ONE ALBUQUERQUE city of albuquerque

Administered by:
Blue Cross and Blue Shield of New Mexico

City of Albuquerque

$175 Deductible EPO

Highlights copayments, deductible, out-of-pocket limit amounts; member coinsurance percentage amounts; and provides a brief description of 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 per Plan Year (Only services subject to a percentage "coinsurance" amount apply toward deductible)[1]	$175 ($350/family)
Annual Out-of-Pocket Limit per Plan Year (Deductible, Coinsurance, and Copayments (for Medical and Rx) apply; penalty amounts and noncovered charges do not.)[2]	$6,350 ($12,700/family)
Primary Preferred Provider (PPP) Office Services*	
Office Visit**, Medication Management** Telehealth Visit	$35 copay/visit $35 copay/visit
Mental Health/Chemical Dependency Services **(office visit only)** Telehealth Visit	$0 copay/visit $0 copay/visit
Specialty Physician Office Services	
Office Visit**, Medication Management**, Office Evaluations**	$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. **20 visits each**/plan year)	$50 copay/visit
Allergy serum/preparation, testing and treatment **Allergy** injection (no office visit billed) **Allergy injection billed with office visit**	20% coinsurance (deductible applies) No Charge OV copay
Ambulance Services	$50 per trip/Ground or $100 per trip/Air[3] (deductible applies)
Autism Spectrum Disorders Applied Behavioral Analysis,[3] and Occupational, Physical, and Speech Therapy	Copay based on place of treatment and type of service
Cardiac Rehabilitation (max. **36** outpatient visits/plan year) **Pulmonary Rehabilitation** (max. **24** outpatient visits/plan year)	$10 copay/visit $35 copay/visit
Dental/Facial Accidents, Oral Surgery, TMJ/CMJ	Based on place of treatment and type of service[4]
Emergency and Urgent Care Services*** Emergency Room (includes all related ER services) Urgent Care Facility	 $200 copay/visit (deductible applies) $50 copay/visit (deductible applies)
Hearing Aids and Related Services: Hearing aids for children under age 21 are paid at **50%** 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.	
Home Health Care (prescribed home nursing care, physician, and therapy care)	No Charge (deductible waived)
Hospice – inpatient	$500 copay/admission (deductible applies)[4]
Hospice – home	No charge (deductible waived)[3]
Infertility Services – **(including drugs and injections)**	50% coinsurance (deductible applies)
Inpatient Hospital/Facility Services	
Room and Board and Physician Care such as Physician Visits, Surgeon, Anesthesiologist, Lab, X-Ray, Other Diagnostic Tests, Medical/Surgical, Inpatient Rehabilitation Mental Health/Chemical Dependency (including partial hospitalization) and Residential Treatment Center	$500 copay/admission (deductible applies)[4] $0 copay/admission[4]
Maternity – initial office visit to diagnose pregnancy Maternity – inpatient delivery Extended Newborn Stay	$35 copay $500 copay (deductible applies)[4] $500 copay (deductible applies)[4]

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Lab Tests, X-Rays, and Other Diagnostic Services	No Charge (deductible waived)
MRI/PET Scans	$125 copay/type of test (deductible applies)[4]
CT Scan (Note: including tests done in office, outpatient facility, freestanding facility, ambulatory surgery facility, or any other place of treatment)	$75 copay/type of test (deductible applies)[4]
Outpatient Facility/Surgeon/Physician (including surgical procedures related to pregnancy and family planning; and nonroutine colonoscopies)	$500/admission (deductible applies)[4]
Outpatient Infusion Therapy (for routine maintenance drugs) Administered by Professional Provider in Home, Office or Infusion Suite Outpatient Facility	$55 copay/visit[4] ($500 copay/visit[4] (deductible applies)
Short-Term Rehabilitation: Skilled Nursing Facility (max. **60 days**/plan year)	$500 copay/admission (deductible applies)[4]
Outpatient (Occupational, Physical and Speech Therapy) (max. **24 visits combined**/plan year)	$35 copay/visit
Sleep Disorder Studies Inpatient Outpatient	$500 copay per admission (deductible applies)[4] $50 copay per test (deductible applies)[3]
Supplies, Durable Medical Equipment, Prosthetics, and Orthotics	50% coinsurance (deductible applies)[5]
Therapy: Chemotherapy (chemotherapy drugs are covered at 20% up to $400/drug) **and Radiation Therapy** **Dialysis**	No Charge 20% coinsurance
Transplant Services (Must use facilities that contract with BCBSNM or through the national BCBS transplant network.)	
Cornea, Kidney, Bone Marrow	Based on place of treatment and type of service[3]
Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney: $10,000 maximum for travel and lodging per diem	$500 copay/admission (deductible applies)[4]
Prescription Drugs	
Pharmacy benefits are administered by Optum Rx Pharmacy Benefits Management (phone number 800-372-8563)	

* 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.

*** Copay waived if admitted into a hospital, then hospital copay applies

Footnotes

[1] Each member's initial covered charges (for most services that are subject to a percentage "coinsurance" amount) are applied to the deductible, per plan year. 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 plan year, BCBSNM pays 100 percent of that member's (or family's) covered charges for the remainder of the plan 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.

NOTE: BCBSNM provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims, except as may be specified in the Administrative Services Agreement.

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