BlueDirect® Basic

Summary of Benefits and Plan Options

Blue Cross and Blue Shield of New Mexico

This summary provides highlights including deductible options, copayments, coinsurance, out-of-pocket features and provides a very brief description of BlueDirect Basic health plan benefits. The member ID card will show the PPO deductible selected.

BlueDirect Basic 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 two times individual amount chosen.[1] **Note:** Services subject to a copayment are not subject to the plan deductible.	$1,000 $2,000 $3,500 $5,000 $7,500 $10,000	$2,000 $4,000 $7,000 $10,000 $15,000 $20,000
Annual Out-of-Pocket Limit – Includes coinsurance only; does NOT include deductible, copayment amounts, penalty amounts, or noncovered charges.[2]	$7,000 ($14,000 family)	$14,000 ($28,000 family)
Office Visits (nonroutine): All other services received during the office visit are subject to deductible and coinsurance as listed below.	$40 copay/visit	50%
Office Surgery (including casts, splints, and dressings)	30%[4]	50%[4]
Lab, X-Ray, and Other Diagnostic Services	30%[4]	50%[4]
Allergy Injections, Tests, Serum	30%	50%
Routine/Preventive Services Routine Adult Physicals and Gynecological Exams, Related Testing (includes routine Pap tests, mammograms, routine colonoscopies, cholesterol tests, urinalysis, etc.), Well-Child Care, Immunizations, Routine Testing, Routine Vision or Hearing Screenings	No charge	No charge
Acupuncture Treatment (max. **$1,500**/year)	30%	50%
Ambulance Services: Ground and Emergency Air Transport	30%	
Ambulance Services: Nonemergency Air Transport	30%[4]	50%[4]
Applied Behavioral Analysis for Autism Spectrum Disorders (max. **$36,000/**year with a **preauthorized** treatment plan)	$40 copay for screening[4] 30% for all other services[4]	No benefit
Cardiac and Pulmonary Rehabilitation	30%[4]	50%[4]
Dental/Facial Accidents, Oral Surgery, and TMJ/CMJ Services	30%[4]	50%[4]
Emergency Room Treatment (includes all ER services)	$250 copay/visit[3]	
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 PPO or NonPPO cost-sharing provisions. Services are not covered for members age 21 and older.		
Home Health Care/Home I.V. Services (max. **100** visits/year combined)	30%[4]	50%[4]
Hospice	30%[4]	50%[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	30%[5]	50%[5]
Routine Nursery Care for Covered Newborn Infants	30%	50%

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

BlueDirect Basic Summary	Member's Share of Covered Charges	
	Preferred Provider (PPO)[1]	Nonpreferred Provider[1]
Lab, X-Ray, and Other Diagnostic Tests	30%[4]	50%[4]
Outpatient Facility and Physician Services	30%[4]	50%[4]
Prescription Drugs, Insulin, Diabetic Supplies, Nutritional Products, Special Medical Foods (You must use a participating retail pharmacy or our Mail-order pharmacy): **4-Tier Rx Plan -** $15/$45/$75/15% (see your Drug Plan Rider for additional details)		
Prosthetics and Orthotics	30%[4,6]	50%[4,6]
Short-Term Rehabilitation: Occupational, Physical, and Speech Therapy **Inpatient Rehab & Skilled Nursing Facility** (max. **30 days**/year) **Outpatient and Office Therapies** (max. **20 visits**/year combined)	30%[4,5]	50%[4,5]
Spinal Manipulation Services (max. **$1,500**/year)	30%	50%
Supplies and Durable Medical Equipment	30%[4,6]	50%[4,6]
Therapy: Chemotherapy, Dialysis, and Radiation	30%[4]	50%[4]
Transplant Services (Must be received at a facility that contracts with BCBSNM or with the national BCBS 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.)	30%[4,5]	No Benefit
Urgent Care Facility	$60 copay/visit	50%

ADDITIONAL FEATURES AND LIMITATIONS:

Age limit for dependent children on a family policy: Children are covered through age **25**.

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 or ABA services if received from nonpreferred providers.)

Services not covered: There are no benefits for maternity services or complications of pregnancy, mental health services, or chemical dependency treatment, including drugs related to mental health or chemical dependency conditions.

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 a fixed-dollar copay, routine/preventive services, 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 (excluding copayments). 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 preauthorization is not obtained from BCBSNM. See a Benefit Booklet for a list of services requiring preauthorization.

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.

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