BlueEdge℠
Individual HSA Plan
Summary of Benefits/Plan Options

Blue Cross and Blue Shield of New Mexico

This is a summary only that lists the out-of-pocket and cost-sharing amounts for each plan (based on choices of Individual or Family coverage and deductible level), and provides a very brief description of BlueEdge Individual HSA Plan benefits. Your ID card will show the deductible amount selected.

BlueEdge Individual HSA Benefits – There is no lifetime maximum benefit. However, certain services have maximum annual limits. See below.	**Member's Share of Covered Charges**	
	Preferred Provider (PPO)[1]	**Nonpreferred Provider**[1]
Individual Coverage: Calendar Year Deductible Options – Check your ID card to verify the Individual Coverage deductible amount chosen by you.	Premier - $1,200 Enhanced - $1,700 Basic - $2,600	
Family Coverage: Calendar Year Deductible Options – Check your ID card to verify the Family Coverage deductible amount chosen by you.	Premier - $2,400 Enhanced - $3,450 Basic - $5,150	
Annual Out-of-Pocket Limit: Based on deductible and type of coverage chosen – Includes deductible, copayments, and coinsurance only; does NOT include penalty amounts or non-covered charges.[2]	**Individual Coverage** $2,000 $3,000 $5,000 **Family Coverage** $4,000 $6,000 $10,000	**Individual Coverage** $3,000 $5,000 $6,000 **Family Coverage** $6,000 $10,000 $12,000
Office Services (nonroutine)	20%	40%
Office Visit	20%	40%
Office Surgery (including casts, splints, and dressings)	20%[3]	40%[3]
Lab Tests, X-Rays, EKGs, Other Diagnostic Tests	20%[3]	40%[3]
Allergy Injections, Tests, Serum	20%	40%
Preventive Services Routine Adult Physicals and Gynecological Exams including Related Testing (e.g., routine Pap tests, mammograms, colonoscopies, cholesterol tests, urinalysis, etc.); Well-Child Care including Immunizations; Routine Lab, and Routine Vision or Hearing Screenings (through age 17)	Plan pays 100% (no deductible) for first $400 in covered charges (thereafter, services are subject to deductible and coinsurance)	No benefit
Acupuncture Treatment (max. **$500**/year)	20%	No benefit
Ambulance Services: Ground and Emergency Air Transport	20%[4]	
Ambulance Services: Nonemergency Air Transfer	20%[3]	40%[3]
Cardiac and Pulmonary Rehabilitation	20%[3]	No benefit
Dental/Facial Accidents, Oral Surgery, TMJ/CMJ Services	20%[3]	40%[3]
Emergency Room Treatment and Urgent Care Facility	20%	40%[4]
Hearing Aids and Related Services: Hearing aids for members under age 21 are paid at 100% of covered charges up to a maximum of **$2,200** per ear during any 3-year period; 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/Hospice (max. **100** visits/year for all three services combined)	20%[3]	40%[3]
Inpatient Hospital/Facility Services (See "Short-Term Rehabilitation" for physical rehabilitation and skilled nursing facility services. Also, see "Transplant Services," if applicable.)		
Room and Board and Physician Care such as Physician Visits, Surgeon, and Anesthesiologist	20%[5]	40%[5]
Routine Nursery Care for Covered Newborn Infants (Other services related to pregnancy are **not** covered.)	20%	40%

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.

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	Preferred Provider (PPO)[1]	**Nonpreferred Provider**[1]
Lab, X-Ray, and Other Diagnostic Tests	20%[3]	40%[3]
Prosthetics and Orthotics	20%[3,6]	40%[3,6] (max. **$1,000**/year)
Short-Term Rehabilitation: Occupational, Physical, and Speech Therapy; including Physical Rehabilitation and Skilled Nursing Facility **Inpatient Rehabilitation** (max. **30 days**/year) **Outpatient and Office Rehabilitation** (max. **$3,500**/year)	20%[3,5]	No benefit
Spinal Manipulation Services (max. **$500**/year)	20%	No benefit
Supplies and Durable Medical Equipment	20%[3,6] (Unlimited benefit)	40%[3,6] (max. of **$1,000**/year)
Surgery, Inpatient or Outpatient (For transplants, see "Transplant Services," below)	20%[3,5]	40%[3,5]
Therapy: Chemotherapy, Dialysis, and Radiation	20%[3]	40%[3]
Transplant Services (Must be received at a facility that contracts with BCBSNM or with the BCBS national transplant network.)		
Cornea, Kidney, and Bone Marrow **Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney**	20%[3,5]	No benefit

Prescription Drugs, Insulin, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods

Note: All covered drugs and other items are subject to the deductible and out-of-pocket limit provisions. Certain drugs, specials medical foods, and enteral nutritional products require prior approval or benefits will be denied.[4]	Type of Prescription	Percentage of covered charge you pay (coinsurance), if the percentage is between the minimum and maximum percentage amounts[7]	Minimum Percentage Amount[7]	Maximum Percentage Amount[7]
Retail Pharmacy Program (up to a 30-day supply or 180 units, whichever is less.)[7]	Generic Drug	25%	$20	$75
	Brand-Name Drug	50%	$40	$125
Mail-Order Plan (up to a 90-day supply or 540 units, whichever is less.)[7]	Generic Drug	25%	$40	$150
	Brand-Name Drug	50%	$80	$250
Nonprescription enteral nutritional products and special medical foods (up to a 30-day supply/30-day period, requires prior approval.)[4]		50%[4]		

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. The Family Coverage deductible is satisfied when one or all covered members have met the total deductible amount chosen. The first $400 in covered preventive care services that are incurred in a calendar year are not subject to the medical plan deductible.

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 Certain services are not covered if prior approval is not obtained from BCBSNM. See a Benefit Booklet for a list of services requiring prior approval.

4 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.

5 Admission review is required for admissions; you pay a $300 penalty for covered facility services if not obtained. See a Benefit Booklet or for details.

6 Rental benefits for medical equipment and other items will not exceed the purchase price of a new unit. In addition to all equipment costing $500 or more, specific equipment, prosthetics, appliances, and orthotics require prior approval or services will not be covered.

7 Prescription drugs and other items covered only under the drug plan (e.g., diabetic supplies) must be purchased at a pharmacy that participates in the Retail Pharmacy or Mail Order Service programs. (BCBSNM has contracted with a separate program for administration of your drug plan benefits.)

Services not covered: There are no benefits for maternity services, mental health services, alcoholism rehabilitation, or chemical dependency treatment. Transplants must be received at facilities that contract with BCBSNM or through the BCBS national transplant network and must be prior-approved in order to be covered.

IMPORTANT: Deductible amounts and coinsurance percentages are applied to BCBSNM's covered charges, which may be less than billed charges. Preferred providers will not charge you the difference between the covered charge and the billed charge for covered services; nonpreferred providers may.