BlueNet® EPO 2000

Plan Highlights – Option C

Blue Cross and Blue Shield of New Mexico

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 in an emergency.		**Member's Share of Covered Charges From a Preferred Provider**
Annual Deductible (Only services subject to a percentage "coinsurance" amount apply towards deductible; except Lab & X-ray.) [1]		$2,000 ($6,000/family)
Annual Out-of-Pocket Limit (Deductible, Coinsurance, and Copayments apply; prescription drugs, penalty amounts, and noncovered charges do not.) [2]		$4,000 ($8,000/family)
Primary Preferred Provider (PPP) Office Services *		$40 copay/visit
Office Visit**, Medication Management **		$40 copay/visit
Office Surgery (including casts, splints, and dressings)		$40 copay/visit
Mental Health/Chemical Dependency Services (outpatient/office)		$40 copay/visit
Specialty Physician Office Services		$55 copay/visit
Office Visit**, Medication Management**, Office Evaluations**		$55 copay/visit
Office Surgery (including casts, splints, and dressings)		$55 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 visits**/year)		$55 copay/visit
Allergy Services (testing and injections)	**Primary Provider**	$40 copay/visit
	Specialist	$55 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		Usual copays or coinsurance based on place of treatment and type of service
Cardiac and Pulmonary Rehabilitation (outpatient)		$55 copay/visit
Dental/Facial Accidents, Oral Surgery, TMJ/CMJ Services		Usual copays or coinsurance based on place of treatment and type of service [3,4]
Emergency and Urgent Care Services Emergency Room (includes all related ER services) Observation Room (including pregnancy) Urgent Care Facility		 $300 copay/visit $300 copay/visit $100 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 **2 hearing aids 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 – **100 visits/**year)		30% coinsurance
Hospice – inpatient		30% coinsurance
Hospice – home		No Charge

* 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.

See footnotes on back.

EPO Benefits – This plan does **not** cover services received from nonpreferred providers, except in an emergency.	**Member's Share of Covered Charges From a Preferred Provider**
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) & Residential Treatment Center	30% coinsurance [4]
Maternity – initial visit to diagnose pregnancy	Office copay for initial visit
Maternity – prenatal & post delivery exams, inpatient delivery	30% coinsurance [4]
Newborn Care – must be enrolled within 31 days of birth	30% coinsurance [4]
Lab Tests, X-Rays, EKGs, MRIs, & Other Diagnostic Services (including tests done in office, outpatient facility, freestanding facility, ambulatory surgery facility, or any other place of treatment)	30% coinsurance [3] (deductible waived)
Outpatient Facility/Surgeon/Physician (including surgical procedures related to pregnancy and family planning; and nonroutine colonoscopies)	30% coinsurance
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 and Outpatient/Office Occupational, Physical, and Speech Therapy, including Skilled Nursing Facility (max. **60 days/visits/**year for all services combined)	30% coinsurance [4]
Supplies, Durable Medical Equipment, Prosthetics, and Orthotics	30% 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 per diem	

FOOTNOTES:

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. You pay a $400 penalty for covered facility services if preauthorization is not obtained. 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.

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