BlueNet H EPO℠ 0010

$25/$40/$750

Blue Cross and Blue Shield of New Mexico

Highlights copayments, coinsurance percentage amounts and provides a brief description of BlueNet H 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 Out-of-Pocket Limit (Copayments, and Coinsurance apply; penalty amounts and noncovered charges do not.)[1]		$2,500 ($7,500/family)[1]
Primary Preferred Provider (PPP) Office Services*		
Office Visit/Exam, Medication Management Virtual Visit (MDLIVE providers)		$25 copay/visit $0 copay/visit
Office Surgery (including casts, splints, and dressings)		$25 copay/visit
Mental Health and Chemical Dependency (office visit only) Virtual Visit (MDLIVE providers)		$25 copay/visit $0 copay/visit
Specialty Physician Office Services		
Office Visit, Medication Management, Office Evaluations		$40 copay/visit
Office Surgery (including casts, splints, and dressings)		$40 copay/visit
Preventive Care Services Includes: Adult medical care/routine exams and routine testing; mammograms; routine colonoscopies (outpatient facility/office); well child care; vision/hearing screening; smoking/tobacco cessation counseling, and immunizations)		No Charge
Lab Tests, X-Rays and Other Basic Diagnostic Services (including tests done in office, outpatient facility, freestanding facility, or any other place of treatment)		No Charge
MRI, PET Scan, CT Scan		$50 copay/test[2]
Allergy Services (testing, injections and serum)	**Primary**	$25 copay/visit
	Specialist	$40 copay/visit
Acupuncture and Spinal Manipulation Services (max. **25 combined visits**/year)		$40 copay/visit
Ambulance Services		$75 per trip/Ground or $150 per trip/Air[2]
Autism Spectrum Disorders Applied Behavioral Analysis,[2] and Occupational, Physical, and Speech Therapy		$25 copay/visit
Cardiac and Pulmonary Rehabilitation (outpatient)		$40 copay/visit
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 $55 copay/visit
Dental/Facial Accidents, Oral Surgery, TMJ/CMJ Services		Usual copays or coinsurance based on place of treatment and type of service[2]
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.		
Hospice – Inpatient and Home		No charge[2,3]
Home Health Care (prescribed home nursing care, physician, and therapy care – max. **100 visits**/year)		No charge
Inpatient Hospital/Facility Services		
Room and Board, Physician Care such as Physician Visits, Surgeon, and Anesthesiologist, Lab, X-Ray, Other Diagnostic Tests, Medical/Surgical, and Mental Health/Chemical Dependency (including partial hospitalization), and Residential Treatment Center		$750 copay/admit[3]
Maternity – initial visit to diagnose pregnancy Maternity – prenatal and post-delivery exams, inpatient delivery Newborn Care – must be enrolled within 31 days of birth.		OV copay $750 copay/admit[3] $750 copay/admit[3]
Outpatient Facility (including surgical procedures related to pregnancy and family planning; and nonroutine colonoscopies)		$200 copay/visit
Outpatient Physician/Surgeon (including surgical procedures related to pregnancy and family planning, and nonroutine colonoscopies)		No Charge

*A "PPP" (or Primary Preferred Provider) 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.

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Outpatient Infusion Therapy (for routine maintenance drugs) Administered by Professional Provider in Home, Office or Infusion Suite Outpatient Facility	 $50 copay/visit[2] $500 copay/visit[2]
Prescription Drugs, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods, Smoking/Tobacco Cessation	See Drug Plan Rider for details
Short-Term Rehabilitation Outpatient Occupational, Physical, and Speech Therapy (max. **60 visits/days**/year combined with Skilled Nursing Facility and Inpatient Rehabilitation)	$25 copay/visit
Skilled Nursing Facility and Inpatient Rehabilitation (max. **60 days/visits**/year combined with Physical, Occupational, and Speech Therapies)	$750 copay/admit[3]
Supplies, Durable Medical Equipment, Prosthetics, and Orthotics	50% coinsurance[4]
Therapy: Chemotherapy, Dialysis, and Radiation Therapy	No Charge
Transplant Services (Must use facilities that contract with BCBSNM or with the national BCBS transplant network.)	
Cornea, Kidney, Bone Marrow	Usual copays based on place of treatment and type of service[2,3]
Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney: **$10,000** maximum for travel and lodging per diem	

Footnotes:

[1] There is no deductible to meet. After a member (or family) reaches the out-of-pocket limit during a calendar year, BCBSNM pays 100 percent of that member's (or family's) covered charges for the remainder of the calendar year.

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

[3] 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.

[4] 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. Copayment and/or coinsurance amounts 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.