Blue Preferred EPO HSA 100[SM] 0011

\$5,000 Deductible Plan

Blue Cross and Blue Shield of New Mexico

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, except for urgent/emergency services.		**Member's Share of Covered Charges When Using Blue Preferred Providers**
Individual Calendar Year Deductible[1]		\$5,000
Family Calendar Year Deductible – Embedded: One family member meets the Individual deductible amount; benefits begin paying at 100% for that member. Remaining Family members continue to apply services to the Family deductible until the total Family deductible is met; then all family members' benefits pay at 100%.[1]		\$10,000
Annual Out-of-Pocket Limit (Includes deductible, coinsurance, and prescription drugs; does not include penalty amounts or noncovered charges.)[2]		\$5,000 (\$10,000/family)
Primary Care Provider (PCP) Office Services *		
Office Visit, Medication Management Virtual Visit (MDLIVE providers)		0% after Deductible 0% after Deductible
Office Surgery (including casts, splints, and dressings)		0% after Deductible
Mental Health/Chemical Dependency Services (office visit only) Virtual Visit (MDLIVE providers)		0% after Deductible 0% after Deductible
Specialty Physician Office Services		
Office Visit, Medication Management, Office Evaluations		0% after Deductible
Office Surgery (including casts, splints, and dressings)		0% after Deductible
Preventive Care Routine Adult Physicals and Gynecological Exams, Well-Child Care; Routine Vision or Hearing Screenings, Related Testing (includes routine Pap tests, cholesterol tests, urinalysis, etc.), Routine Colonoscopies (outpatient/office), and Immunizations		No Charge (deductible waived)
Acupuncture/Spinal Manipulation (max. **25 visits**/year/combined)		0% after Deductible
Allergy Services (testing and injections)	**Primary Provider**	0% after Deductible
	Specialist	0% after Deductible
Allergy Serum		0% after Deductible
Ambulance Services		0% after Deductible[3]
Autism Spectrum Disorders Applied Behavioral Analysis,[3] and Occupational, Physical, and Speech Therapy		0% after Deductible
Cardiac and Pulmonary Rehabilitation (outpatient)		0% after Deductible
Chemotherapy, Dialysis, and Radiation Therapy		0% after Deductible
Dental/Facial Accidents, Oral Surgery, TMJ/CMJ Services		0% after Deductible[3]
Durable Medical Equipment, Supplies, Prosthetics, and Orthotics		0% after Deductible[5]
Emergency and Urgent Care Services Emergency Room (includes all related ER services) Observation Room (including pregnancy) Urgent Care Facility		0% after Deductible
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. **100 visits**/year)		0% after Deductible
Hospice		0% after Deductible[3,4]
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		0% after Deductible[4]
Maternity Services		
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	0% after Deductible [3,4]
Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney: **$10,000** maximum for travel and lodging per diem	

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.

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