

The following are the highlights of the Medical Plan administered by Lovelace Insurance Company for State of New Mexico employees. These benefits are effective July 1, 2013. Any services received must be Medically Necessary and when required benefit certification must be obtained by your physician to be covered. The specific terms of coverage, limitations and exclusions are detailed in Sections 4, 5 and 6 of your Summary Plan Description (SPD) booklet.

| BENEFIT HIGHLIGHTS | | |
|--|---|--------------------------------|
| Contract Year Deductible ¹ | Member deductible <ul style="list-style-type: none"> • Single • 2-Party • Family | \$350 \$700 \$1,050 |
| Contract Year Out-of-Pocket Maximum ¹ | Out-of-pocket maximum <ul style="list-style-type: none"> • Single • 2-Party • Family | \$3,500 \$7,000 \$10,500 |
| Lifetime Maximum | Unlimited (Certain services are subject to Contract Year and/or lifetime maximums or are limited per condition.) | |

| COVERED SERVICES | BENEFIT/SERVICE DESCRIPTION | MEMBER'S COST (Co-pay/Co-Insurance may be subject to Deductible) |
|--|--|--|
| Physician Services | Office visit <ul style="list-style-type: none"> • Primary/OB/GYN Services • Specialty care (No referral required) | \$25 ² office visit Co-pay \$40 office visit Co-pay |
| | Preventive services <ul style="list-style-type: none"> • Adult wellness exam • Well child care • Vision screening (through age 17) • Hearing screening (through age 25) • Immunizations • Adult wellness • Laboratory and X-ray (associated with wellness exam) • Colonoscopy | No Co-pay ⁵ |
| | Women's Preventive Care Services <ul style="list-style-type: none"> • Well-woman visits to include adult and female-specific screenings • Mammograms • Cytologic Screening (Pap tests) including screening for papillomavirus • Screening for gestational diabetes • Counseling for HIV and sexually transmitted diseases • Screening and counseling for interpersonal and domestic violence | |
| | Laboratory | 20% Coinsurance |
| | X-ray | 20% Coinsurance |
| | Allergy testing and treatment | \$40 office visit Co-pay |
| | Allergy injections by a nurse | No Co-pay |
| | Allergy extract preparation | No Co-pay |
| | Family Planning - Women's Preventive Services ⁶ : <ul style="list-style-type: none"> • Surgical sterilization procedures for women's sterilization; must be FDA approved methods <ul style="list-style-type: none"> • Inpatient • Outpatient • Physician's office • Contraceptive implant insertion/re-insertion fee • Contraception counseling | No Co-pay |
| | Hospital Services | Hospitalization (includes but not limited to: Room and board, Inpatient Physician care, Physician visits, surgeon, x-ray, lab and anesthesiologist) ³ |
| MRI/PET Scans/CT Scans | | 20% Coinsurance (maximum \$200 per test) |
| Hospital Observation Services (no admission or surgical procedure) | | \$250 Co-pay |
| Surgery/Outpatient Facility (applies to facility only) | | 20% Coinsurance |

| COVERED SERVICES | BENEFIT/SERVICE DESCRIPTION | MEMBER'S COST (Co-pay/Co-Insurance may be subject to Deductible) | |
|------------------------------|--|---|----------------------------------|
| Maternity Services | Physician/midwife services (delivery, prenatal/postnatal care) | \$25 Co-pay – initial visit only, all other visits no Co-pay | |
| | Laboratory and X-ray (including ultrasounds) | 20% Coinsurance | |
| | Hospital Admission ² | \$500 Co-pay per pregnancy | |
| | Routine nursery care for newborns (unless baby is admitted post delivery) | No Co-pay | |
| | Breast feeding support, supplies and counseling | No Co-pay | |
| Emergency Services | Emergency room visit ² Urgent Care Center Ambulance (waived if admitted) • Ground transportation • Air ambulance | \$175 Co-pay \$50 Co-pay \$30 Co-pay per trip \$100 Co-pay per trip | |
| | Outpatient services | \$25 office visit Co-pay | |
| Behavioral/ Mental Health | Inpatient services ³ Partial hospitalization ³ | \$500 Co-pay per Admission \$250 Co-pay per Admission | |
| | Residential Treatment Center (limited to 60 days per contract year; must be Medically Necessary) ³ | \$500 Co-pay per Admission | |
| | Outpatient services | \$25 office visit Co-pay | |
| Substance Abuse | Inpatient services Partial hospitalization ³ Intensive outpatient (non-Step Down) | \$500 Co-pay per Admission \$250 Co-pay per Admission \$100 Co-pay per Admission | |
| | Residential Treatment Center (limited to 60 days per contract year; must be Medically Necessary) ³ | \$500 Co-pay per admission | |
| | Bariatric Surgery (for Morbid Obesity; must meet defined criteria in this SPD) • Inpatient ³ • Outpatient physician visit | \$500 Admission Co-pay \$40 office visit Co-pay | |
| | Biofeedback (for specified medical conditions only) | \$40 Office visit Co-pay | |
| Other Services | Cardiac or pulmonary rehabilitation | \$40 Office visit Co-pay | |
| | Chemotherapy and/or radiation therapy | No Co-pay | |
| | Chiropractic Services and Acupuncture (\$1,500 combined Plan Year maximum) ⁴ | \$40 Office visit Co-pay | |
| | Dental services (for specified medical conditions only) • Inpatient ³ • Outpatient | \$500 Co-pay per admission \$40 Office visit Co-pay | |
| | Dialysis | No Co-pay | |
| | Durable Medical Equipment, orthotics, prosthetics and appliances ³ | 20% Coinsurance | |
| | Hearing Aids (to include repair, replacement and associated testing) | No Co-pay up to \$2,500 per ear every 3 years ⁵ | |
| | Home health care ³ | \$40 Physician Co-pay; no Co-pay for non-physician services | |
| | Hospice ^{3,4} • Bereavement counseling (limited to 3 sessions during the Hospice benefit period) • Respite care (lifetime maximum of 2 sessions of up to 10 days for each Hospice benefit period) | No Co-pay | |
| | Infertility related services (only limited services covered) | Co-pay based on services | |
| | Injectable drugs received in the office ³ • If billed in conjunction with an office visit • If provided by a nurse and no office visit is billed | Included in office visit Co-pay No Co-pay | |
| | Naprapathy (\$500 per Plan Year maximum) | \$50 Co-pay | |
| | Physical, occupational and speech therapy | \$40 office visit Co-pay | |
| | Skilled nursing facility (Admission Co-pay waived if within 15 days) ³ | \$500 Admission Co-pay | |
| | Sleep disorder studies • Inpatient ³ • Sleep lab (outpatient facility) | \$500 Admission Co-pay 20% Coinsurance | |
| | Smoking cessation (does not include prescription drugs—see pharmacy vendor) | 50% Coinsurance | |
| | Transplants | Coverage for human organ transplants (refer to SPD for details on transplant coverage) ⁶ | Co-pay based on place of service |
| | Prescription Drugs | Administered by ExpressScripts. Call ExpressScripts at 800.743.1720 | |

1. A maximum of three family members are required to satisfy the Family Deductible and Out of Pocket amount; 2. The \$175 emergency care is waived if an Admission results. Then, the Hospital Admission Co-pay applies; 3. Benefit Certification may be required or benefits may be denied. Please refer to specific benefit details in SPD for additional information on which services require Benefit Certification; 4. This benefit includes an annual maximum payment, annual visit limitation, lifetime visit limitation and/or lifetime maximum payment; 5. Not subject to the Deductible; 6. Patients are responsible for copayments related to place of service, ancillary services, and additional procedures performed at the same time. Prior authorization may apply.