

Endorsement:

BlueEdgeSM 100 High Deductible Health Plan (HSA-Eligible) Individual Plans



This *BlueEdge 100 High Deductible Health Plan (HSA-Eligible): Individual Plans* endorsement is made a part of the Blue Cross and Blue Shield of New Mexico (BCBSNM) BlueEdge health care plan benefit booklet (NM80009). All of the provisions of the BlueEdge benefit booklet and its amendments or endorsements apply to BlueEdge 100 High Deductible Health Plan with the following exceptions. If you have a question about these changes, please call your Customer Service Unit representative at the phone number printed on the bottom of the page or on the back of your identification card.

BY:

A handwritten signature in black ink that reads "Elizabeth A. Watrin".

Elizabeth A. Watrin
President
Blue Cross and Blue Shield of New Mexico

How Your Plan Works

Throughout the benefit booklet, remove all references to Preferred Provider member coinsurance amounts. After you meet the Preferred Provider deductible in a calendar year, this plan pays 100 percent of your covered charges for preferred provider services and for items payable under the drug plan (see below) for the rest of the calendar year.

Cost-Sharing Features

Replace the "Cost-Sharing Features" section in Section 2 of your booklet with the following "Cost-Sharing Features" provision:

Annual Deductibles

Calendar year — January 1 through December 31 of the same year. The initial calendar year benefit period is from a member's effective date of coverage through December 31 of the same year, which may be less than 12 months.

Deductible — The amount of covered charges that you must pay in a calendar year before this Plan begins to pay its share of covered charges incurred by you during the rest of the same calendar year.

Individual Coverage — There are two individual deductible amounts indicated on your *Summary of Benefits*. Once the "Individual Coverage" member's deductible payments reach the individual preferred provider deductible amount, this Plan will begin paying its share of the member's covered preferred provider charges. The member must meet the higher nonpreferred provider deductible before this Plan begins to pay its share of his/her covered charges from nonpreferred providers. Covered charges for preferred provider services are **not** applied to the nonpreferred provider deductible, or vice versa.

Family Coverage — If you have "Family Coverage," your family has two separate deductibles to meet each year: a preferred provider deductible and a nonpreferred provider deductible. Covered charges for preferred provider services are not applied to the nonpreferred provider deductible, or vice versa.

Each family member also has an individual deductible as explained under “Individual Coverage,” above. Payments toward family members’ individual deductible are also applied to the overall family deductible (either the preferred provider deductible or the nonpreferred provider deductible). The entire family meets the annual family deductible when the total deductible amounts for two or more family members reach the family deductible listed under “Family Coverage” on your *Summary of Benefits*. Note: If a member with “Family Coverage” reaches his or her individual deductible amount, no more charges incurred by that member may be used to satisfy the “Family Coverage” family deductible.

The first \$400 you incur in covered preventive services from preferred providers is **not** subject to a deductible.

Admissions Spanning Two Benefit Periods — If a deductible has been met while you are an inpatient and the admission continues into a new year, no additional deductible is applied to that admission’s covered services. However, all other services received during the new year are subject to the deductibles for the new year.

Timely Filing Reminder — Benefits for most covered nonpreferred provider services are payable only after BCBSNM’s records show that the deductible has been met. If you file your own claims for services from nonparticipating providers, you must file them within **12 months** of the date of service. Preferred providers and providers that have “participating” provider agreements with BCBSNM will file claims for you and must submit them within a specified amount of time. If a claim is returned for further information, resubmit it **within 45 days**. See “Filing Claims” in *Section 6* for details.

Coinsurance and Out-of-Pocket Limits

Coinsurance — The **percentage** of covered charges that you must pay for some nonpreferred provider covered services, usually after the applicable deductible has been met. After your share has been calculated, this Plan pays the rest of the covered charge, up to maximum benefit limits, if any. **Remember:** The covered charge may be less than the billed charge for a covered service. Nonpreferred providers may bill you the difference between the covered charge and their billed charge, in addition to your deductible and coinsurance.

Out-of-pocket limits — The maximum amount of **deductible and coinsurance** that you pay in a calendar year. Once the applicable limit is met, this Plan begins paying 100 percent of your preferred or nonpreferred provider covered charges, not to exceed any benefit limits. You have a higher limit to reach before this Plan begins paying nonpreferred provider services at 100 percent of the covered charge.

Coinsurance — After the deductible is met, the member pays a percentage of covered charges for some nonpreferred provider services. This is called “coinsurance” and your percentage is listed on the *Summary of Benefits*. (The deductible is waived for some well-child care services, but you are still responsible for paying the percentage of the covered charge indicated on the *Summary of Benefits*.)

Individual Coverage Out-of-Pocket Limits — Once the “Individual Coverage” member meets the preferred provider deductible, this Plan begins paying 100 percent of the member’s covered preferred provider and drug plan charges. Once a member’s deductible and coinsurance amounts for nonpreferred provider services reach the nonpreferred provider amount indicated on the *Summary of Benefits*, this Plan pays 100 percent of the member’s covered nonpreferred provider charges for the rest of the calendar year. The higher nonpreferred provider limit must be met before this Plan pays 100 percent of the member’s covered charges for nonpreferred provider services. Coinsurance for preferred provider services is **not** applied to the nonpreferred provider out-of-pocket limit, nor vice versa.

Family Coverage Out-of-Pocket Limits — There are two out-of-pocket-limit amounts indicated on your *Summary of Benefits*. One is for preferred provider and drug plan services. The other is for nonpreferred provider services. Covered charges for preferred provider services are not applied to the

nonpreferred provider out-of-pocket limits, or vice versa. Under “Family Coverage,” all amounts applied to an individual’s limits also apply to the applicable family limit.

Each family member also has an individual limit as explained under “Individual Coverage Out-of-Pocket Limits,” on the previous page. Payments toward family members’ individual limits are also applied to the overall family limits (either the preferred provider/drug plan limit or the nonpreferred provider limit). The entire family meets the applicable family limit when the total deductible and coinsurance amounts for two or more family members reach the family limit listed under “Family Coverage” on your *Summary of Benefits*. **Note:** If a member’s individual limit is met under “Family Coverage,” no more charges incurred by that member may be used to satisfy the “Family Coverage” family limit.

The preferred provider/drug plan limits include the preferred provider/drug plan deductible amounts only. Once the preferred provider/drug plan deductible is met for an individual (or for an entire family), that member’s (or family’s) covered preferred provider/drug plan charges are paid at 100 percent of covered charges. You will not need to pay any amounts over the covered charge if you visit a preferred provider for covered services.

When using nonpreferred providers, a family member may meet the individual nonpreferred provider out-of-pocket limit, which is higher than the preferred provider/drug plan limit. The nonpreferred provider limit includes nonpreferred provider deductible and coinsurance amounts. Once the nonpreferred provider out-of-pocket limit is met, the Plan pays 100 percent of nonpreferred provider covered charges.

Penalty amounts; amounts in excess of covered charges (including amounts in excess of annual or lifetime benefit limits); noncovered expenses (including services in excess of annual or lifetime day/visit limitations) are **not** applied to the out-of-pocket limits and are not eligible for 100 percent payment under this provision.

Benefit Limits

There is a general lifetime maximum benefit under this Plan of **\$5,000,000** per member. Certain services also have separate benefit limits per admission, per calendar year, etc. **See your *Summary of Benefits* for details.**

Preventive Services: Well-Child Care

Children through age 17 may obtain preventive/routine services from a nonpreferred provider, subject to 20% coinsurance, for up to \$250 in benefits each year. Under “Using the Informational Graphics: Preferred Provider Benefit Only” in *Section 1*, replace the “preventive services” bullet with the following bullet:

- adult preventive services (ages 18 and older)

Prescription Drugs and Other Items

On pages 29, 30, and 31, remove all references to member coinsurance and minimum and maximum copayments and replace both of the tables (on pages 30 and 31) with the following table:

Type of Prescription	Plan Pays After Annual Deductible is Met:
Generic Drug	100%
Brand-Name Drug	100%
Nonprescription Enteral Nutritional Products and Special Medical Foods	100% of covered charge; both brand-name and generic products require prior approval

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