BlueEdge HSA℠ 0001

$2,900 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 Plan benefits.

PPO Benefits – There is no lifetime maximum benefit. However, certain services have maximum annual limits.	**Member's Share of Covered Charges**	
	Preferred Provider[1]	**Nonpreferred Provider[1]**
Individual Annual Deductible	$2,900	
Family Annual Deductible: Embedded - One family member meets the Individual deductible dollar amount; coinsurance benefits begin for that member. Remaining Family members continue to apply services to the Deductible until the total Family Deductible amount is met.	$5,800	
Annual Out-of-Pocket Limit (Includes deductible, coinsurance, and prescription drugs only - NOT penalty amounts or noncovered charges.)[2]	$4,000/Individual Coverage $8,000/Family Coverage	$12,000/Individual Coverage $24,000/Family Coverage
Office Services (nonroutine)	20% coinsurance	40% coinsurance
Office Visit/Exams/Consultations Virtual Visit (MDLIVE providers)	20% coinsurance 20% coinsurance	40% coinsurance Not Covered
Allergy Injections, Tests, Serum	20% coinsurance	40% coinsurance
Office Surgery (including casts, splints, and dressings)	20% coinsurance	40% coinsurance
Mental Health and Chemical Dependency (office visit only) Virtual Visit (MDLIVE providers)	20% coinsurance 20% coinsurance	40% coinsurance Not Covered
Preventive Services Routine Adult Physicals and Gynecological Exams, Related Testing (includes routine Pap tests, mammograms, cholesterol tests, urinalysis, etc.), Routine colonoscopies (outpatient/office), Immunizations, Well-Child Care; and Routine Vision or Hearing Screenings	No Charge (Deductible waived)	40% coinsurance
Acupuncture Treatment (max. **25 visits**/year)	20% coinsurance	40% coinsurance
Ambulance Services: Ground and Emergency Air Transport	20% coinsurance[3]	
Ambulance Services: Nonemergency Air Transfer	20% coinsurance[4]	40% coinsurance[4]
Autism Spectrum Disorders Applied Behavioral Analysis,[4] and Occupational, Physical, and Speech Therapy	20% coinsurance	40% coinsurance
Cardiac and Pulmonary Rehabilitation, Outpatient	20% coinsurance	40% coinsurance
Dental/Facial Accident, Oral Surgery, and TMJ/CMJ Services	20% coinsurance[4]	40% coinsurance[4]
Emergency Room Treatment	20% coinsurance[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)	20% coinsurance	40% coinsurance
Hospice Services	20% coinsurance[4,5]	40% coinsurance[4,5]
Inpatient Hospital/Facility and Physician Services		
Medical/Surgical, Mental Health/Chemical Dependency (including partial hospitalization), Residential Treatment Center, Maternity-Related Room and Board and Covered Ancillaries	20% coinsurance[5]	40% coinsurance[5]
Routine Nursery Care for Covered Newborns	20% coinsurance	40% coinsurance
Lab, X-Ray, and Other Diagnostic Tests	20% coinsurance	40% coinsurance
MRIs, CT Scans, PET Scans	20% coinsurance[4]	40% coinsurance[4]
Maternity Services (pre- and post-natal, delivery, and newborn charges)	20% coinsurance[5]	40% coinsurance[5]
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)	20% coinsurance[5]	40% coinsurance[5]
Spinal Manipulation Services (max. **25 visits**/year)	20% coinsurance	40% coinsurance
Supplies, Durable Medical Equipment, Prosthetics, Orthotics	20% coinsurance[6]	40% coinsurance[6]
Outpatient Facility/Surgeon/Physician (surgical procedures, pregnancy-related services, and non-routine colonoscopies)	20% coinsurance	40% coinsurance

PPO Benefits – There is no lifetime maximum benefit. However, certain services have maximum annual 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	
Therapy: Chemotherapy, Dialysis, and Radiation	20% coinsurance	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)	20% coinsurance[4,5]	No Benefit
Urgent Care Facility	20% coinsurance	40% coinsurance

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.

[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 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.