



Summary of Benefits: Basic Plan

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

BlueEdge HSA Group Plan Benefits – There is no lifetime maximum benefit. However, certain services have maximum annual limits. See below.	Member’s Share of Covered Charges	
	Preferred Provider ¹	Nonpreferred Provider ¹
Individual Coverage Option: Calendar Year Deductible – Check your ID card to verify the amount chosen by your group and your coverage type.	\$2,600	
Family Coverage Option: Calendar Year Deductible – Check your ID card to verify the amount chosen by your group and your coverage type. No individual deductible.	\$5,150	
Annual Out-of-Pocket Limit – Based on Coverage Type chosen. (Includes deductible, copayments, and coinsurance amounts only - NOT penalty amounts or noncovered charges.) ²	\$5,000/Individual Coverage \$10,000/Family Coverage	\$10,000/Individual Coverage \$20,000/Family Coverage
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 Tests	20% ⁴	40% ⁴
Allergy Injections, Tests, Serum	20%	40%
Preventive Services		
Routine Adult Physicals and Gynecological Exams (ages 18 and older), Related Testing (includes routine Pap tests, mammograms, colonoscopies, cholesterol tests, urinalysis, etc.), and Immunizations	Plan pays 100% (no deductible) for first \$400 in covered charges (thereafter, services are subject to deductible and coinsurance)	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)
Acupuncture Treatment (max. \$1,500/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/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%
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
Prosthetics and Orthotics	20% ^{4,6} (Unlimited benefit)	40% ^{4,6} (max. \$1,000/year)

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.

BlueEdge HSA Group Benefits — There is no lifetime maximum benefit. However, certain services have maximum annual limits. See below.	Member's Share of Covered Charges	
	Preferred Provider¹	Nonpreferred Provider¹
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/visits per year for inpatient services. Chemical dependency also limited to services received within a maximum of two 12-month benefit periods .) Administered by BCBSNM.	20% ^{4,5}	No benefit
Short-Term Rehabilitation: Occupational, Physical, and Speech Therapy; including Physical Rehabilitation and Skilled Nursing Facility Inpatient Rehabilitation (max. 30 days/year) Outpatient and Office Rehabilitation (max. \$3,500/year)	20% ^{4,5}	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/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		

Prescription Drugs, Insulin, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods				
All covered drugs and other items are subject to the deductible and out-of-pocket limit provisions. Certain drugs, specials medical foods, and enteral nutritional products require prior approval or benefits will be denied. ⁴	Type of Prescription	Percentage of covered charge you pay (coinsurance), if the percentage is between the minimum and maximum percentage amounts	Minimum Percentage Amount	Maximum Percentage Amount ⁷
Retail Pharmacy Program (up to a 30-day supply or 180 units, whichever is less.) ⁷	Generic Drug	25%	\$20	\$75
	Brand-Name Drug	50%	\$40	\$125
Mail-Order Plan (up to a 90-day supply or 540 units, whichever is less.) ⁷	Generic Drug	25%	\$40	\$150
	Brand-Name Drug	50%	\$80	\$250
Nonprescription enteral nutritional products and special medical foods (up to a 30-day supply/30-day period, needs prior approval.) ⁴		50% ⁴		

FOOTNOTES:

1 The Individual or Family Coverage deductible (as applicable) must be met before benefit payments are made, including for services covered under the drug plan. The Family Coverage deductible is satisfied when one or all covered members have met the deductible amount chosen. The first \$400 in covered preventive care services that are incurred in a calendar year not subject to the medical plan deductible.

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 limit. Preferred Provider/prescription drug coinsurance and copayment amounts do not cross-apply to the Nonpreferred Provider 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 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.