

BluePPO EvolutionSM 0021

\$2,000 Deductible Plan



Highlights copayments, deductible, out-of-pocket limits, member coinsurance percentage amounts, and provides a brief description of BluePPO Evolution Health Care Plan benefits.

PPO Benefits There is no lifetime maximum benefit. However, certain services have maximum annual limits. See below.	Member's Share of Covered Charges	
	Preferred Provider ¹	Nonpreferred Provider ¹
Annual Deductible¹ Deductible does not apply to services with copays or "no charge."	\$2,000 (\$4,000/family)	\$4,000 (\$8,000/family)
Annual Out-of-Pocket Limit (Includes deductible, coinsurance, and copayments; NOT penalty amounts or noncovered charges ²)	\$4,000 (\$8,000/family)	\$12,000 (\$24,000/family)
Primary Preferred Provider (PPP)* Office Visit/Exam and initial office visit to diagnose pregnancy Virtual Visit (MDLIVE providers)	\$20 copay/visit \$0 copay/visit	40% coinsurance Not Covered
Mental Health and Chemical Dependency (office visit only) Virtual Visit (MDLIVE providers)	\$20 copay/visit \$0 copay/visit	40% coinsurance Not Covered
Specialist Office Visit and initial office visit to diagnose pregnancy	\$35 copay/visit	40% coinsurance
Office Surgery (including casts, splints, and dressings)	Office Visit (OV) Copay	40% coinsurance
Allergy Injections, Tests, Serum	Office Visit (OV) Copay	40% coinsurance
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)	40% coinsurance
Acupuncture Treatment (max. 25 visits/year)	Office Visit (OV) Copay	40% coinsurance
Ambulance Services: Ground and Emergency Air Transport	20% coinsurance	
Ambulance Services: Nonemergency Air Transfer	20% coinsurance ⁴	40% coinsurance ⁴
Autism Spectrum Disorders Applied Behavioral Analysis, ⁴ and Occupational, Physical, and Speech Therapy	\$20 copay/visit	40% coinsurance
Cardiac and Pulmonary Rehabilitation	20% coinsurance	40% coinsurance
Dental/Facial Accident, Oral Surgery, and TMJ/CMJ Services	20% coinsurance ⁴	40% coinsurance 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)	20% coinsurance	40% coinsurance
Hospice Services	20% coinsurance ^{4,5}	40% coinsurance ^{4,5}
Lab, X-Ray, and Other Basic Diagnostic Tests	No Charge	40% coinsurance
MRIs, CT Scans, PET Scans	\$150 copay/test ⁴	40% coinsurance ⁴
Inpatient Hospital/Facility Services		
Medical/Surgical, Mental Health/Chemical Dependency (including Partial Hospitalization), Residential Treatment Center, Maternity-Related Room and Board, and Covered Ancillaries	20% coinsurance ⁵	40% coinsurance ⁵
Maternity Services	20% coinsurance ⁵	40% coinsurance ⁵
Routine Nursery/Pediatrician Care for Covered Newborns	20% (deductible waived) ⁵	40% coinsurance ⁵
Extended Newborn Stay	20% coinsurance ⁵	40% coinsurance ⁵

* A Primary Preferred Provider 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 preferred provider network.

PPO Benefits There is no lifetime maximum benefit. However, certain services have maximum annual limits. See below.	Member's Share of Covered Charges	
	Preferred Provider¹	Nonpreferred Provider¹
Outpatient Facility/Surgeon/Physician (including surgical procedures related to pregnancy and family planning; and non-routine colonoscopies)	20% coinsurance	40% coinsurance
Outpatient Infusion Therapy (for routine maintenance drugs) Administered by Professional Provider in Home, Office or Infusion Suite Outpatient Facility	\$50 copay/visit ⁴ \$500 copay/visit ⁴	40% coinsurance ⁴
Prescription Drugs, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods, Smoking/Tobacco Cessation	See your separately issued Prescription Drug Plan Rider	
Short-Term Rehabilitation: Skilled Nursing Facility/Inpatient Rehabilitation (max. 30 days/year/combined) ⁵ Outpatient – Occupational, Physical and Speech Therapy (max. 35 visits/year/combined)	20% coinsurance ⁵ \$20 copay/visit	40% coinsurance ⁵
Spinal Manipulation Services (max. 25 visits/year)	Office Visit (OV) Copay	40% coinsurance
Supplies, Durable Medical Equipment, Prosthetics, Orthotics	20% coinsurance ⁶	40% coinsurance ⁶
Therapy: Chemotherapy, Dialysis, and Radiation	20% coinsurance	40% coinsurance
Transplant Services (Must be received at a facility that contracts with BCBSNM or with the national BCBS transplant network.)		
Cornea, Kidney, and Bone Marrow	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)	20% coinsurance ^{4,5}	Not Covered
Urgent Care Facility	\$45 copay/visit	

Footnotes:

¹ The deductible must be met before benefit payments are made for services with coinsurance. Deductible amounts do not cross-apply in the Preferred Provider and Nonpreferred Provider benefit levels.

² After a member reaches the applicable out-of-pocket limit, BCBSNM pays 100 percent of most of that member's covered Preferred or Nonpreferred Provider charges, whichever is applicable. Out-of-pocket amounts do not cross-apply in the Preferred Provider and Nonpreferred Provider benefit levels.

³ Initial treatment of a medical emergency is paid at Preferred Provider level. Follow-up treatment and treatment that is not for an emergency is paid at Nonpreferred 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. Some services, such as transplants and inpatient physical rehabilitation, require additional preauthorization. If you do not receive preauthorization for these individually-identified procedures and services, benefits for any related admissions will be denied. 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.

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