



Summary of Benefits: July 1, 2011

The following are the highlights of the State of New Mexico PPO Plan administered by Blue Cross and Blue Shield of New Mexico. Any services received must be medically necessary to be covered.

| Benefit Highlights | | Preferred Provider ^{1,2} | Nonpreferred Provider ^{1,2} |
|---|---|--|--|
| Highlights of Cost-Sharing Features | Annual Plan Year Deductible ¹ (All services are subject to deductible unless noted otherwise.) | \$400 Individual \$800 Two-Person \$1,200 Family* | \$1,600 Individual \$3,200 Two-Person \$4,800 Family* |
| | Annual Plan Year Out-of-Pocket Limit ² (Includes medical deductible, coinsurance, and copayments only; not drug plan payments.) | \$3,000 Individual \$6,000 Two-Party \$9,000 Family* | \$6,000 Individual \$12,000 Two-Party \$18,000 Family* |
| | Lifetime Maximum | Unlimited (Certain services are subject to Plan year and/or lifetime maximums or are limited per condition.) | |
| Type of Service | Description of Service and Limitations | Your Share After Plan Year Deductible ^{1,2} | |
| | | Preferred Provider | Nonpreferred Provider |
| Physician Services, Office | PPO Primary Provider (PPP) Office Visit/Exam Copayment (nonpreventive) – Office Surgery (including casts, splints, etc.) – Lab Tests, X-Rays, EKGs, Other Diagnostics | \$25 per visit (deductible waived) \$25 per visit (deductible waived) ⁴ 10% ⁴ | Not Applicable |
| | Other Non-Routine Office Services: Includes services of non-PPP preferred providers (PPO Specialists) and nonpreferred providers. – Office Surgery – Therapeutic Injections, Allergy Tests, Serum – Allergy Injections | \$40 per visit ⁴ \$40 per visit ⁴ No copay (deductible waived) | 40% ⁴ |
| | Preventive Services, including immunizations, lab, x-ray, colonoscopies, Pap tests, mammograms, immunizations, and other wellness services; smoking/tobacco use cessation counseling, etc. | No copay (deductible waived) | 40% (deductible waived) |
| Diagnostic Testing, Outpatient | – PET scans ⁴ , CT scans ⁴ , MRIs, (unless covered as part of a fixed-dollar copayment during ER visit, admission, etc.) – Other lab, x-ray, EKGs | 10% ⁴ (up to a max. member share of \$200 per test) 10% ⁴ | 40% ⁴ |
| Inpatient Hospital Services, Acute Care | Hospitalization (includes semi-private room, board, drugs, medications, and ancillaries; inpatient physician visits, surgeon, assistant, and anesthesiologist) | \$400 per admission ⁵ (Related physician subject to deductible then no copay) | 40% ^{3,5} |
| Outpatient Hospital Services | Surgery – operating and recovery room Observation (nonemergency) | 10% ⁴ \$200 per visit | 40% ⁴ |
| | Other treatment room services not otherwise specified in this Summary | 10% ⁴ | 40% ⁴ |
| | Related physician services | 10% | 40% |
| Emergency Services and Urgent Care | Emergency room or emergency observation room visit (and no operating room used) | \$175 per visit | \$175 per visit ³ |
| | Urgent care center | \$50 per visit | \$50 per visit |
| | Ambulance (nonemergency air transfer) | 20% ⁴ | 40% ⁴ |
| | Ambulance (ground and emergency air transport) | 20% | 20% ³ |
| Transplants | Bone marrow, heart, heart-lung, liver, lung, pancreas-kidney, and other medically necessary transplants (Case management required. Maximums apply to covered travel & lodging.) | Applicable copays based on place and type of service ^{4,5,6} | Not Covered |

| Type of Service | Description of Service and Limitations | Your Share After Plan Year Deductible ^{1,2} | |
|---|--|---|------------------------------|
| | | Preferred Provider | Nonpreferred Provider |
| Maternity Services | Initial visit to confirm pregnancy | \$25 for initial visit if to a PPP (deductible waived) | 40% |
| | Physician/midwife services (delivery, prenatal/postnatal care) | Applicable copays based on place and type of service ^{4,5,6} | 40% |
| | Hospital admission | \$400 per admission ⁵ | 40% ⁵ |
| | Routine nursery care for covered newborn (Child covered from birth, but must apply for coverage within 31 days.) | No copay ⁵ (Related physician subject to deductible then no copay) | 40% ⁵ |
| Mental Health and Substance Abuse Rehabilitation Services | – Outpatient/office services | \$40 per visit ⁴ | 40% ^{4,5} |
| | – Inpatient services | \$400 per admission ⁵ | |
| | – Partial hospitalization | \$200 per admission ^{5,7} | |
| | – Intensive outpatient program | \$35 per visit ^{4,7} | |
| – Residential treatment center (max. 60 days/Plan year) | \$400 per admission ⁵ Related inpatient, RTC, partial hospital physician = No copay after deductible is met ⁴ | | |
| Other Office and Home Services | Acupuncture, rolfing, massage therapy, naprapathy, spinal manipulation (max. benefit of \$1,500/Plan year) | \$40 per visit ⁸ | 40% ⁸ |
| | Biofeedback (for specified conditions only) | \$40 per visit | 40% |
| | Cardiac or pulmonary rehabilitation | \$40 per visit ⁴ | 40% ⁴ |
| | Chemotherapy; radiation therapy; dialysis | \$40 per visit ⁴ | 40% ⁴ |
| | TMJ/CMJ, oral surgery, & dental accident services | Applicable copayments, deductible, and/or coinsurance based on place and type of treatment ^{4,5} | |
| | Durable medical equipment, diabetic equipment and supplies; orthopedic appliances, prosthetics and orthotics (Rental benefits not to exceed the purchase price of a new unit. Supplies limited to a 30-day supply during a 30-day period.) | 25% ⁴ (unlimited benefit) | 40% ⁴ |
| | Hearing exam/test | \$40 per visit ⁴ | 40% ⁴ |
| | Hearing aids (max. benefit of \$2500 per ear every 36 months starting with date of purchase) | No copay (deductible waived) | No copay (deductible waived) |
| | Home health care and home I.V. services (up to 100 visits/Plan year) | \$40 per visit ⁴ | 40% ⁴ |
| | Hospice | No copay (deductible waived) ⁴ | 40% ⁴ |
| Short-term rehabilitation: inpatient and outpatient physical, occupational, and speech therapies, rehabilitation facility, skilled nursing facility | \$40 per office/outpatient ^{4,8} \$400 per admission ⁵ (Related professional charges = No copay after deductible is met) | 40% ^{4,5} | |

Footnotes:

- All benefits are based on the covered charge as determined by BCBSNM. The deductible must be met before benefit payments are made for most covered services in a Plan year. (“Deductible waived” is indicated above for those services that are excluded from the deductible requirement.). Preferred provider amounts do **not** cross-apply to the nonpreferred provider deductible nor vice versa. A Plan year begins July 1 each year and ends on June 30 of the following year. Any amounts applied to the Plan year deductible during the last quarter of the Plan year (i.e., April 1 through June 30) will be used to help satisfy the next Plan year deductible. Note: A “PPP” is any preferred provider with a specialty of Family Practice, Internal Medicine, General Practice, Gynecology, Pediatrics, or Obstetrics/Gynecology.
- After you reach the applicable out-of-pocket limit, BCBSNM pays 100 percent of most of your covered preferred or nonpreferred provider charges, whichever is applicable, for the rest of the Plan year. Preferred provider amounts do **not** cross-apply to the nonpreferred provider limit nor vice versa. Amounts in excess of covered charges, penalty amounts, and noncovered charges do not count toward the out-of-pocket limit or deductible.
- Initial treatment of a medical emergency at a preferred or nonpreferred emergency room or trauma center is paid at the Preferred Provider benefit level. If you must be admitted as an inpatient as a result of an emergency, the entire, related hospitalization is paid at the Preferred Provider benefit level. Follow-up treatment and treatment that is not for an emergency are paid at the Nonpreferred Provider level. The emergency room or observation room copayment is waived if an inpatient admission results; then inpatient hospital benefits apply.

- 4 Certain services are not covered if preauthorization is not obtained from BCBSNM. Nonemergency air ambulance transfer services are covered only when it is medically necessary to transfer the patient from one facility to another. A list of services requiring preauthorization is in your benefit booklet.
- 5 Preauthorization (or admission review approval) is required for inpatient admissions. You pay a **\$300** penalty for covered nonemergency medical/surgical facility services if admission review approval is not obtained before being admitted to a nonpreferred facility. Some services, such as transplants and physical rehabilitation, require additional approval. If you do not receive preauthorization for these individually identified procedures and services, benefits for any related admissions will be denied. The \$300 penalty will not apply in such cases. See a benefit booklet.
- 6 Transplants must be received at a facility that contracts with BCBSNM or with the national BCBS transplant network.
- 7 The partial hospitalization copayment is waived if the patient is directly admitted into the program from an inpatient facility.
- 8 Covered massage therapy received as part of a chiropractic or physical therapy session are covered under the short-term rehabilitation benefit (when rendered by a licensed medical doctor, doctor of osteopathy, registered physical therapist, licensed physical therapist, chiropractor, or doctor of oriental medicine). Massage therapy under the "Alternative Therapy" benefit must be provided by a licensed massage therapist. Rolwing must be provided by a licensed rolfer.

*** Note about Family "aggregate" deductibles and out-of-pocket limits:** If you have a Family contract, an entire family meets an applicable deductible or out-of-pocket limit for a Plan year when the total deductible amount or out-of-pocket limit for all family members reaches three times the Individual deductible or out-of-pocket limit amount (the deductible and out-of-pocket limit amounts for three *or more* family members are *combined* to satisfy the Family deductible and the Family out-of-pocket limit). However, once a member meets an Individual deductible, that member's applicable deductible is satisfied for the Plan year, and no more charges incurred by that member can be used to satisfy the Family deductible.