City of Las Cruces EPO
$500 Plan

Administered by:

Blue Cross and Blue Shield of New Mexico

Highlights the copayments, deductible and out-of-pocket limit amounts; member coinsurance percentage amounts; and provides a brief description of City of Las Cruces 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 toward deductible; except Lab & X-ray.)[1]	$500/Individual $1,000/Two-Person $1,500/Family
Annual Out-of-Pocket Limit - Includes medical deductible, coinsurance, copayments, and prescription drug copayments; NOT penalty amounts, or noncovered charges. [2]	$4,500/Individual $9,000/Two-Person $13,500/Family
Lifetime Maximum Benefit	Unlimited; certain services have calendar year or benefit period limitations, as listed below.
Primary Preferred Provider (PPP) Office Services *	$30 copay/visit
Office Visit, Medication Management, Office Evaluations	
Office Surgery (including casts, splints, and dressings)	
Mental Health/Chemical Dependency Services (outpatient/office)	
Specialty Physician Office Services	$45 copay/visit
Office Visit, Medication Management, Office Evaluations	
Office Surgery (including casts, splints, and dressings)	
Preventive Care (Outpatient/office adult medical care/routine exams; well child care; routine lab and X-rays, vision and hearing screenings; mammogram, routine colonoscopy)	No Charge
Acupuncture Treatment and Spinal Manipulation (max. **20** visits/year combined)	$45 copay/visit
Allergy Services (Office visit and testing) – **Primary Provider**	$30 copay/visit
Allergy Services (Office visit and testing) – **Specialist**	$45 copay/visit
Allergy Serum and Allergy Injections	No Charge
Ambulance Services	$30 per trip/ground or $100 per trip/air[3]
Applied Behavioral Analysis for Autism Spectrum Disorders for Children (preauthorized treatment plan is required.)	Usual copays or coinsurance based on place of treatment and type of service [3]
Cardiac and Pulmonary Rehabilitation (outpatient)	$45 copay/visit[3]
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	 $250 copay/ER visit $250 copay/visit $75 copay/visit
Hearing Aids and Related Services for Adults and Children: Hearing aids are paid at 100% (Deductible waived) of covered charges up to a maximum of **2 hearing aids during any 3 year period**; exams and testing are subject to usual cost-sharing provisions.	
Home Health Care (prescribed home nursing care, physician, and therapy care – **100** visits/year)	$45 copay/visit
Hospice Services	No Charge[3,4]
Lab Tests, X-Rays, EKGs, and Other Diagnostic Services (including tests done in office, outpatient facility, freestanding facility, ambulatory surgery facility, or any other place of treatment)	20% coinsurance (deductible waived)[3]
MRI, CT Scans, and PET Scans	$200 copay/test [3]

*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.

NOTE: BCBSNM EPO members can access contracted Blue Cross and Blue Shield providers anywhere within the U.S. and in more than 200 countries outside the U.S.

Blue Cross and Blue Shield of New Mexico (BCBSNM) is a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

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	
Medical/Surgical, Mental Health/Chemical Dependency (including Partial Hospitalization), Residential Treatment Center (RTC), Maternity-Related Room and Board, and Covered Ancillaries	$500 copay/admission[4]
Maternity – initial visit to diagnose pregnancy Maternity – prenatal & post-delivery exams, inpatient delivery Newborn Care – must be enrolled within 31 days of birth	Office copay for initial visit $500 copay/admission[4] $500 copay/admission[4]
Naprapathy (max. **$500**/year)	$45 copay/visit
Outpatient Facility, Physician/Surgeon (including surgical procedures related to pregnancy and family planning; and nonroutine colonoscopies)	20% coinsurance[3]
Short-Term Rehabilitation: Outpatient/Office Occupational, Physical, and Speech Therapy (max. **60** visits/year for all services combined)	$45 copay/visit
Skilled Nursing Facility / Inpatient Rehabilitation	$500 copay/admission[4]
Supplies, Equipment, Prosthetics, and Orthotics	20% coinsurance[5]
Therapy: Chemotherapy, Dialysis, and Radiation Therapy	No Charge
Transplant Services (Must use facilities that contract with BCBSNM or through 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 lodging per diem	

FOOTNOTES:

[1] Each member's initial covered charges (for most services that are subject to a percentage "coinsurance" amount unless stated otherwise) 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 preventive care, lab, X-ray, imaging, and covered services that are subject to a fixed-dollar copayment.

[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. 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.