that is not for an emergency is paid at NonPPO Provider level.

[4] Certain services are not covered if preauthorization is not obtained from BCBSNM. See a Member's Benefit Booklet for a list of services requiring preauthorization.

[5] Preauthorization is required for inpatient admissions. See a Member's 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.

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