

# BlueDirect<sup>®</sup> Plan C



Blue Cross and Blue Shield  
of New Mexico

## Summary of Benefits and Plan Options

**This is a summary only** that lists the deductible options, copayments, coinsurance, and out-of-pocket features, and provides a very brief description of, BlueDirect Plan C health plan benefits. The member ID card will show the PPO deductible selected. For more information, see the BlueDirect Benefit Booklet.

BlueDirect Plan C Benefit Summary		Member's Share of Covered Charges	
		Preferred Provider (PPO) <sup>1</sup>	Nonpreferred Provider <sup>1</sup>
<b>Calendar Year Deductible Options (per individual) – Check your ID card to verify the individual PPO deductible amount chosen by you.</b> Family deductible is three times individual amount chosen. <sup>1</sup>		\$500 \$1,000 \$2,000 \$5,000	(Based on PPO amount chosen) \$1,000 \$2,000 \$4,000 \$10,000
<b>Annual Out-of-Pocket Limit</b> – Includes percentage coinsurance and copayment amounts only; does NOT include deductible, penalty amounts, or noncovered charges. <sup>2</sup>		\$5,000 (\$15,000 family)	\$10,000 (\$30,000 family)
<b>Lifetime Maximum</b>		\$5,000,000 per member	
<b>Primary Provider* Office Visits</b> includes exam, medication management, and preventive/wellness visits; office surgery (including casts, splints, and dressings) <sup>4</sup>		\$40**	50% <sup>4</sup>
<b>Specialty Physician Office Services</b> includes exam, medication management, and preventive/wellness visits; office surgery <sup>4</sup> (including casts, splints, and dressings)		\$55**	50% <sup>4</sup>
<b>Acupuncture Treatment</b> (max. \$1,500/year)		\$55**	50%
<b>Allergy Injections and Tests</b>	<b>PPP*</b>	\$40**	50%
	<b>Specialist</b>	\$55**	50%
<b>Allergy Serum</b>		50%	50%
<b>Ambulance Services: Ground and Emergency Air Transport</b>		<b>Ground:</b> \$75 per trip <sup>3</sup> ; <b>Air:</b> \$150 per trip <sup>3</sup>	
<b>Ambulance Services: Nonemergency Air Transfer</b>		\$150/trip <sup>4</sup>	50% <sup>4</sup>
<b>Cardiac and Pulmonary Rehabilitation</b>		30% <sup>4</sup>	50% <sup>4</sup>
<b>Dental/Facial Accidents, Oral Surgery, and TMJ/CMJ Services</b>		Based on place of treatment and type of service <sup>4</sup>	50% <sup>4</sup>
<b>Emergency Room/Observation Room Treatment</b> (includes all emergency room services)		\$300/visit <sup>3</sup>	
<b>Hearing Aids and Related Services:</b> 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.			
<b>Home Health Care/Home I.V. Services</b> (prescribed home nursing care, physician, and therapy care – 100 visits per calendar year)		30% <sup>4</sup>	50% <sup>4</sup>
<b>Hospice - home</b>		No charge <sup>4</sup>	50% <sup>4</sup>
<b>Hospice - inpatient</b>		30% <sup>5</sup>	50% <sup>5</sup>
<b>Lab, X-Ray, EKG, MRI, and Other Diagnostic Tests</b> (including routine pap tests, mammograms, preventive care tests, and tests done in the office or freestanding facility)		30% <sup>4</sup> (no deductible)	50% <sup>4</sup>

\* A Primary 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 Provider in the preferred provider network.

\*\* If therapy is received or diagnostic tests are performed during the visit, please see additional services listed on this summary. In such cases, you will pay both the office visit copay – if an office exam is billed – and the amount due for the therapy or diagnostic test.

**See footnotes on back.**

BlueDirect Plan C Benefit Summary	Member's Share of Covered Charges	
	Preferred Provider (PPO) <sup>1</sup>	Nonpreferred Provider <sup>1</sup>
<b>Inpatient Hospital/Facility Services</b> (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; Lab, X-Ray, Diagnostic Tests	30% <sup>5</sup>	50% <sup>5</sup>
Routine Nursery Care for Covered Newborn Infants	30%	50%
<b>Prescription Drugs, Insulin, Diabetic Supplies, Nutritional Products, Special Medical Foods</b>	2-Tier 25%/50% plan; see your Drug Plan Rider (\$5,000 Plan DED option covers mandated prescription drugs only.)	
<b>Prosthetics and Orthotics</b>	30% <sup>4,6</sup> (Unlimited benefit)	50% <sup>4,6</sup> (Maximum of <b>\$1,000/year</b> )
<b>Short-Term Rehabilitation:</b> Occupational, Physical, and Speech Therapy; including Physical Rehabilitation and Skilled Nursing Facility <b>Inpatient Rehabilitation</b> (max. <b>30 days/year</b> ) <b>Outpatient and Office Rehabilitation</b> (max. <b>\$3,500/year</b> )	30% <sup>4,5</sup>	50% <sup>4,5</sup>
<b>Spinal Manipulation Services</b> (max. <b>\$1,500/year</b> )	\$55**	50%
<b>Supplies and Durable Medical Equipment</b> (equipment and supplies costing over \$500 require prior approval)	30% <sup>4,6</sup> (Unlimited benefit)	50% <sup>4,6</sup> (Maximum of <b>\$1,000/year</b> )
<b>Surgery, Inpatient or Outpatient</b> (For transplants, see "Transplant Services," below)	30% <sup>4,5</sup>	50% <sup>4,5</sup>
<b>Therapy: Chemotherapy, Dialysis, and Radiation</b>	30% <sup>4</sup>	50% <sup>4</sup>
<b>Transplant Services</b> (Must be received at a facility that contracts with BCBSNM or with the BCBS national transplant network.)		
<b>Cornea, Kidney, and Bone Marrow</b>	Based on place of treatment and type of service <sup>4,5</sup>	No Benefit
<b>Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney</b> \$10,000 max. for travel, food, and lodging (travel +\$125 per diem)		
<b>Urgent Care Facility</b>	\$100	50%

**Age limit for children:** Children are covered only through age 24.

**Choose who is covered:** Coverage is offered just for kids, just for adults, or for the whole family.

**Choose your providers:** Members choose from our statewide network of preferred providers, including PPPs, facilities, and specialists, for lowest out-of-pocket costs. Or members may see nonpreferred providers for covered services and receive less extensive benefits. (There is no coverage for transplant services if received from nonpreferred providers.) Covered services received from out-of-state preferred providers that contract with their local BCBS Plan as preferred providers are also eligible for the Preferred Provider level of coverage under this plan.

**Services not covered:** There are no benefits for maternity services or complications of pregnancy, mental health services, or alcoholism and substance abuse treatment.

**FOOTNOTES:**

1 Each member's initial covered charges that are incurred in a calendar year are applied to the calendar year deductible; the deductible must be met before benefit payments are made (excluding services for which you pay only a fixed-dollar copay, most diagnostic tests received from a preferred provider, and hearing aids). Preferred Provider deductible amounts do not cross-apply to the Nonpreferred Provider deductible amount, or vice versa.

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 or Nonpreferred Provider covered charges, whichever is applicable. Preferred Provider coinsurance 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 prior approval is not obtained from BCBSNM. See a Benefit Booklet for a list of services requiring prior approval.

5 Admission review is required for inpatient admissions; you pay a \$400 penalty for covered facility services if approval is not obtained. Some admissions may be denied. See a 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 billed charges. Preferred providers will not charge you the difference between the covered charge and the billed charge for covered services; nonpreferred providers may.**