BlueDirect® Plan B

Summary of Benefits and Plan Options

Blue Cross and Blue Shield of New Mexico

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 B health plan benefits. The member ID card will show the PPO deductible selected. For more information, see the BlueDirect Benefit Booklet.

BlueDirect Plan B Benefit Summary	Member's Share of Covered Charges	
	Preferred Provider (PPO)[1]	Nonpreferred Provider[1]
Calendar Year Deductible Options (per individual) – Check your ID card to verify the individual PPO deductible amount chosen by you. Family deductible is three times individual amount chosen.[1]	$250 $500 $1,000 $2,000 $5,000	(Based on PPO amount chosen) $500 $1,000 $2,000 $4,000 $10,000
Annual Out-of-Pocket Limit – Includes coinsurance only; does NOT include deductible, copayment amounts, penalty amounts, or noncovered charges.[2]	$2,000 ($6,000 family)	$4,000 ($12,000 family)
Lifetime Maximum	$5,000,000 per member	
Office Visits (nonroutine) All other services received during the office visit are subject to deductible and coinsurance as listed below.)	$20 copay/visit [4] (deductible waived)	40%
Office Surgery (including casts, splints, and dressings)	20%	40% [4]
Lab Tests, X-Rays, EKGs, Other Diagnostic Tests	20%	40% [4]
Allergy Injections, Tests, Serum	20%	40%
Preventive Services Routine Adult Physicals and Gynecological Exams, Related Testing (includes routine Pap tests, mammograms, colonoscopies, cholesterol tests, urinalysis, etc.), Well-Child Care, Immunizations, Routine Testing, Routine Vision or Hearing Screenings (only through age 17)	Plan pays 100% (no deductible) for first $400 in covered charges (thereafter, services are subject to deductible and coinsurance)	40%
Acupuncture Treatment (max. **$1,500**/year)	20%	40%
Ambulance Services: Ground and Emergency Air Transport	20%	
Ambulance Services: Nonemergency Air Transfer	20%[4]	40%[4]
Cardiac and Pulmonary Rehabilitation	20%[4]	40%[4]
Dental/Facial Accidents, Oral Surgery, and TMJ/CMJ Services	20%[4]	40%[4]
Emergency Room Treatment (includes all ER services)	$150 copay/visit	
Urgent Care Facility	$30 copay/visit	40%
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)	20%[4]	40%[4]
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	20%	40%

See footnotes on back.

BlueDirect Plan B Benefit Summary	Member's Share of Covered Charges	
	Preferred Provider (PPO)[1]	Nonpreferred Provider[1]
Lab, X-Ray, and Other Diagnostic Tests	20%[4]	40%[4]
Prescription Drugs, Insulin, Diabetic Supplies, Nutritional Products, Special Medical Foods	4-Tier Rx Plan: $10/$35/$75/15% (see your Drug Plan Rider) ($5,000 plan option covers mandated prescription drugs only)	
Prosthetics and Orthotics	20%[4,6] (Unlimited benefit)	40%[4,6] (Maximum of **$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%[4,5]	40%[4,5]
Spinal Manipulation Services (max. **$1,500**/year)	20%	40%
Supplies and Durable Medical Equipment	20%[4,6] (Unlimited benefit)	40%[4,6] (Maximum of **$1,000**/year)
Surgery, Inpatient or Outpatient (For transplants, see "Transplant Services," below)	20%[4,5]	40%[4,5]
Therapy: Chemotherapy, Dialysis, and Radiation	20%[4]	40%[4]
Transplant Services (Must be received at a facility that contracts with BCBSNM or with our national transplant network.)		
Cornea, Kidney, and Bone Marrow **Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney** (Subject to a separate $5,000 out-of-pocket limit per transplant type. Additional benefit maximums also apply. Calendar year deductible does not apply.)	20%[4,5]	No Benefit

ADDITIONAL FEATURES AND LIMITATIONS:

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 and specialists for lowest out-of-pocket costs. Or members may see other providers for covered services and receive less extensive benefits. (There is no coverage for transplant services if received from nonpreferred providers.)

Services not covered: There are no benefits for maternity services or complications of pregnancy, mental health services, or alcoholism and substance abuse treatment. Transplants must be received at facilities that contract with BCBSNM or through our national transplant network and must be prior-approved in order to be covered.

FOOTNOTES:

1 The 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 and hearing aids). Preferred Provider deductible amounts do not cross-apply to the Nonpreferred Provider deductible amount, or vice versa.

2 After a member reaches the applicable out-of-pocket limit, BCBSNM pays 100 percent of that member'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 admissions; you pay a $300 penalty for covered facility services if not obtained. 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.