BlueNet EPO℠ 0091 B

Blue Cross and Blue Shield of New Mexico

$6,000 Deductible – Option B

Highlights copayments, deductible, out-of-pocket limits, member coinsurance percentage amounts; and provides a brief description of BlueNet 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 from a Preferred Provider**
Annual Deductible (Only services subject to a percentage "coinsurance" amount apply toward deductible; except Lab and X-ray.)[1]		$6,000 ($12,000/family)
Annual Out-of-Pocket Limit (Deductible, Coinsurance, and Copayments apply; penalty amounts and noncovered charges do not.)[2]		$7,350 ($14,700/family)
Primary Preferred Provider (PPP) Office Services*		
Office Visit**, Medication Management** Virtual Visit (MDLIVE providers)		$35 copay/visit $0 copay/visit
Office Surgery (including casts, splints, and dressings)		$35 copay/visit
Mental Health/Chemical Dependency Services (office visit only) Virtual Visit (MDLIVE providers)		$35 copay/visit $0 copay/visit
Specialty Physician Office Services		
Office Visit**, Medication Management**, Office Evaluations**		$50 copay/visit
Office Surgery (including casts, splints, and dressings)		$50 copay/visit
Preventive Care 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)
Acupuncture/Spinal Manipulation (max. **25 combined visits**/year)		$50 copay/visit
Allergy Services (testing and injections)	**Primary Provider**	$35 copay/visit
	Specialist	$50 copay/visit
Allergy Serum		50% coinsurance
Ambulance Services		$75 per trip/Ground or $150 per trip/Air[3]
Autism Spectrum Disorders Applied Behavioral Analysis,[3] and Occupational, Physical, and Speech Therapy		$35 copay/visit
Cardiac and Pulmonary Rehabilitation (outpatient)		$50 copay/visit
Dental/Facial Accidents, Oral Surgery, TMJ/CMJ Services		Usual copays or coinsurance based on place of treatment and type of service[3]
Emergency and Urgent Care Services Emergency Room (includes all related ER services) Observation Room (including pregnancy) Urgent Care Facility		 $150 copay/visit $150 copay/visit $50 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 – inpatient		20% coinsurance[4]
Hospice – home		No charge after deductible[3]
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		20% coinsurance[4]
Maternity – initial visit to diagnose pregnancy Maternity – prenatal and post-delivery exams, inpatient delivery Newborn Care – must be enrolled within 31 days of birth		Office copay for initial visit 20% coinsurance[4] 20% coinsurance[4]
Lab Tests, X-Rays, EKG, MRI, CT Scans and Other Diagnostic Services (including tests done in office, outpatient facility, freestanding facility, ambulatory surgery facility, or any other place of treatment)		20% coinsurance[3] (deductible waived)
Outpatient Facility/Surgeon/Physician (including surgical procedures related to pregnancy and family planning; and nonroutine colonoscopies)		20% coinsurance

* 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** **Outpatient (Occupational, Physical and Speech Therapy)** (max. **60 days/visits**/year for all services combined)	 20% coinsurance[4] $35 copay/visit
Supplies, Durable Medical Equipment, Prosthetics, and Orthotics	20% coinsurance[5]
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	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 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 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.