HMO Blue[SM] 0060

Plan 35 ($2,000 Deductible)

Blue Cross and Blue Shield of New Mexico

Summary provides a brief description listing plan benefits, copayments and coinsurance amounts.

Annual Deductible	$2,000/Individual – $6,000/Family	
Annual Out-of-Pocket Limit	$6,000/Individual – $16,300/Family	
Lifetime Maximum Benefit	Unlimited (Some services are specifically limited)	
Type of Service	**Copayments**	**Additional Information**
Physician Services (See "Rehabilitation Therapy" on the next page for physical, occupational, and speech therapy.)		
Office Visit/Exam/Consultations/Virtual Visits, including Medical Supplies, Medication Checks, and Intake Evaluations.		
Primary Care Provider Virtual Visit (MDLIVE providers)	$35 Copay $0 Copay	You may visit any BCBSNM HMO-participating provider without a referral. However, if you must visit a nonparticipating provider for nonemergency services, you must have preauthorization or services will be denied.
Specialist Care	$50 Copay	
Mental Health and Chemical Dependency (office visit only) Virtual Visit (MDLIVE providers)	$35 Copay $0 Copay	
Therapeutic and Allergy Injections	OV Copay	
Preventive Services Routine Adult Physicals and Gynecological Exams, Well-Child Care; Related Testing (includes routine Pap tests, mammo-grams, cholesterol tests, urinalysis, etc.), Routine Colonoscopies, Routine Vision or Hearing Screenings; and Immunizations	No Charge	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.
Surgery in Office	OV copay	
Acupuncture Treatment	$50/Specialist Copay	Maximum benefit of **20 visits**/calendar year.
Ambulance Services	$50 for Ground $100 for Air	Preauthorization is required for nonemergency air ambulance.
Autism Spectrum Disorders Applied Behavioral Analysis*****, and Occupational, Physical, and Speech Therapy	$35 Copay	A preauthorized treatment plan is required.
Cardiac and Pulmonary Rehabilitation (outpatient)	$50/Specialist Copay	
Chiropractic/Spinal Manipulation Services	$50/Specialist Copay	Maximum benefit of **20 visits**/calendar year.
Diagnostic Testing Lab and X-Ray, MRI*, PET Scan*, Sleep Studies*, Psychological Testing*	$50 for MRI; No Charge for other diagnostic testing	Preauthorization required for MRI, PET, CT scans, sleep studies, and psychological testing.
Emergency Room/Observation	$150 Copay	Preauthorization is **not** required for emergencies.
Home Health Care, Hospice, and Home I.V. Services Including Nurse and Physician Visits, Medical Supplies, and Therapy	No Charge	
Hospital Services, Acute Care Hospitalization/Partial Hospitalization includes Medical, Surgical, Mental Health/Chemical Dependency, Residential Treatment Center Admissions*	20% after deductible	Mental health/Chemical dependency also requires preauthorization. No copay required for related physician services.
Surgery – Hospital Outpatient	20% after deductible	Surgery includes invasive diagnostic procedures.
Newborn Care: Routine Care or Extended Stay	20% after deductible for Extended Stay	An additional amount is required if the newborn remains in the hospital longer than his/her mother.
Maternity/Family Planning Pre- and Post-natal care; Physician Delivery Hospital Admission	OV Copay 20% after deductible	Office copay required for initial maternity visit only; thereafter admission copayment applies upon delivery.
Medical Equipment/Prosthetics Orthopedic Appliances/DME, Prosthetics, Oxygen and Equipment	50% of Covered Charge	No maximum benefit limit, except that rental benefits will not exceed the purchase price of a new unit. Note: Certain diabetic supplies are covered only under the drug plan rider.
Medical Therapy – Office or Outpatient Chemotherapy, Radiation Therapy, Kidney Dialysis	No Charge	

Type of Service	Copayments	Additional Information
Outpatient Infusion Therapy (for routine maintenance drugs) Administered by Professional Provider in Home, Office or Infusion Suite Outpatient Facility	$50 Copay $500 Copay	Preauthorization is required.
Prescription Drugs, Insulin, Diabetic Supplies, and Special Medical Foods See separately issued Drug Plan Rider**.**		
Rehabilitation Therapy Inpatient (including Skilled Nursing Facility), Outpatient, and Office		
Physical, Occupational, Speech Therapy Inpatient/Skilled Nursing Facility Services* Outpatient Services	$1,000 Copay $35 Copay	Preauthorization is required for inpatient rehabilitation and skilled nursing facility services.
Transplant Services* (Must use facilities that contract with BCBSNM as HMO providers or through the national BCBS transplant network.)		
Cornea, Kidney, Bone Marrow	Based on Place of Treatment/Type of Service	
Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney		$10,000 maximum for travel and lodging per diem.
Urgent Care Facility	$75 Copay	Call 1-800-810-BLUE (2583) if you are outside the service area.

* Services require preauthorization from BCBSNM. Some services may not be preauthorized for payment.

What is a Primary Care Provider (PCP)? Your PCP is your personal physician who coordinates all your health care. Although you do not have to obtain a PCP referral before arranging to receive covered services from an HMO-participating provider, please contact your PCP whenever your have a health need. Because your PCP knows you and your medical history, your PCP is best qualified to coordinate all your medical care, including visits to specialists. **You *must* choose a PCP upon enrollment**.

What is preauthorization? It is an authorization received from BCBSNM **before** delivery of certain types of services. For certain services to be covered you or your provider must obtain preauthorization from BCBSNM **before** you receive those services.

When do I need preauthorization? Preauthorization is required for all inpatient admissions, a few specified services (listed in your benefit booklet), and if you want to go outside the BCBSNM HMO provider network. **Important:** BCBSNM must preauthorize all nonemergency services of a nonparticipating provider. If services are preauthorized, you may be responsible for amounts above the covered charge. If preauthorization is not obtained, benefits will be denied for the services.

Reminder: You do **not** need a PCP referral before seeking covered services from a BCBSNM HMO network provider. However, if you are **admitted** to a hospital, receive **certain services** (listed in your benefit booklet) or visit a **nonparticipating** provider without first obtaining **preauthorization** from BCBSNM, **the services will not be covered**. Check your provider directory or visit the BCBSNM Web site at bcbsnm.com for a list of HMO-participating providers.

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