PPO Plans 1, 2, 3 Summary of Benefits

EFFECTIVE 9/01/04

This is a **summary** of benefits: Please refer to your contract documents for exclusions, limitations and allowable charges. Lifetime maximum benefit is $2,000,000. (Certain services have additional limits.) All annual limits are for calendar year.

Alliance PPO Plan Benefits	**Benefit Level: Choose from 1 of 3 plans**					
	Preferred Provider (PPO)[1]			**Nonpreferred Provider[1]**		
	Plan 1	**Plan 2**	**Plan 3**	**Plan 1**	**Plan 2**	**Plan 3**
Annual Deductible Options (per individual): Family deductible is three times individual amount chosen.[1,2]	$1,000	$2,500	$10,000	$2,000	$5,000	$17,000
Coinsurance Percentage of covered charges that the member pays after the deductible is met. The covered charge may be less than the billed charge. You pay difference between covered charge and billed charge if you visit a nonpreferred provider. Family limit is two times the individual amount.[2]	50% $5,000 ($10,000 family)	50% $5,000 ($10,000 family)	Plan pays 100%	70% $7,000 ($14,000 family)	70% $7,000 ($14,000 family)	20% $3,000 ($6,000 family)
Stop-Loss Amount: The stop-loss amount is the shared coinsurance with the carrier and does not include the deductible. The carrier pays 100% after stop-loss. Family amounts are shown in aggregate.	$10,000 ($20,000 family)	$10,000 ($20,000 family)	N/A	$10,000 ($20,000 family)	$10,000 ($20,000 family)	$15,000 ($30,000 family)
Annual Out-of-Pocket Limit: Includes deductible and coinsurance only – does not include copayments, penalty amounts or non-covered charges. Copays and special deductibles do not apply to calendar year deductible or out-of-pocket maximums.	$6,000 ($13,000 Family)	$7,500 ($17,500 Family)	$10,000 ($30,000 Family)	$9,000 ($20,000 Family)	$12,000 ($29,000 Family)	$20,000 ($57,000 Family)
PPO Primary Provider (PPP)* vs. PPO Specialist (including Urgent Care) Office Visit/Exam Copayment	$30/$40	$40/$50	$50/$60	NA	NA	NA
Office Visit/Exams (nonroutine) and Urgent Care: All other services received during the office visit are subject to deductible and coinsurance as listed below	PPP* or Specialist office visit/exam copay (deductible does not apply)			Non-PPO deductible/coinsurance		
Office Surgery (including casts, splints and dressings)	PPO deductible/coinsurance[4]			non-PPO deductible/coinsurance[4]		
Diagnostic (nonroutine) Lab Tests, X-Rays, EKGs, Other Diagnostic tests	PPO deductible/coinsurance[4]			non-PPO deductible/coinsurance[4]		
Theraputic injections: Allergy injections, tests, serum	PPO deductible/coinsurance			non-PPO deductible/coinsurance		
Family planning services (IUD insertion, Norplant, cervical cap)	PPO deductible/coinsurance			non-PPO deductible/coinsurance		
All other services received during an office visit	PPO deductible/coinsurance			non-PPO deductible/coinsurance		
Preventative/Routine Services (max. **$500/calendar year**)						
Office exam/physical	PPP or Specialist office visit/exam copay (deductible does not apply)			non-PPO deductible/coinsurance		
Routine lab and x-ray, mammograms, Pap tests, immunizations, routine vision or hearing screenings (screening only through age 17), immunizations	Plan pays in full for all routine services except exam/physical			non-PPO deductible/coinsurance		
Acupuncture Treatment (max. **$500/calendar year**)	PPO deductible/coinsurance			No benefit		
Ambulance Services, Group and Emergency Air Ambulance	PPO deductible/coinsurance[4]					
Ambulance, Nonemergency Air Transport	PPO deductible/coinsurance			non-PPO deductible/coinsurance		
Cardiac and Pulmonary Rehabilitation, Outpatient	PPO deductible/coinsurance[4]			No benefit		
Emergency Room Treatment	$100 copayment plus PPO coinsurance (deductible waived on 50% coinsurance plans)[3]					
Home Health Care/Home I.V. Services (max. **100 visits /calendar year**)	PPO deductible/coinsurance[4]			non-PPO deductible/coinsurance[4]		
Hospice Services (max. **six months of care**)	PPO deductible/coinsurance[4]			non-PPO deductible/coinsurance[4]		
Inpatient Hospital/Facility Services: Acute Care Medical Surgical Facility (Also see "Transplant Services", if applicable)						
Medical/Surgical and Maternity-Related Room and Board, Covered Ancillaries	PPO deductible/coinsurance[5]			non-PPO deductible/coinsurance[5]		
Routine Nursery Care for Covered Newborns (deductible waived if mother is covered and the baby is discharged on same day)	PPO deductible/coinsurance			non-PPO deductible/coinsurance		
Lab X-Ray and Other Diagnostic Tests	PPO deductible and member coinsurance[4]			non-PPO deductible/coinsurance[4]		
Maternity Services, Including Routine Pediatrician Care for Covered Newborns (Also see "Inpatient Hospital/Facility Services")	PPO deductible/coinsurance[5] (plus OV copay for first office visit to confirm pregnancy)			non-PPO deductible/coinsurance[5]		
Mental Health Services, Inpatient and Outpatient Inpatient hospitalization Outpatient therapy, medication checks, intake evaluations	PPO deductible/coinsurance[5] Specialist copay[4]			Not covered		
Prosthetics and Orthotics	PPO deductible/coinsurance[4.7] (Unlimited benefit)			non-PPO deductible/coinsurance[4.7] **(Maximum of $1,000/year)**		

Alliance PPO Plan Benefits (continued)	Preferred Provider (PPO) [1]	Nonpreferred Provider[1]
Short-Term Rehabilitation, Inpatient and Outpatient (Includes services in a rehabilitation facility and outpatient physical, occupational and speech therapy services.) Inpatient hospitalization (max. **10 days**/calendar year) Outpatient Therapy	PPO deductible/coinsurance[5] PPO deductible/coinsurance[4]	Not covered
Smoking/Tobacco Use Cessation Counseling: A maximum of two **90-day** courses of drug therapy (see "Prescription Drugs" below); up to **90 minutes** total provider contact time OR two multi-session group counseling programs per calendar year.	PPO deductible/coinsurance	Not covered
Spinal Manipulation (max. benefit of $500/calendar year)	PPO deductible/coinsurance	
Supplies and Durable Equipment	PPO deductible/coinsurance[4.7] (Unlimited benefit)	non-PPO deductible/coinsurance [4.7]**(Maximum of $1,000/year)**
Surgery, Inpatient or Outpatient (For transplants, see "Transplant Services" below.)	PPO deductible/coinsurance	non-PPO deductible/coinsurance[4.5]
Therapy: Chemotherapy, Dialysis and Radiation	PPO deductible/coinsurance[4]	non-PPO deductible/coinsurance[4]
TMJ/CMJ Services, Dental Accidents, Oral Surgery (Only limited and specific procedures are covered.)	PPO deductible/coinsurance[4]	non-PPO deductible/coinsurance[4]
Transplant Services (Must be received at a facility that contracts with BCBSNM or with the national BCBS transplant network.) **Heart, Kidney, Liver, Lung, Bone Marrow Only** (Subject to a lifetime maximum benefit of **$250,000** for all transplant services combined, excluding outpatient prescription drugs.)	PPO deductible/coinsurance[4]	Not covered
OPTIONAL Chemical Dependency Rehabilitation (Alcoholism and Drug Abuse Services). You may elect to include coverage for this rider at additional cost.		
Inpatient Services (max. **30 days/calendar year**) Outpatient/office services (max. **30 visits/calendar year**)	PPO deductible/coinsurance[4] PPO deductible/coinsurance[4]	Not covered Not covered

Prescription Drugs, Insulin, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods				
Copayments are not applied to out-of-pocket or subject to deductible. Certain drugs, special medical foods and enteral nutritional products require prior approval or benefits will be denied. Benefits are limited to **$5,000/year**. [6]	**Generic Drug**	**Brand-Name Drug**		
		If a generic equivalent is available and you buy the brand-name, you pay:	**If there is no generic equivalent available:**	
			Formulary	**Nonformulary**
Retail Pharmacy Program (up to a 30-day supply or 120 units, whichever is less)	$20	$20 plus difference in covered charge between the brand-name and the generic equivalent	$40	$60
Mail-Order Plan (up to 90-day supply or 120 units whichever is less)	Three copayments, as listed above			
Nonprescription enteral nutritional products and special medical foods (up to a 30-day supply per 30-day period; require prior approval)	50%	50%	50%	50%

* A "PPP" is any preferred provider with a specialty of Family Practice, Internal Medicine, General Practice, Gynecology, Pediatrics or Obstetrics/Gynecology.

[1] The deductible must be met before benefit payments are made (excluding prescription drug plan services and services for which you pay a fixed-dollar copayment).

[2] Deductibles and coinsurance for Preferred Provider and Nonpreferred Provider charges are separate and do not apply to one another. After you reach the applicable out-of-pocket limit, BCBS pays 100 percent of most of your covered preferred or nonpreferred provider charges, whichever is applicable.

[3] Initial treatment of a medical emergency is paid at the Preferred Provider benefit level. Follow-up treatment and treatment that is not for an emergency is paid at the Nonpreferred Provider level.

[4] Certain services are not covered if prior approval is not obtained from BCBSNM. A list of services requiring prior approval is listed in the contract.

[5] Admission review is required for inpatient admissions. You pay a 25 percent penalty for covered medical/surgical facility services if admission review 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. The 25 percent penalty will not apply in such cases. See contract for details.

[6] Prescription drugs must be purchased at a pharmacy that participates in the Retail Pharmacy or Mail Order Service programs. (BCBSNM has contracted with a separate program for administration of your prescription drug benefits. This program is not an affiliate of BCBSNM.)

[7]Benefits for supplies are limited to a 30 day supply purchased during a 30-day period. Rental benefits for medical equipment and other items will not exceed purchase price of a new unit.

Note: The specific terms of coverage, exclusions and limitations are contained in the BlueCross BlueShield policy booklet.