BlueEdge HCA PPO℠ 0031

\$5,000 Deductible Plan

Blue Cross and Blue Shield of New Mexico

Highlights copayments, deductible, out-of-pocket limits, member coinsurance percentage amounts, and provides a brief description of BlueEdge HCA's Health Care Plan benefits.

PPO 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]**
Annual Deductible[1] – Deductible does not apply to services with copays or "no charge."	\$5,000 (\$10,000/family)	\$10,000 (\$20,000/family)
Annual Out-of-Pocket Limit (Includes deductible, coinsurance, and copayments; NOT penalty amounts, or noncovered charges.[2]	\$5,850 (\$11,700/family)	\$17,550 (\$35,100/family)
Health Care Account (HCA): Employer-owned account used to assist their employees and family members to meet their PPO deductible. **HCA** pays first \$1,500 of the PPO Deductible.	\$1,500/Individual \$3,000/Two-party or Family	
Primary Preferred Provider (PPP)* Office Visit/Exam and initial office visit to diagnose pregnancy Virtual Visit (MDLIVE providers)	\$30 copay/visit \$0 copay/visit	50% coinsurance Not Covered
Mental Health and Chemical Dependency (office visit only) Virtual Visit (MDLIVE providers)	\$30 copay/visit \$0 copay/visit	50% coinsurance Not Covered
Specialist Office Visit and initial office visit to diagnose pregnancy	\$50 copay/visit	50% coinsurance
Office Surgery (including casts, splints, and dressings)	Office Visit (OV) Copay	50% coinsurance
Allergy Injections, Tests, Serum	Office Visit (OV) Copay	50% coinsurance
Preventive Services 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)	50% coinsurance
Acupuncture Treatment (max. **25 visits**/year)	Office Visit (OV) Copay	50% coinsurance
Ambulance Services: Ground and Emergency Air Transport	30% coinsurance[3]	
Autism Spectrum Disorders Applied Behavioral Analysis[4], and Occupational, Physical, and Speech Therapy	\$30 copay/visit	50% coinsurance
Cardiac and Pulmonary Rehabilitation	30% coinsurance	50% coinsurance
Dental/Facial Accident, Oral Surgery, and TMJ/CMJ Services	30% coinsurance[4]	50% coinsurance[4]
Emergency Room Treatment	\$200 copay/visit[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 **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/Home I.V. Services (max. **100 visits**/year)	30% coinsurance	50% coinsurance
Hospice Services	30% coinsurance[4,5]	50% coinsurance[4,5]
Lab, X-Ray, and Other Basic Diagnostic Tests	30% coinsurance (deductible waived)	50% coinsurance
MRI, CT Scans, PET Scans	\$250 copay per day[4]	50% coinsurance[4]
Inpatient Hospital/Facility Services		
Medical/Surgical, Mental Health/Chemical Dependency (including Partial Hospitalization), Residential Treatment Center, Maternity-Related Room and Board, and Covered Ancillaries	30% coinsurance[5]	50% coinsurance[5]
Maternity Services	30% coinsurance[5]	50% coinsurance[5]
Routine Nursery/Pediatrician Care for Covered Newborns	30% (deductible waived)[5]	50% coinsurance[5]
Extended Newborn Stay	30% coinsurance[5]	50% coinsurance[5]
Outpatient Facility/Surgeon/Physician (including surgical procedures related to pregnancy and family planning; and nonroutine colonoscopies)	30% coinsurance	50% coinsurance

* A Primary Preferred Provider 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. A "PPP" is a Primary Preferred Provider in the preferred provider network.

PPO 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]**
Outpatient Infusion Therapy (for routine maintenance drugs) Administered by Professional Provider in Home, Office or Infusion Suite Outpatient Facility	\$50 copay/visit[4] \$500 copay/visit[4]	50% coinsurance
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 (max. **35 visits**/year/combined)	\$30 copay/visit	50% coinsurance
Skilled Nursing Facility and Inpatient Rehabilitation (max. **30 days**/year/combined)	30% coinsurance[5]	50% coinsurance[5]
Spinal Manipulation Services (max. **25 visits**/year)	Office Visit (OV) Copay	50% coinsurance
Supplies, Durable Medical Equipment, Prosthetics, Orthotics	30% coinsurance[6]	50% coinsurance[6]
Therapy: Chemotherapy, Dialysis, and Radiation	30% coinsurance	50% coinsurance
Transplant Services (Must be received at a facility that contracts with BCBSNM or with the national BCBS transplant network.)		
Cornea, Kidney, and Bone Marrow	Usual copays or coinsurance based on place of treatment and type of service[4,5]	
Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney (**\$10,000** maximum for travel and lodging per diem)	30% coinsurance[4,5]	Not Covered
Urgent Care Facility	\$75 copay/visit	\$75 copay/visit

Footnotes:

[1] The deductible must be met before benefit payments are made for services with coinsurance. Deductible amounts do not cross-apply in the Preferred Provider and Nonpreferred Provider benefit levels.

[2] After a member reaches the applicable 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 preauthorization is not obtained from BCBSNM. See a Member's Benefit Booklet for a list of services requiring preauthorization.

[5] Preauthorization is required for inpatient admissions. Some services, such as transplants and inpatient physical rehabilitation, require additional preauthorization. If you do not receive preauthorization for these individually-identified procedures and services, benefits for any related admissions will be denied. See a Member's Benefit Booklet for details.

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

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.

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