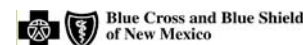


# Alliance Summary of Benefits: PPO Plans 4, 5, 6



**This is a summary only** that lists the deductible, out-of-pocket limit, and prescription drug plan copayments, the coinsurance percentages, and a brief description of Alliance PPO Plans 4, 5, 6 benefit options.

Alliance PPO Plans 4,5,6 Benefit Options: Check Your ID Card to Verify Your Plan	Benefit Level: Your Share of Covered Charges					
	Preferred Provider (PPO) <sup>1</sup>			Nonpreferred Provider <sup>1</sup>		
	Plan 4	Plan 5	Plan 6	Plan 4	Plan 5	Plan 6
<b>Annual Deductible Options (per individual):</b> Family deductible is an aggregate of three times individual amount chosen. <sup>1</sup>	\$1,000	\$2,500	\$10,000	\$2,000	\$5,000	\$17,000
<b>Annual Out-of-Pocket Limit:</b> Includes deductible and coinsurance only - does not include copayments, penalty amounts, or noncovered charges. Family aggregate. <sup>2</sup>	\$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)
<b>Member Coinsurance</b> (Percentage of covered charges that <b>you</b> pay after deductible is met. The covered charge may be less than the billed charge; therefore, you also pay the difference if you visit a nonpreferred provider.)	50%	50%	Plan pays 100%	70%	70%	20%
<b>PPO Primary Provider (PPP)* vs. PPO Specialist (including Urgent Care) Office Visit/Exam Copayment</b>	\$30/\$40	\$40/\$50	\$50/\$60	NA	NA	NA
<b>Office Visit/Exams (Nonroutine) and Urgent Care</b>	PPP* or Specialist Office Visit/Exam Copay (deductible waived)			non-PPO Deductible/Coinsurance		
Office surgery (including casts, splints, and dressings) <sup>4</sup>						
Diagnostic (nonroutine) Lab Tests, X-Rays, EKGs, Other Diagnostic Tests						
Therapeutic injections; Allergy injections, tests, serum						
Family planning services (IUD insertion, cervical cap, diaphragm)						
All other services received during an office visit (unless specifically mentioned below as being subject to deductible and coinsurance; e.g., chemotherapy)						
<b>Preventive/Routine Services</b>	PPP* or Specialist Office Visit/Exam Copay (deductible waived)			non-PPO Deductible/Coinsurance		
Office exam/physical						
Routine lab and x-ray, mammograms, Pap tests, immunizations, routine vision or hearing screenings, immunizations	Plan pays in full			non-PPO Deductible/Coinsurance		
<b>Acupuncture Treatment</b> (max. benefit \$500/calendar year)	PPO Deductible/Coinsurance			Not covered		
<b>Ambulance Services: Ground and Emergency Air</b>	PPO Deductible/Coinsurance <sup>4</sup>					
<b>Ambulance Services: Nonemergency Air Transport</b>	PPO Deductible/Coinsurance			non-PPO Deductible/Coinsurance		
<b>Cardiac Rehabilitation, Outpatient</b> (max. benefit 36 visits/calendar year)	PPO Deductible/Coinsurance <sup>4</sup>			Not covered		
<b>Emergency Room Treatment</b> (If admitted to hospital, benefits for facility services paid as part of hospital admission; inpatient benefits will apply in such cases.)	\$100 Copayment plus PPO Coinsurance (deductible waived) <sup>3</sup>					
<b>Hearing Aids and Related Services:</b> Hearing aids for members under age 21 are paid at 100% of covered charges up to a maximum of \$2200 per ear during any 3-year period; exams and testing are subject to usual cost-sharing provisions. These services are not covered for members age 21 and older.						
<b>Home Health Care/Home I.V. Services</b> (max. 100 visits/cal. year)	PPO Deductible/Coinsurance <sup>4</sup>			non-PPO Deductible/Coinsurance <sup>4</sup>		
<b>Hospice Services</b> (max. six months of care)	PPO Deductible/Coinsurance <sup>4</sup>			non-PPO Deductible/Coinsurance <sup>4</sup>		
<b>Inpatient Hospital/Facility Services: Acute Care Medical/Surgical Facility</b> (Also, see "Transplant Services," if applicable.)						
Medical/Surgical and Maternity-Related Room and Board, Covered Ancillaries	PPO Deductible/Coinsurance <sup>5</sup>			non-PPO Deductible/Coinsurance <sup>5</sup>		
Routine Nursery Care for Covered Newborns (deductible waived if mother is covered and baby is discharged on same day)	PPO Deductible/Coinsurance			non-PPO Deductible/Coinsurance		
<b>Lab, X-Ray, and Other Diagnostic Tests (Independent Facility or Outpatient)</b>	PPO Deductible/Coinsurance <sup>4</sup>			non-PPO Deductible/Coinsurance <sup>4</sup>		
<b>Maternity Services</b> , Including Routine Pediatrician Care for Covered Newborns (Also see "Inpatient Hospital/Facility Services.")	PPO Deductible/Coinsurance (plus OV Copay for first office visit to confirm pregnancy)			non-PPO Deductible/Coinsurance <sup>5</sup>		
<b>Mental Health Services, Inpatient and Outpatient</b>	PPO Deductible/Coinsurance <sup>5</sup> Specialist Copay <sup>4</sup>			Not covered		
Inpatient hospitalization Outpatient therapy, medication checks, intake evaluations Outpatient group therapy	\$35 <sup>4</sup>	\$45 <sup>4</sup>	\$55 <sup>4</sup>			
<b>Prosthetics and Functional Orthotics</b> (Combined PPO & Non PPO limit \$2,500 per calendar year. Max does not include breast prosthetics.)	PPO Deductible/Coinsurance <sup>4,7</sup>			non-PPO Deductible/Coinsurance <sup>4,7</sup>		
<b>Pulmonary Rehabilitation</b> (max. 20 visits/calendar year)	PPO Deductible/Coinsurance <sup>4</sup>			Not covered		

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

Alliance PPO Plan 4, 5, 6 Options (continued)	Benefit Level: Your Share of Covered Charges	
	Preferred Provider (PPO) <sup>1</sup>	Nonpreferred Provider <sup>1</sup>
<b>Short-Term Rehabilitation, Inpatient and Outpatient</b> (Includes services in a rehabilitation facility and outpatient physical, occupational, and speech therapy services.) Inpatient hospitalization (max. <b>10 days</b> /calendar year) Outpatient (max. <b>20 visits</b> each therapy type/calendar year)	PPO Deductible/Coinsurance <sup>5</sup> PPO Deductible/Coinsurance <sup>4</sup>	Not covered
<b>Smoking/Tobacco Use Cessation Counseling:</b> A maximum of <b>two 90-day</b> courses of drug therapy <sup>4</sup> (see "Prescription Drugs," below); up to <b>90 minutes</b> total provider contact time OR <b>two</b> multi-session group counseling programs per calendar year.	PPO Deductible/Coinsurance	Not covered
<b>Spinal Manipulation</b> (max. benefit \$500/calendar year)	PPO Deductible/Coinsurance	Not covered
<b>Supplies and Durable Medical Equipment</b> (Combined PPO & Non PPO limit \$2,500 per calendar year. Max. does not include oxygen or diabetic equipment)	PPO Deductible/Coinsurance <sup>4,7</sup>	non-PPO Deductible/Coinsurance <sup>4,7</sup>
<b>Surgery, Inpatient or Outpatient</b> (For transplants, see "Transplant Services" below.)	PPO Deductible/Coinsurance <sup>4,5</sup>	non-PPO Deductible/Coinsurance <sup>4,5</sup>
<b>Therapy: Chemotherapy, Dialysis, and Radiation</b>	PPO Deductible/Coinsurance <sup>4</sup>	non-PPO Deductible/Coinsurance <sup>4</sup>
<b>TMJ/CMJ Services, Dental Accidents, Oral Surgery</b> (Only limited and specific procedures are covered. See <i>Section 3.</i> )	PPO Deductible/Coinsurance <sup>4</sup>	non-PPO Deductible/Coinsurance <sup>4</sup>
<b>Transplant Services</b> (Must be received at a facility that contracts with BCBSNM or with the national BCBS transplant network.) <b>Heart, Kidney, Liver, Lung, Bone Marrow Only</b> (Subject to a lifetime maximum benefit of <b>\$250,000</b> for all transplant services combined, excluding outpatient prescription drugs.)	PPO Deductible/Coinsurance <sup>4</sup>	Not covered
<b>Chemical Dependency Rehabilitation</b> (Alcoholism and Drug Abuse Services.)		
Inpatient services (max. <b>30 days</b> /calendar year)	PPO Deductible/Coinsurance <sup>4</sup>	Not covered
Outpatient/office services (max. <b>30 visits</b> /calendar year)	PPO Deductible/Coinsurance <sup>4</sup>	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/calendar year. <sup>6</sup>	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:	
			On Drug List	Not on Drug List
<b>Retail/Specialty Pharmacy Program</b> (up to a 30-day supply or 120 units, whichever is less)	\$20	\$20 plus difference in covered charge between brand-name and generic	\$40	\$60
<b>Mail-Order Plan</b> (up to a 90-day supply or 360 units, whichever is less)	\$50	\$50 plus difference in covered charge between the brand-name and generic	\$100	\$150
<b>Nonprescription enteral nutritional products and special medical foods</b> (up to a 30-day supply per 30-day period; require prior approval)	50%	50%	50%	50%

- The deductible must be met before benefit payments are made (excluding prescription drug plan services, preventive services, hearing aids, and services for which you pay a fixed-dollar copayment). Covered charges for preferred provider services are **not** applied to the Nonpreferred Provider deductible, nor vice versa. **Note:** A "PPP" is any preferred provider with a specialty of Family Practice, Internal Medicine, General Practice, Gynecology, Pediatrics, or Obstetrics/Gynecology. See a member's benefit booklet for details.
- 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. Coinsurance for preferred provider services is **not** applied to the Nonpreferred Provider out-of-pocket limit, nor vice versa.
- 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 are paid at the Nonpreferred Provider level.
- Certain services are not covered if prior approval is not obtained from BCBSNM. A list of services requiring prior approval is in the member's benefit booklet.
- Admission review is required for inpatient admissions. You pay a 25 percent penalty for covered 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**. See a member's benefit booklet for details.
- Prescription drugs, enteral nutritional products, special medical foods, insulin, and diabetic supplies must be purchased at a pharmacy that participates in the Retail/Specialty Pharmacy or Mail Order Service programs. Insulin and diabetic supplies are not applied to the calendar year maximum benefit under the drug plan. (BCBSNM has contracted with a separate program for administration of your prescription drug benefits.)
- Benefits for medical 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. Prior approval is required for certain items (listed in the benefit booklet) and for items costing \$500 or more or requiring long-term rental. The annual maximum does not include amounts for diabetic equipment, breast prosthetics, or oxygen.

**Deductibles and coinsurance percentages are applied to BCBSNM's covered charges.**