

BlueEdgeSM HSA 100

Summary of Benefits – Option 2



Blue Cross and Blue Shield
of New Mexico

This is a summary only that lists the deductible, out-of-pocket limits, and member coinsurance percentage amounts, and provides a brief description of BlueEdge HSA 100 Plan benefits.

BlueEdge HSA 100 Group Plan Benefits	Member's Share of Covered Charges	
	Preferred Provider ¹	Nonpreferred Provider ¹
	Option 2	
Individual Coverage Type: Calendar Year Deductible	\$5,000	\$10,000
Family Coverage Type: Calendar Year Deductible – No individual deductible under Family Coverage.	\$10,000	\$20,000
Annual Out-of-Pocket Limit – Based on Coverage Type chosen. (Does not include penalty amounts or noncovered charges.) ²	\$5,000 Ind \$10,000 Fam	\$20,000 Ind \$40,000 Fam
Lifetime Maximum (per member)	\$2,000,000	
Office Services (nonroutine); Office Visit/Exam	Plan pays 100% after Deductible	40%
Office Surgery (including casts, splints, and dressings)	Plan pays 100% after Deductible	40% ⁴
Lab Tests, X-Rays, EKGs, Other Diagnostic Tests		40% ⁴
Allergy Injections, Tests, Serum		40%
Preventive Services Routine Adult Physicals and Gynecological Exams (ages 18 and older), Related Testing (includes routine Pap tests, mammograms, preventive/routine colonoscopies, cholesterol tests, urinalysis, etc.), and Immunizations	Deductible waived up to first \$400 in covered charges, thereafter services subject to member cost sharing.	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 \$250 & deductible is waived)
Acupuncture Treatment (max. \$1,500 /year)	Plan pays 100% after Deductible	No benefit
Ambulance Services: Ground and Emergency Air Transport	100% after Deductible ³	
Ambulance Services: Nonemergency Air Transfer	Plan pays 100% after Deductible ⁴	40% ⁴
Cardiac and Pulmonary Rehabilitation, Outpatient	Plan pays 100% after Deductible ⁴	No benefit
Dental/Facial Accident, Oral Surgery, and TMJ/CMJ Services	Plan pays 100% after Deductible ⁴	40% ⁴
Emergency Room Treatment	Plan pays 100% after Deductible 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 /year)	Plan pays 100% after Deductible ⁴	40% ⁴
Hospice Services (lifetime max. \$10,000)	Plan pays 100% after Deductible 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	Plan pays 100% after Deductible ⁵	40% ⁵
Routine Nursery Care for Covered Newborns	Plan pays 100% after Deductible	40%

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BlueEdge HSA 100 Group Benefits	Member's Share of Covered Charges	
	Preferred Provider ¹	Nonpreferred Provider ¹
Lab, X-Ray, and Other Diagnostic Tests	Plan pays 100% after Deductible ⁴	40% ⁴
Maternity Services , including Routine Pediatric Care for Covered Newborns (also see "Inpatient Hospital/Facility Services")	Plan pays 100% after Deductible ⁵	40% ⁵
Outpatient Facility/Physician (including surgical procedures related to pregnancy and family planning, nonroutine colonoscopies)	Plan pays 100% after Deductible ^{4,5}	40% ^{4,5}
Prosthetics and Orthotics	Plan pays 100% after Deductible ^{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/year for outpatient services and 30 days/year for inpatient services. Chemical dependency also limited to services received within a maximum of two 12-month benefit periods .) Administered by BCBSNM.	Plan pays 100% after Deductible ^{4,5}	No benefit
Short-Term Rehabilitation: Occupational, Physical, and Speech Therapy; including Physical Rehabilitation and Skilled Nursing Facility; maximum benefit of up to \$3,500/year for outpatient services and 30 days/year for inpatient services.	Plan pays 100% after Deductible ^{4,5}	No benefit
Smoking/Tobacco Cessation Counseling (90 minutes total or 2 group sessions/year)	Plan pays 100% after Deductible	No benefit
Spinal Manipulation Services (max. \$1,500/year)	Plan pays 100% after Deductible	No benefit
Supplies, Durable Medical Equipment	Plan pays 100% after Deductible ^{4,6} (unlimited benefit)	40% ^{4,6} (max. \$1,000/year)
Therapy: Chemotherapy, Dialysis, and Radiation	Plan pays 100% after Deductible 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	Plan pays 100% after Deductible ^{4,5}	No benefit
Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney		
Prescription Drugs, Insulin, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods		
Retail Pharmacy/Specialty Pharmacy Program (up to a 30-day supply or 180 units, whichever is less. Includes nonprescription enteral nutritional products and special medical foods.) ^{4,7}	Plan pays 100% after Deductible ⁴	
Mail-Order Plan (up to a 90-day supply or 540 units, whichever is less.) ^{4,7}	Plan pays 100% after Deductible ⁴	

FOOTNOTES:

1 The Individual or Family Coverage Type deductible (as applicable) must be met before benefit payments are made, including for services covered under the drug plan. The Family Coverage Type deductible is satisfied when one or all covered members have met the deductible amount chosen.

2 After a member or family reaches the applicable out-of-pocket limit, BCBSNM pays 100 percent of that member's or family's Preferred Provider or Nonpreferred Provider covered charges, whichever is applicable. Amounts paid under the drug plan are subject to the Preferred Provider deductible. Preferred Provider/prescription drug plan amounts do not cross-apply to the Nonpreferred Provider deductible or out-of-pocket limit amount, or vice versa.

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 will not exceed the purchase price of a new unit. In addition to all equipment costing \$500 or more, specific equipment, prosthetics, appliances, and orthotics require prior approval or services will not be covered.

7 Prescription drugs and other items covered only under the drug plan (e.g., diabetic supplies) must be purchased at a pharmacy that participates in the Retail/Specialty Pharmacy or Mail Order Service programs. (BCBSNM has contracted with a separate program for administration of your drug plan benefits.)

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.