ONE ALBUQUERQUE city of albuquerque

Administered by

BlueCross BlueShield of New Mexico

City of Albuquerque

$175 Deductible PPO

Highlights copayments, deductible, out-of-pocket limits, member coinsurance percentage amounts, and provides a brief description of PPO 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 Deductible per Plan Year[1] Deductible does not apply to services with copays or "no charge."	$175 ($350/family)	$500 ($1,000/family)
Annual Out-of-Pocket Limit per Plan Year (Includes deductible, coinsurance, and copayments (for Medical and Rx); NOT penalty amounts or noncovered charges.[2]	$6,350 ($12,700/family)	$12,700 ($25,400/family)
Primary Preferred Provider (PPP)* Office visit/exam and initial office visit to diagnose pregnancy Telehealth Visit Virtual Visit (MDLIVE Providers 1-888-858-5074)	$40 copay/visit $40 copay/visit $0 copay/visit	40% coinsurance
Mental Health and Chemical Dependency (office visit only) Telehealth Visit Virtual Visit (MDLIVE Providers 1-888-858-5074)	$0 copay/visit $0 copay/visit $0 copay/visit	40% coinsurance
Specialist Office Visit and initial office visit to diagnose pregnancy Telehealth Visit	$55 copay/visit $55 copay/visit	40% coinsurance
Allergy testing and serum	20% coinsurance	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. **20 visits**/plan year)	$55 copay/visit	40% coinsurance
Ambulance Services: Ground	$50 copay/trip (deductible applies)	
Ambulance Services: Air Transfer	$100 copay/trip (deductible applies)[4]	
Ambulance Services: Interfacility transport	No Charge[4]	
Autism Spectrum Disorders Applied Behavioral Analysis,[4] and Occupational, Physical, and Speech Therapy	Based on place of treatment and type of service	40% coinsurance
Cardiac Rehabilitation (max. **36** outpatient visits/plan year) **Pulmonary Rehabilitation** (max. **24** outpatient visits/plan year)	$10 copay/visit $40 copay/visit	40% coinsurance
Dental/Facial Accident, Oral Surgery, and TMJ/CMJ Services	Based on place of treatment and type of service[4]	40% coinsurance[4]
Emergency Room Treatment**	$200 copay/visit (deductible applies)[3]	
Hearing Aids and Related Services: Hearing aids for members under age 21; 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.	50% coinsurance	50% coinsurance
Home Health Care	No Charge	40% coinsurance
Hospice Services: Inpatient In Home	$500 copay/admission (deductible applies)[4,5] No Charge[4]	40% coinsurance
Lab, X-Ray, and Other Basic Diagnostic Tests (outpatient) **Home Sleep Study**	No Charge $50 copay/study (deductible applies)	40% coinsurance
MRI or PET Scans	$125 copay/type of test (deductible applies)[4]	40% coinsurance[4]
CT Scans	$75 copay/type of test (deductible applies)[4]	40% coinsurance[4]
Infertility Services: Coverage is limited only to diagnosing the cause of infertility and surgical treatment to correct the medical condition causing infertility.	50% coinsurance	50% coinsurance

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]**
Inpatient Hospital/Facility Services		
Medical/Surgical, Maternity-Related Room and Board, and Covered Ancillaries; Inpatient Rehabilitation Mental Health/Chemical Dependency (including Partial Hospitalization), Residential Treatment Center	$500 copay/admission (deductible applies)[5] $0 copay/admission[5] (deductible waived)	40% coinsurance[5]
Maternity Services		40% coinsurance[5]
Inpatient delivery Routine Nursery/Pediatrician Care for Covered Newborns	$500 copay/admission[5] (deductible applies) No Charge	40% coinsurance[5]
Extended Newborn Stay	$500 copay/admission (deductible applies)[5]	40% coinsurance[5]
Outpatient Facility/Surgeon/Physician (including surgical procedures related to pregnancy and family planning; and nonroutine colonoscopies)	$500/admission[4] (deductible applies)	40% coinsurance
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)	40% coinsurance[4]
Short-Term Rehabilitation: **Skilled Nursing Facility** (max. **60 days**/plan year)[5] **Outpatient – Occupational, Physical and Speech Therapy**	$500 copay/admission (deductible applies)[5] $40 copay/visit	40% coinsurance[5]
Spinal Manipulation Services (max. **20 visits**/plan year)	$55 copay/visit	40% coinsurance
Supplies, Durable Medical Equipment, Prosthetics, Orthotics	50% coinsurance[6]	50% coinsurance[6]
Therapy: Chemotherapy and Radiation (chemotherapy drugs are covered at 20% up to $400/drug) **Dialysis**	No Charge 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)	$500 copay/admission (deductible applies)[4,5]	Not Covered
Urgent Care Facility	$50 copay/visit (deductible applies)	
Prescription Drugs		
Pharmacy benefits are administered by Optum Rx Pharmacy Benefits Management (phone number 800-372-8563)		

* 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.

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

Footnotes:

[1] The deductible must be met before benefit payments are made for services with coinsurance, per plan year. 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 per plan year, 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.

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.