BlueEdge HSA 100[SM] 0031

\$6,900 Deductible Plan

Blue Cross and Blue Shield of New Mexico

Highlights the deductible, out-of-pocket limits, member coinsurance percentage amounts, and provides a brief description of BlueEdge HSA 100 Plan benefits.

PPO Benefits – There is no lifetime maximum, however some services have benefit limits.	**Member's Share of Covered Charges**	
	Preferred Provider[1]	**Nonpreferred Provider[1]**
Individual Calendar Year Deductible	\$6,900	\$10,000
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%.	\$10,000	\$20,000
Annual Out-of-Pocket Limit (Includes deductible, coinsurance, and prescription drugs; does not include penalty amounts or noncovered charges.)[2]	\$6,900 Individual \$10,000 Family	\$15,000 Individual \$30,000 Family
Office Services (nonroutine): Office Visit/Exam/Consultation Office Surgery (including casts, splints, and dressings) Allergy Injections, Tests, Serum	0% after Deductible	40% coinsurance
Virtual Visit (MDLIVE providers)	0% after Deductible	Not Covered
Mental Health/Chemical Dependency (office visit only) Virtual Visit (MDLIVE providers)	0% after Deductible 0% after Deductible	40% coinsurance Not Covered
Preventive Services Routine Adult Physicals and Gynecological Exams, Related Testing (includes routine Pap tests, mammograms, cholesterol tests, urinalysis, etc.), Routine Colonoscopy (outpatient/office), Smoking/Tobacco Cessation Counseling, and Immunizations Well-Child Care; Routine Vision or Hearing Screenings; Routine Testing, and Immunizations	No Charge (Deductible waived)	40% coinsurance
Acupuncture Treatment (max. **25 visits**/year)	0% after Deductible	40% coinsurance
Ambulance Services: Ground and Emergency Air Transport	0% after PPO Deductible[3]	
Ambulance Services: Nonemergency Air Transport	0% after Deductible[4]	40% coinsurance[4]
Autism Spectrum Disorders Applied Behavioral Analysis,[4] and Occupational, Physical, and Speech Therapy	0% after Deductible	40% coinsurance
Cardiac and Pulmonary Rehabilitation (outpatient)	0% after Deductible	40% coinsurance
Dental/Facial Accident, Oral Surgery, and TMJ/CMJ Services	0% after Deductible[4]	40% coinsurance[4]
Emergency Room Treatment	0% after PPO Deductible[3]	
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/Home I.V. Services (max. **100 visits**/year)	0% after Deductible	40% coinsurance
Hospice Services	0% after Deductible[4,5]	40% coinsurance[4,5]
Hospital/Facility Services (See "Short-Term Rehabilitation" for physical rehabilitation and skilled nursing facility, and "Transplant Services," if applicable.)		
Medical/Surgical, Mental Health/Chemical Dependency (including partial hospitalization), Residential Treatment Center, Maternity-Related Room and Board and Covered Ancillaries	0% after Deductible[5]	40% coinsurance[5]
Routine Nursery Care for Covered Newborns	0% after Deductible	40% coinsurance
Maternity Services, including Routine Pediatrician Care for Covered Newborns (also see "Hospital/Facility Services")	0% after Deductible[5]	40% coinsurance[5]
Lab, X-Ray, and Other Diagnostic Tests	0% after Deductible	40% coinsurance
MRIs, CT Scans, PET Scans	0% after Deductible[4]	40% coinsurance[4]
Outpatient Facility/Physician (including surgical procedures related to pregnancy and family planning, nonroutine colonoscopies)	0% after Deductible	40% coinsurance

PPO Benefits – There is no lifetime maximum, however some services have benefit limits.	**Member's Share of Covered Charges**	
	Preferred Provider[1]	**Nonpreferred Provider[1]**
Prescription Drugs, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods, Smoking/Tobacco Cessation	See your separately issued Prescription Drug Plan Rider	
Short-Term Rehabilitation: **Skilled Nursing Facility/Inpatient Rehabilitation** (max. **30 days**/year/combined)[5] **Outpatient – Occupational, Physical and Speech Therapy** (max. **35 visits**/year/combined)	0% after Deductible[5]	40% coinsurance[5]
Spinal Manipulation Services (max. **25 visits**/year)	0% after Deductible	40% coinsurance
Supplies, Durable Medical Equipment, Prosthetics, Orthotics	0% after Deductible[6]	40% coinsurance[6]
Therapy: Chemotherapy, Dialysis, and Radiation	0% after Deductible	40% 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 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)	0% after Deductible[4,5]	No Benefit
Urgent Care Facility	0% after Deductible	40% coinsurance

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 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 preauthorization is not obtained from BCBSNM. See a Benefit Booklet for a list of services requiring preauthorization.

[5] 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. See a Benefit Booklet for details.

[6] Rental benefits 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.