BlueDirect® Plan C

Blue Cross and Blue Shield of New Mexico

Summary of Benefits and Plan Options

Effective 10/15/06

This is a summary only that lists each deductible option and out-of-pocket limit amounts; lists copayment and coinsurance percentage amounts; and provides a brief description of BlueDirect Plan C health care plan benefits. Your member ID card will show your chosen deductible; please verify that your ID card shows the correct deductible chosen by you.

BlueDirect Plan C Benefit Summary – This plan does **not** cover services received from nonpreferred providers, except in an emergency.		**Member's Share of Covered Charges From a Preferred Provider**
Annual Deductible Options (Except for outpatient diagnostic tests – which are not subject to a deductible -- only covered charges for services subject to percentage "coinsurance" amounts are subject to the deductible.) [1]		$500 ($1,500/family) $1,000 ($3,000 family) $2,000 ($6,000/family) $5,000 ($15,000/family)
Annual Out-of-Pocket Limit (based on deductible chosen) (Coinsurance and copayments only apply; deductible, penalty amounts, and noncovered charges do not.) [2]		$5,000 ($15,000/family)
Lifetime Maximum Benefit		$5,000,000 per member
Preferred Primary Provider (PPP) Office Services *		
Office Visit**, Medication Management **		$40
Office Surgery (including casts, splints, and dressings)		$40 [3]
Preventive Office Care (Adult medical care/routine exams; well child care; vision/hearing screening for members age 17 and under)		$40
Specialty Physician Office Services		$55
Office Visit**, Medication Management**, Office Evaluations**		$55
Office Surgery (including casts, splints, and dressings)		$55 [3]
Lab Tests, X-Rays, EKGs, MRIs, & Other Diagnostic Services (including routine pap tests, mammograms, preventive care tests, and tests done in office or freestanding facility)		30%[3] No deductible
Allergy Services (testing and injections)	**Preferred Primary Provider**	$40
	Specialist	$55
Allergy Serum		50%
Acupuncture Treatment (max. **$1,500**/year)		$55
Ambulance Services		$75 per trip/ground or $150 per trip/air
Cardiac and Pulmonary Rehabilitation		30% [3]
Emergency and Urgent Care Services		
Emergency Room (includes all related ER services)		$300
Observation Room (including pregnancy)		$300
Urgent Care Facility		$100
Dental/Facial Accidents, Oral Surgery, TMJ/CMJ Services		Usual copays or coinsurance based on place of treatment and type of service [3,4]

* A Preferred Primary Provider (PPP) 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.

** 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 – Except in an emergency, services received from nonpreferred providers are not covered under this plan.	**Member's Share of Covered Charges**
Hospice – inpatient	30%[4]
Hospice – home	No charge [3]
Home Health Care (prescribed home nursing care, physician, and therapy care – **100 visits** per calendar year)	30%[3]
Inpatient Hospital/Facility Services (See "Short-Term Rehabilitation" for physical rehabilitation and skilled nursing facility admissions and "Transplant Services," if applicable.)	
Room and Board and Physician Care such as Physician Visits, Surgeon, and Anesthesiologist, Lab, X-Ray, and other Diagnostic Tests	30%[4]
Prescription Drugs, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods	2-Tier 25%/50% plan (see your Drug Plan Rider) ($5,000 plan option covers mandated prescription drugs only.)
Short-Term Rehabilitation: Occupational, Physical, and Speech Therapy; including Skilled Nursing Facility Inpatient Rehabilitation (max. **30 days/**calendar year) [4] Outpatient/Office Rehabilitation (limit **$3,500**/calendar year) [3]	30%[3,4]
Spinal Manipulation Services (max. **$1,500**/year)	$55
Supplies, Equipment, Prosthetics, and Orthotics (equipment and supplies over $500 require prior approval)	30%[3,5]
Surgery, Outpatient (includes facility, physician, & ancillary services)	30%[3]
Therapy: Chemotherapy, Dialysis, and Radiation Therapy	30% [3]
Transplant Services (Must use facilities that contract with BCBSNM or through the national BCBSNM transplant network.)	
Cornea, Kidney, Bone Marrow	Usual copays or coinsurance based on place of treatment and type of service
Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney: **$10,000** maximum for travel, food, and lodging (travel + **$125** per diem)	

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, including primary providers, specialists, and facilities for covered medical services. (There is no coverage for nonemergency services received from nonpreferred providers.) Covered services received from preferred providers that contract with their local BCBS Plan as preferred providers are also eligible for coverage under this plan.

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

FOOTNOTES:

1 Each member's initial covered charges (for most services that are subject to a percentage "coinsurance" amount) are applied to the deductible. The deductible must be met before benefit payments are made for such services. Note: A deductible is not required for covered services that are subject to a fixed-dollar copayment or for some diagnostic testing.

2 After a member (or family) reaches the out-of-pocket limit during a single calendar year, BCBSNM pays 100 percent of that member's (or family's) covered charges for the remainder of the calendar year.

3 Certain services are not covered if prior approval is not obtained from BCBSNM. See a benefit booklet for details.

4 Admission review is required for inpatient admissions. You pay a $400 penalty for covered facility services if approval is not obtained. Some services, such as transplants, require additional approval. If you do not receive approval for these individually identified procedures and services, benefits for any related admissions will be denied.

5 Rental benefits for medical equipment and other items will not exceed the purchase price of a new unit.

Important Note: You must use a BCBSNM preferred provider, unless in an emergency. Deductibles, copayments, and coinsurance percentages are applied to BCBSNM's covered charges, which may be less than billed charges.