



Summary of Benefits - Enhanced Plan

This is a summary only that lists the deductible amounts, health care account limit, out-of-pocket limit amounts, and member coinsurance percentages of the BlueEdge HCA Plan.

BlueEdge HCA Plan Benefits – There is no lifetime maximum benefit. However, certain services have maximum annual limits.	Member’s Share of Covered Charges	
	Preferred Provider ^{1,2}	Nonpreferred Provider ^{1,2}
Enhanced Calendar Year Deductible	Enhanced - \$1,500 Individual/\$3,000 Family	
BlueEdge Health Care Account (HCA) – Enhanced Plan: Used to offset deductible, the HCA covers half the deductible. Once the HCA is exhausted, the remainder of the deductible and coinsurance will apply.	Enhanced - \$750 Individual/\$1,500 Family	
Enhanced Calendar Year Out-of-Pocket Limit (Individual/Family): Based on deductible chosen. Family out-of-pocket is aggregate of two times the individual amount. Includes deductible and coinsurance only, NOT penalty amounts, or noncovered charges. ²	Enhanced - \$4,500/\$9,000	Enhanced - \$9,000/\$18,000
Office Services (nonroutine)	20%	40%
Office Visit	20%	40%
Office Surgery (including casts, splints, and dressings)	20% ⁴	40% ⁴
Lab Tests, X-Rays, EKGs, Other Diagnostic Services	20% ⁴	40% ⁴
Allergy Injections, Tests, Serum	20%	40%
Preventive Services	Plan pays 100% (no deductible) for first \$400 in covered charges; thereafter, services are subject to deductible and coinsurance	No benefit
Routine Adult Physicals and Gynecological Exams (ages 18 and older), Related Testing (includes routine Pap tests, mammograms, colonoscopies, cholesterol tests, urinalysis, etc.), and Immunizations		
Well-Child Care; Routine Vision or Hearing Screenings (only through age 17); Routine Testing, and Immunizations	Plan pays 100% (no deductible)	40% (limited to \$250)
Acupuncture Treatment (max. \$1,500/calendar year)	20%	No benefit
Ambulance Services: Ground and Emergency Air Transport	20% ³	
Ambulance Services: Nonemergency Air Transfer	20% ⁴	40% ⁴
Cardiac and Pulmonary Rehabilitation, Outpatient	20% ⁴	No benefit
Dental/Facial Accident, Oral Surgery, and TMJ/CMJ Services	20% ⁴	40% ⁴
Emergency Room Treatment and Urgent Care Facility	20%	40% ³
Hearing Aids and Related Services: Hearing aids for members under age 21 are paid at 100% of covered charges up to a maximum of \$2,200 per ear during any 3-year period; exams and testing are subject to usual cost-sharing provisions. These services are not covered for members age 21 and older.		
Home Health Care/Home I.V. Services (max. 100 visits/cal. year)	20% ⁴	40% ⁴
Hospice Services (lifetime max. \$10,000)	20% ⁴	40% ⁴
Inpatient Hospital/Facility Services (See “Short-Term Rehabilitation” for physical rehabilitation and skilled nursing facility admissions. See “Psychotherapeutic Services” for inpatient treatments related to mental health or chemical dependency. See “Transplant Services,” if applicable.)		
Medical/Surgical and Maternity-Related Room and Board and Covered Ancillaries	20% ⁵	40% ⁵
Routine Nursery Care for Covered Newborns	20%	40%

See numbered footnotes on back.

BlueEdge HCA Plan Benefits — There is no lifetime maximum benefit. However, certain services have maximum annual limits.	Member's Share of Covered Charges	
	Preferred Provider¹	Nonpreferred Provider¹
Lab, X-Ray, and Other Diagnostic Tests	20% ⁴	40% ⁴
Maternity Services , including Routine Pediatrician Care for Covered Newborns (also see "Inpatient Hospital/Facility Services")	20% ⁵	40% ⁵
Prescription Drugs, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods, Smoking/Tobacco Cessation	See your separately issued Prescription Drug Plan Rider	
Prosthetics and Orthotics	20% ^{4,6} (Unlimited benefit)	40% ^{4,6} (Max. \$1,000/year)
Psychotherapeutic Services, Inpatient and Outpatient (Includes mental health services and chemical dependency rehabilitation; maximum benefit of up to \$3,500 /calendar year for outpatient services and 30 days/visits per calendar year for inpatient services. Chemical dependency also limited to services received within a maximum of two 12-month benefit periods .) Administered by BCBSNM.	20% ⁵	No benefit
Short-Term Rehabilitation, Inpatient and Outpatient (Includes services in a rehabilitation facility or skilled nursing facility, and outpatient physical, occupational, and speech therapy services. Benefits limited to \$3,500 per calendar year for outpatient services and 30 days/visits per calendar year for inpatient services.)	20% ⁵	No benefit
Smoking/Tobacco Cessation Counseling (90 minutes total or 2 group sessions per calendar year)	20%	No benefit
Spinal Manipulation Services (max. \$1,500 /calendar year)	20%	No benefit
Supplies and Durable Medical Equipment	20% ^{4,6} (Unlimited benefit)	40% ^{4,6} (Max. \$1,000/year)
Surgery, Inpatient or Outpatient (For transplants, see "Transplant Services," below)	20% ^{4,5}	40% ^{4,5}
Therapy: Chemotherapy, Dialysis, and Radiation	20% ⁴	40% ⁴
Transplant Services (Must be received at a facility that contracts with BCBSNM or with the national BCBS transplant network.)		
Cornea, Kidney, and Bone Marrow	20% ^{4,5}	No benefit
Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney		

FOOTNOTES:

1 The initial covered charges that are incurred in a calendar year are applied to the calendar year deductible. The deductible must be met before benefit payments are made (excluding hearing aids, specified routine/preventive services, and items covered under the drug plan).

2 After a member reaches the out-of-pocket limit, 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 prior approval is not obtained from BCBSNM. See a Benefit Booklet for a list of services requiring prior approval.

5 Admission review is required for inpatient admissions. You pay a \$300 penalty for covered medical/surgical facility services if approval is not obtained. Some services, such as transplants and physical rehabilitation, require additional approval. If you do not receive approval for these individually identified procedures and services, benefits for any related admissions will be denied. See a Benefit Booklet for details.

6 Rental benefits for medical equipment and other items will not exceed the purchase price of a new unit.

IMPORTANT: Deductibles 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.