Blue Preferred EPO HSA 100SM 0001



\$2,900 Deductible Plan

Highlights deductible, out-of-pocket limits, member coinsurance percentage amounts; and provides a brief description of Blue Preferred EPO HSA 100 health care plan benefits.

EPO Benefits – This plan does not cover services received from nonpreferred providers, sexpect for urgent/merregency services. Member's Shares of Covered Charges When Using Blue Preferred Providers \$2,900 Family Calendar Year Deductible \$2,900 \$2,900 Family Calendar Year Deductible \$2,900 \$5,800 Family Calendar Year Deductible \$5,800 \$5,800 Intervised Earling \$5,800 \$2,900 Annual Out-of-Peckta Limit (Includes deductible, colrages,)* \$5,800 \$2,900 Frimary Care Providers \$5,800 \$2,900 Office Surger, Medication Management \$2,900 \$2,900 Office Surger, Including casts, splints, and dressings) \$0% after Deductible \$2,900 Office Surger, Including casts, splints, and dressings) \$0% after Deductible \$0% after Deductible Office Surger, Including casts, splints, and dressings) \$0% after Deductible \$0% after Deductible Office Surger, Including casts, splints, and dressings) \$0% after Deductible \$0% after Deductible Office Surger, Including casts, splints, and dressings) \$0% after Deductible \$0% after Deductible Office Surger, Including casts, splints, and dressings) \$0% after Deductible \$0%	Blue Preferred EPO HSA 100 health care plan benefits.		
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Emergency Room (includes all related ER services) Observation Room (including pregnancy) Urgent Care Facility0% after DeductibleHearing Aids and Related Services: Hearing aids for members under age 21 are paid at 100% after deductible, up to a maximum of 1 hearing aid per hearing-impaired ear every 3 years; exams and testing are subject to usual cost-sharing provisions. These services are not covered for members age 21 and older.0% after Deductible, up to a maximum of 1 hearing aid per hearing-impaired ear every 3 years; exams and testing are subject to usual cost-sharing provisions. These services are not covered for members age 21 and older.Home Health Care (prescribed home nursing care, physician, and therapy care – max. 100 visits/year)0% after DeductibleHospice0% after DeductibleHospice0% after Deductible ^{3,4} Inpatient Hospital/Facility Services0% after Deductible ^{3,4} Room and Board and Physician Care such as Physician Visits, Surgeon, Anesthesiologist, Lab, X-Ray, Other Diagnostic Tests for: Medical/Surgical, Mental Health/Chemical Dependency (including partial hospitalization), Residential Treatment Center and Maternity-Related and Delivery0% after Deductible ⁴ Maternity Services0% after DeductibleRoutine Nursery/Pediatrician Care for Covered Newborns0% after Deductible			0% after Deductible ⁵
Hearing Aids and Related Services: Hearing aids for members under age 21 are paid at 100% after deductible, up to a maximum of 1 hearing aid per hearing-impaired ear every 3 years; exams and testing are subject to usual cost-sharing provisions. These services are not covered for members age 21 and older. Home Health Care (prescribed home nursing care, physician, and therapy care – max. 10% after Deductible 0% after Deductible Hospice 0% after Deductible Hong Health/Facility Services 0% after Deductible Room and Board and Physician Care such as Physician Visits, Surgeon, Anesthesiologist, Lab, X-Ray, Other Diagnostic Tests for: Medical/Surgical, Mental Health/Chemical Dependency (including partial hospitalization), Residential Treatment Center and Maternity-Related and Delivery 0% after Deductible ⁴ Maternity Services 0% after Deductible 0% after Deductible Routine Nursery/Pediatrician Care for Covered Newborns 0% after Deductible 0% after Deductible	Emergency Room (includes all related ER services) Observation Room (including pregnancy)		0% after Deductible
100 visits/year) 0% after Deductible Hospice 0% after Deductible ^{3,4} Inpatient Hospital/Facility Services 0% after Deductible ⁴ Room and Board and Physician Care such as Physician Visits, Surgeon, Anesthesiologist, Lab, X-Ray, Other Diagnostic Tests for: Medical/Surgical, Mental Health/Chemical Dependency (including partial hospitalization), Residential Treatment Center and Maternity-Related and Delivery 0% after Deductible ⁴ Maternity Services 0% after Deductible	Hearing Aids and Related Services: Hearing aids for members u of 1 hearing aid per hearing-impaired ear every 3 years; exams services are not covered for members age 21 and older.	and testing are subje	
Inpatient Hospital/Facility Services Room and Board and Physician Care such as Physician Visits, Surgeon, Anesthesiologist, Lab, X-Ray, Other Diagnostic Tests for: Medical/Surgical, Mental Health/Chemical Dependency (including partial hospitalization), Residential Treatment Center and Maternity-Related and Delivery Maternity Services Routine Nursery/Pediatrician Care for Covered Newborns			0% after Deductible
Room and Board and Physician Care such as Physician Visits, Surgeon, 0% after Deductible 4 Anesthesiologist, Lab, X-Ray, Other Diagnostic Tests for: Medical/Surgical, Mental 0% after Deductible 4 Health/Chemical Dependency (including partial hospitalization), Residential Treatment 0% after Deductible 4 Maternity Services 0% after Deductible 4 Routine Nursery/Pediatrician Care for Covered Newborns 0% after Deductible			0% after Deductible ^{3,4}
Anesthesiologist, Lab, X-Ray, Other Diagnostic Tests for: Medical/Surgical, Mental 0% after Deductible ⁴ Health/Chemical Dependency (including partial hospitalization), Residential Treatment 0% after Deductible ⁴ Center and Maternity-Related and Delivery Maternity Services Routine Nursery/Pediatrician Care for Covered Newborns 0% after Deductible			
Routine Nursery/Pediatrician Care for Covered Newborns 0% after Deductible	Anesthesiologist, Lab, X-Ray, Other Diagnostic Tests for: Medical/Surgical, Mental Health/Chemical Dependency (including partial hospitalization), Residential Treatment Center and Maternity-Related and Delivery		0% after Deductible ⁴
	Maternity Services		F
Extended Newborn Stay 0% after Deductible ⁴	Routine Nursery/Pediatrician Care for Covered Newborns		0% after Deductible
	Extended Newborn Stay		0% after Deductible ⁴

* A Primary Care Provider (PCP) is a physician or other professional provider in one of the following categories of practice: Family or General Practice, Internal Medicine, Pediatrics, Obstetrics and Gynecology, and Gynecology Only.

EPO Benefits – This plan does not cover services received from nonpreferred providers, except for urgent/emergency services.	Member's Share of Covered Charges When Using Blue Preferred Providers	
Lab Tests, X-Rays, and Other Diagnostic Services (including tests done in office, outpatient facility, freestanding facility, ambulatory surgery facility, or any other place of treatment)	0% after Deductible	
MRI, CT Scans, PET Scans (including tests done in office, outpatient facility, freestanding facility, ambulatory surgery facility, or any other place of treatment)	0% after Deductible ³	
Outpatient Facility/Surgeon/Physician (including surgical procedures related to pregnancy and family planning; and nonroutine colonoscopies)	0% after Deductible	
Prescription Drugs, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods, Smoking/Tobacco Cessation	See your separately issued Prescription Drug Plan Rider	
 Short-Term Rehabilitation: Occupational, Physical, and Speech Therapy, including Skilled Nursing Facility and Inpatient Rehabilitation Skilled Nursing Facility (max. 60 days/year)⁴ Outpatient Physical, Speech and Occupational Therapies (max. 30 visits/year/combined) 	0% after Deductible	
Transplant Services (Must use facilities that contract with BCBSNM or with the national BCBS transplant network.)		
Cornea, Kidney, Bone Marrow Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney: \$10,000 maximum for travel and lodging per diem	0% after Deductible ^{3,4}	

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.

² After a member (or family) reaches the out-of-pocket limit during a single calendar year, BCBSNM pays 100 percent of that member's (or family's) covered charges for the remainder of the calendar year.

³ Certain services are not covered if preauthorization is not obtained from BCBSNM. See a benefit booklet for details.

⁴ Preauthorization is required for inpatient admissions. Some services, such as transplants, require additional preauthorization. If you do not receive preauthorization for these individually-identified procedures and services, benefits for any related admissions will be denied.

⁵ Rental benefits for medical equipment and other items will not exceed the purchase price of a new unit.

This is a summary only – please refer to the Summary of Benefits and Coverage (SBC) document and Benefit Booklet for more details.

Blue Cross and Blue Shield of New Mexico (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.