BlueNet EPOSM 0040 C

\$1,500 Deductible - Option C



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

| providers, except for urgent / emergency services. Annual Deducible (Only services subject to a percentage "coinsurance" amount apply (\$4,500family) (\$7,000family) (\$7,00 | description of BlueNet EPO health care plan benefits. | | |
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| toward deductible; except Lab and X-ray.)¹ Annual Out-of-Decket Limit (Deductible; Coinsurance, and Copayments apply; penalty announts and noncovered charges do not.)² Annual Out-of-Decket Limit (Deductible; Coinsurance, and Copayments apply; penalty (\$7,000/family) Primary Preferred Provider (PPP) Office Services* Office Visit**, Medication Management** Succeptivitial Visit (MDILVE providers) Office Surgery (including casts, splints, and dressings) Shecialty Physician Office Services Office Surgery (including casts, splints, and dressings) Specialty Physician Office Services Office Visit**, Medication Management**, Office Evaluations** Specialty Physician Office Services Office Visit**, Medication Management**, Office Evaluations** Specialty Physician Office Services Office Visit**, Medication Management**, Office Evaluations* Specialty Physician Office Services Office Visit**, Medication Management**, Office Evaluations* Specialty Physician Office Services Office Visit**, Medication Management**, Office Evaluations* Specialty Physician Office Services Routine Adult Physicials and Gynecological Exams, Well-Child Care; Routine Vision or Hearing Screenings, Related Testing (includes routine Pap tests, cholesteroltests, urinalysis, etc.), Routine Colonoscopies (outpatient) office), and Immunizations Acupenture/Spinal Manipulation (max. 25 combined visits/year) Specialist Allergy Services (testing and injections) Primary Provider Specialist Special | providers, except for urgent / emergency services. | | from a Preferred Provider |
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| Specialty Physician Office Services \$55 copay/visit | | | |
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| 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) Hospice – inpatient Hospice – home No charge after deductible ³ Room and Board and Physician Care such as Physician Visits, Surgeon, Anesthesiologist, Lab, X-Ray, Other Diagnostic Tests, Medical/Surgical, and Mental Health/Chemical Dependency (including partial hospitalization) and Residential Treatment Center Maternity – initial visit to diagnose pregnancy Maternity – prenatal and post-delivery exams, inpatient delivery Newborn Care – must be enrolled within 31 days of birth 30% coinsurance ⁴ Lab Tests, X-Rays, EKGs, MRIs, and Other Diagnostic Services (including tests done in office, outpatient facility, freestanding facility, ambulatory surgery facility, or any other place of treatment) Outpatient Facility/Surgeon/Physician (including surgical procedures related to pregnancy and family planning; and nonroutine) | | s under age 21 are paid a | |
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| Hospice - inpatient 30% coinsurance ⁴ | | | 000/ |
| Hospice – inpatient30% coinsurance4Hospice – homeNo charge after deductible3Inpatient Hospital/Facility ServicesNo charge after deductible3Room and Board and Physician Care such as Physician Visits, Surgeon, Anesthesiologist, Lab, X-Ray, Other Diagnostic Tests, Medical/Surgical, and Mental Health/Chemical Dependency (including partial hospitalization) and Residential30% coinsurance4Treatment CenterMaternity – initial visit to diagnose pregnancy Maternity – prenatal and post-delivery exams, inpatient delivery Newborn Care – must be enrolled within 31 days of birthOffice copay for initial visit 30% coinsurance4Lab Tests, X-Rays, EKGs, MRIs, and Other Diagnostic Services (including tests done in office, outpatient facility, freestanding facility, ambulatory surgery facility, or any other place of treatment)30% coinsurance3 (deductible waived)Outpatient Facility/Surgeon/Physician (including surgical procedures related to pregnancy and family planning; and nonroutine30% coinsurance | (prescribed home nursing care, physician, and therapy care – max, 100 visits/ year) | | 30% coinsurance |
| No charge after deductible | | | 30% coinsurance⁴ |
| Inpatient Hospital/Facility Services Room and Board and Physician Care such as Physician Visits, Surgeon, Anesthesiologist, Lab, X-Ray, Other Diagnostic Tests, Medical/Surgical, and Mental Health/Chemical Dependency (including partial hospitalization) and Residential Treatment Center Maternity – initial visit to diagnose pregnancy Maternity – prenatal and post-delivery exams, inpatient delivery Newborn Care – must be enrolled within 31 days of birth Lab Tests, X-Rays, EKGs, MRIs, and Other Diagnostic Services (including tests done in office, outpatient facility, freestanding facility, ambulatory surgery facility, or any other place of treatment) Outpatient Facility/Surgeon/Physician (including surgical procedures related to pregnancy and family planning; and nonroutine) 30% coinsurance 30% coinsurance 30% coinsurance 30% coinsurance | • | | |
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| Surgery facility, or any other place of treatment) Outpatient Facility/Surgeon/Physician (including surgical procedures related to pregnancy and family planning; and nonroutine 30% coinsurance | | | |
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| | olonoscopies) | | 5070 COMBUILDE |

^{*} A Primary Preferred Provider (PPP) is a preferred 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 from a Preferred Provider | |
|---|--|--|
| Outpatient Infusion Therapy (for routine maintenance drugs) Administered by Professional Provider in Home, Office or Infusion Suite Outpatient Facility | \$50 copay/visit ³ \$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: Inpatient Rehabilitation/Skilled Nursing Facility | 20% coinsurance ⁴ | |
| Outpatient (Occupational, Physical and Speech Therapy) (max. 60 days/visits/year for all services combined) | \$40 copay/visit | |
| Supplies, Durable Medical Equipment, Prosthetics, and Orthotics | 30% coinsurance⁵ | |
| Therapy: Chemotherapy, Dialysis, and Radiation Therapy | \$100 copay/visit | |
| Transplant Services (Must use facilities that contract with BCBSNM or with the national BCBS transplant network.) | | |
| Cornea, Kidney, Bone Marrow Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney: \$10,000 maximum for travel and lodging per diem | Usual copays or coinsurance based on place of treatment and type of service ^{3,4} | |

Footnotes:

Important Note: You must use a BCBSNM Preferred Provider, unless in an emergency. Deductibles, copayments, and coinsurance percentages are applied to BCBSNM's covered charges, which may be less than billed charges. Covered services received from Preferred Providers that contract with their local BCBS Plan are also eligible for coverage under this plan.

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

Blue Cross and Blue Shield of New Mexico (BCBSNM) is a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

¹ Each member's initial covered charges (for most services that are subject to a percentage "coinsurance" amount) 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 covered services that are subject to a fixed-dollar copayment, preventive services, hearing aids, or outpatient diagnostic testing.

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.