



## Summary of Benefits and Plan Options

This is a summary only that lists the deductible options, 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 <sup>1,2</sup>	Nonpreferred Provider <sup>1,2</sup>
<b>Calendar Year Deductible Options:</b> Check your ID card for the amount chosen by your group. <sup>1</sup>	<b>Basic</b> - \$2,000 Individual/\$4,000 Family <b>Enhanced</b> - \$1,500 Individual/\$3,000 Family <b>Premier</b> - \$1,000 Individual/\$2,000 Family	
<b>BlueEdge Health Care Account (HCA):</b> Used to offset deductible, the HCA covers half the deductible. Once the HCA is exhausted, the remainder of the deductible and coinsurance will apply.	<b>Basic</b> - \$1,000 Individual/\$2,000 Family <b>Enhanced</b> - \$750 Individual/\$1,500 Family <b>Premier</b> - \$500 Individual/\$1,000 Family	
<b>Calendar Year Out-of-Pocket Limit (Individual/Family):</b> Based on deductible chosen. Family out-of-pocket is aggregate of two times the individual amount. Includes deductible and coinsurance only, <b>NOT</b> penalty amounts, or noncovered charges. <sup>2</sup>	<b>Basic</b> - \$6,000/\$12,000 <b>Enhanced</b> - \$4,500/\$9,000 <b>Premier</b> - \$3,000/\$6,000	<b>Basic</b> - \$12,000/\$24,000 <b>Enhanced</b> - \$9,000/\$18,000 <b>Premier</b> - \$6,000/\$12,000
<b>Office Services (nonroutine)</b>	20%	40%
Office Visit	20%	40%
Office Surgery (including casts, splints, and dressings)	20% <sup>4</sup>	40% <sup>4</sup>
Lab Tests, X-Rays, EKGs, Other Diagnostic Services	20% <sup>4</sup>	40% <sup>4</sup>
Allergy Injections, Tests, Serum	20%	40%
<b>Preventive Services</b>	Plan pays 100% (no deductible) for first \$400 in covered charges; thereafter, services are subject to deductible and coinsurance	
Routine Adult Physicals and Gynecological Exams (ages 18 and older), Related Testing (includes routine Pap tests, mammograms, colonoscopies, cholesterol tests, urinalysis, etc.), and Immunizations	No benefit	
Well-Child Care; Routine Vision or Hearing Screenings (only through age 17); Routine Testing, and Immunizations	Plan pays 100% (no deductible)	40% (limited to <b>\$250</b> )
<b>Acupuncture Treatment (max. \$1,500/calendar year)</b>	20%	No benefit
<b>Ambulance Services: Ground and Emergency Air Transport</b>	20% <sup>3</sup>	
<b>Ambulance Services: Nonemergency Air Transfer</b>	20% <sup>4</sup>	40% <sup>4</sup>
<b>Cardiac and Pulmonary Rehabilitation, Outpatient</b>	20% <sup>4</sup>	No benefit
<b>Dental/Facial Accident, Oral Surgery, and TMJ/CMJ Services</b>	20% <sup>4</sup>	40% <sup>4</sup>
<b>Emergency Room Treatment and Urgent Care Facility</b>	20%	40% <sup>3</sup>
<b>Hearing Aids and Related Services:</b> 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.		
<b>Home Health Care/Home I.V. Services (max. 100 visits/cal. year)</b>	20% <sup>4</sup>	40% <sup>4</sup>
<b>Hospice Services (lifetime max. \$10,000)</b>	20% <sup>4</sup>	40% <sup>4</sup>
<b>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.)</b>		
Medical/Surgical and Maternity-Related Room and Board and Covered Ancillaries	20% <sup>5</sup>	40% <sup>5</sup>
Routine Nursery Care for Covered Newborns	20%	40%

**See numbered footnotes on back.**

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

**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.**