

## Summary of PNM Resources' Health Care Benefits — Active Employees — 2011

The following charts show deductibles, limits, benefit levels and copay amounts for the PNM Resources medical, dental and vision programs. For more information — including covered services and supplies and expenses not covered — see each individual section.

### Medical Coverage

	Blue Cross and Blue Shield of New Mexico			Presbyterian Health Plan
	Premium Option	Standard Option	Value Option	
<b>Plan Features</b>				
<b>Annual Deductible</b> • Individual • Family	\$350 \$1,050	\$500 \$1,500	\$2,100 \$4,300	\$350 \$1,050
<b>Out of Pocket Maximum</b> • Individual • Family	\$3,000 \$6,000	\$4,000 \$8,000	\$5,000 \$10,000	\$3,000 \$6,000
<b>Limitations on Pre-Existing Conditions</b>	None	None	None	None
<b>Overall Lifetime Maximum Benefit</b>	Unlimited	Unlimited	Unlimited	Unlimited
<b>Other Lifetime Maximums</b> • Hospice care  • Infertility  • Outpatient physical, speech & occupational therapy (combined)  • Skilled Nursing Facilities & inpatient rehabilitation facilities	<ul style="list-style-type: none"> <li>• \$7,500/lifetime. Additional max. of 2 benefit periods/lifetime. Respite care limited to 5 consecutive days for each 60 days of hospice care. Additional max. of 2 respite stays.</li> <li>• \$5,000 in medical/surgical benefits. Additional \$5,000 in prescription drug benefits.</li> <li>• \$3,500/condition</li> <li>• 30 days/condition</li> </ul>			<ul style="list-style-type: none"> <li>• \$7,500/lifetime. Additional max. of 2 benefit periods/lifetime. Respite care limited to 5 consecutive days for each 60 days of hospice care. Additional max. of 1 respite stay.</li> <li>• \$5,000 in medical/surgical benefits. Additional \$5,000 in prescription drug benefits.</li> <li>• \$3,500/condition</li> <li>• 30 days/condition</li> </ul>
<b>Other Maximums</b> • Acupuncture	• \$1,500/calendar year — for preferred providers. No coverage/benefits for non-preferred providers.			• \$1,500/calendar year — for preferred providers. No coverage/benefits for non-preferred providers.

	Blue Cross and Blue Shield of New Mexico			Presbyterian Health Plan
	Premium Option	Standard Option	Value Option	
Plan Features <i>(cont'd)</i>				
<p><b>Other Maximums</b></p> <ul style="list-style-type: none"> <li>• Travel related to organ and tissue transplants</li> <li>• Home health care</li> <li>• Medical supplies &amp; durable medical equipment from a non-preferred provider</li> <li>• Orthotics &amp; prosthetics from a non-preferred provider (combined)</li> <li>• Spinal manipulation/ chiropractic</li> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>• \$10,000/transplant for travel expenses, including meals and lodging. Meals and lodging further limited to \$125/day for recipient and one eligible adult (2 adults if patient is under 18)</li> <li>• 100-visits/calendar year.</li> <li>• \$1,000/calendar year — for supplies from non-preferred providers. Diabetic supplies and oxygen are not subject to max. No annual max for preferred providers. Regardless of provider, mastectomy bras limited to 2/year and support hose limited to 2 pair/year.</li> <li>• \$1,000/calendar year — for non-preferred providers. No annual max. for preferred providers. Breast prosthetics are not subject to max.</li> <li>• \$1,500/calendar year — for preferred providers. No coverage/benefits for non-preferred providers.</li> </ul>	<ul style="list-style-type: none"> <li>• \$10,000/transplant for travel expenses, including meals and lodging. Meals and lodging further limited to \$150/day for recipient and companion (combined) for in-state and out-of-state travel. Transportation costs only covered for out-of-state travel.</li> <li>• 100-visits/calendar year.</li> <li>• \$1,000/calendar year — for supplies from non-preferred providers. Diabetic supplies from a durable medical equipment provider are not subject to max. No annual max for preferred providers. Regardless of provider, mastectomy bras limited to 2/year and support hose limited to 2 pair/year.</li> <li>• \$1,000/calendar year — for non-preferred providers. (Breast prosthetics and supplies for individuals with diabetes are not subject to max.) No annual max. for preferred providers.</li> <li>• \$1,500/calendar year — for preferred providers. (X-rays and physical therapy are not subject to max.). No coverage/benefits for non-preferred providers.</li> <li>•</li> </ul>		

Blue Cross and Blue Shield of New Mexico							Presbyterian Health Plan	
Premium Option		Standard Option		Value Option				
<b>Plan Features (cont'd)</b>								
<b>Penalties for Failure to Call:</b> <ul style="list-style-type: none"> <li>For Prior Approval of specific expenses, surgeries &amp; procedures</li> <li>For Admission Review of a Hospital admission or other facility admission</li> </ul>		<ul style="list-style-type: none"> <li>Denial of benefits</li> <li>\$300 penalty/admission or denial of benefits if admission is not Medically Necessary</li> </ul>				<ul style="list-style-type: none"> <li>Denial of benefits</li> <li>\$300 penalty/admission</li> </ul>		
<b>Services With A Copay For In-Network/ Preferred Provider Care</b>								
	<b>Preferred Provider</b>	<b>Non-Preferred Provider<sup>1</sup></b>	<b>Preferred Provider</b>	<b>Non-Preferred Provider<sup>1</sup></b>	<b>Preferred Provider</b>	<b>Non-Preferred Provider<sup>1</sup></b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Doctor's Office Visit — PPP &amp; Other Providers</b> <ul style="list-style-type: none"> <li>PPO Primary Provider (PPP)</li> <li>Other preferred and non-preferred Doctors</li> <li>Includes regular office visits, as well as covered diabetes education, family planning and gynecological services &amp; prenatal visits</li> </ul> <p><i>A PPP is a BCBS preferred provider in one of the following specialties: Family Practice, General Practice, Internal Medicine, Obstetrics/Gynecology, Gynecology and Pediatrics.</i></p>	<p><i>PPP:</i> 100% after a \$15 copay <i>No deductible</i></p> <p><i>Other Preferred Providers:</i> 100% after \$30 copay <i>No deductible</i></p>	70%	<p><i>PPP:</i> 100% after a \$20 copay <i>No deductible</i></p> <p><i>Other Preferred Providers:</i> 100% after \$40 copay <i>No deductible</i></p>	60%	<p><i>PPP:</i> 100% after a \$25 copay <i>No deductible</i></p> <p><i>Other Preferred Providers:</i> 100% after \$50 copay <i>No deductible</i></p>	50%	100% after \$15 copay <i>No deductible</i>	70%
<b>Doctor's Office Visit — Specialist</b> <ul style="list-style-type: none"> <li>Includes regular office visits, as well as covered diabetes education, family planning and gynecological services &amp; prenatal visits</li> </ul>	100% after \$30 copay <i>No deductible</i>	70%	100% after \$40 copay <i>No deductible</i>	60%	100% after \$50 copay <i>No deductible</i>	50%	100% after \$30 copay <i>No deductible</i>	70%

Blue Cross and Blue Shield of New Mexico							Presbyterian Health Plan	
Premium Option		Standard Option		Value Option				
Services With A Copay For In-Network/ Preferred Provider Care (cont'd)	Preferred Provider	Non-Preferred Provider <sup>1</sup>	Preferred Provider	Non-Preferred Provider <sup>1</sup>	Preferred Provider	Non-Preferred Provider <sup>1</sup>	In-Network	Out-of-Network
<b>Emergency Room/ Observation Room – Facility Charges, Emergency Only</b>	100% after \$100 copay <i>No deductible</i>	100% after \$100 copay <i>No deductible</i>	100% after \$125 copay <i>No deductible</i>	100% after \$125 copay <i>No deductible</i>	100% after \$150 copay <i>No deductible</i>	100% after \$150 copay <i>No deductible</i>	100% after \$100 copay <i>No deductible</i>	100% after \$100 copay <i>No deductible</i>
<b>Urgent Care</b>	100% after \$20 copay <i>No deductible</i>	70%	100% after \$35 copay <i>No deductible</i>	60%	100% after \$50 copay <i>No deductible</i>	50%	100% after \$20 copay <i>No deductible</i>	70%
<b>Wellness/Preventive Visits –</b> <ul style="list-style-type: none"> <li>• Annual physical</li> <li>• Annual Ob/Gyn</li> <li>• Well-child care</li> <li>• Adult &amp; child immunizations</li> <li>• Mammogram</li> <li>• Colonoscopy</li> <li>• Diabetes management</li> </ul>	100% after \$15 copay <i>No deductible</i>	70%	100% after \$20 copay <i>No deductible</i>	60%	100% after \$25 copay <i>No deductible</i>	50%	100% after \$15 copay <i>No deductible</i>	70%
Services With Coinsurance	Preferred Provider	Non-Preferred Provider <sup>1</sup>	Preferred Provider	Non-Preferred Provider <sup>1</sup>	Preferred Provider	Non-Preferred Provider <sup>1</sup>	In-Network	Out-of-Network
<b>Abortion<sup>2</sup></b>	90%	70%	80%	60%	75%	50%	90%	70%
<b>Acupuncture</b> <i>Up to \$1,500/year</i>	90%	Not Covered	80%	Not Covered	75%	Not Covered	90%	Not Covered
<b>Allergy Injections, Tests, Serum</b>	90%	70%	80%	60%	75%	50%	90%	70%
<b>Ambulance<sup>2</sup></b> <ul style="list-style-type: none"> <li>• Ground/Emergency Air</li> <li>• Non-emergency Air</li> </ul>	90%	90%	80%	80%	75%	75%	90%	90%
	90%	70%	80%	60%	75%	50%	90%	70%
<b>Cardiac Rehabilitation – Outpatient<sup>2</sup></b>	90%	70%	80%	60%	75%	50%	90%	70%
<b>Cochlear Implants<sup>2</sup></b>	90%	70%	80%	60%	75%	50%	90%	70%

Services With Coinsurance <i>(cont'd)</i>	Blue Cross and Blue Shield of New Mexico						Presbyterian Health Plan	
	Premium Option		Standard Option		Value Option		In-Network	Out-of-Network
	Preferred Provider	Non-Preferred Provider <sup>1</sup>	Preferred Provider	Non-Preferred Provider <sup>1</sup>	Preferred Provider	Non-Preferred Provider <sup>1</sup>		
<b>Dental Related/TMJ Services &amp; Oral Surgery<sup>2</sup></b> <ul style="list-style-type: none"> <li>• Facility charges for dental services</li> <li>• Oral surgery</li> <li>• Treatment of TMJ</li> </ul> <i>For a non-surgical office visit for treatment of a dental accident, see "Doctor's Office Visit."</i>	90%	70%	80%	60%	75%	50%	90%	70%
<b>Diagnostic Services<sup>2</sup></b> <ul style="list-style-type: none"> <li>• Lab</li> <li>• X-ray</li> <li>• Other diagnostic tests — EKG, EEG, PET &amp; CT scans, ultrasounds, etc.</li> </ul>	90%	70%	80%	60%	75%	50%	90%	70%
<b>Durable Medical Equipment<sup>2</sup></b> <i>Limitations apply. See "Other Maximums."</i>	90%	70%	80%	60%	75%	50%	90%	70%
<b>Emergency Room/ Observation Room — Non-Emergency</b>	90%	70%	80%	60%	75%	50%	90%	70%
<b>Emergency Room — Physician &amp; Other Professional Provider Charges</b>	90%	90%	80%	80%	75%	75%	90%	<i>Emergency: 90%</i> <i>Non-emergency: 70%</i>
<b>Eyeglasses/Contacts After Cataract Surgery or Keratoconus Correction<sup>2</sup></b> <i>Limitations apply. The durable medical equipment maximum applies — see "Other Maximums."</i>	90%	70%	80%	60%	75%	50%	90%	Not Covered

Blue Cross and Blue Shield of New Mexico							Presbyterian Health Plan		
							Premium Option	Standard Option	Value Option
Services With Coinsurance <i>(cont'd)</i>	Preferred Provider	Non-Preferred Provider <sup>1</sup>	Preferred Provider	Non-Preferred Provider <sup>1</sup>	Preferred Provider	Non-Preferred Provider <sup>1</sup>	In-Network	Out-of-Network	
<b>Home Health Care/Home Intravenous Services<sup>2</sup></b> <i>Up to 100 visits/year</i>	90%	70%	80%	60%	75%	50%	90%	70%	
<b>Hospice Care<sup>2</sup></b> <i>Up to \$7,500/lifetime</i>	90%	70%	80%	60%	75%	50%	90%	70%	
<b>Hospital Inpatient<sup>2,3</sup></b> <ul style="list-style-type: none"> <li>• Medical/surgical, maternity related</li> <li>• Room &amp; board</li> <li>• Covered ancillaries</li> <li>• Routine nursery care for newborns</li> <li>• Intensive care, cardiac care unit</li> </ul>	90%	70%	80%	60%	75%	50%	90%	70%	
<b>Infertility<sup>2,3</sup> — Physician/Facility</b> <i>Up to \$5,000/lifetime</i>	Based on services	70%	Based on services	60%	Based on services	50%	Based on services	70%	
<b>Mastectomy &amp; Reconstructive Surgery<sup>2,3</sup></b>	90%	70%	80%	60%	75%	50%	90%	70%	
<b>Maternity Services</b> <ul style="list-style-type: none"> <li>• Including delivery &amp; routine pediatrician care for covered newborns</li> <li>• Also see "Hospital"</li> </ul> <i>Initial visit may require a copay.</i>	90%	70%	80%	60%	75%	50%	90%	70%	
<b>Medical Supplies<sup>2</sup></b> <i>Limitations apply. See "Other Maximums."</i>	90%	70%	80%	60%	75%	50%	90%	70%	
<b>Mental Health — Outpatient<sup>2</sup></b>	100% after \$15 copay <i>No deductible</i>	70%	100% after \$20 copay <i>No deductible</i>	60%	100% after \$25 copay <i>No deductible</i>	50%	100% after \$15 copay <i>No deductible</i>	70%	

Blue Cross and Blue Shield of New Mexico							Presbyterian Health Plan		
							Premium Option	Standard Option	Value Option
Services With Coinsurance <i>(cont'd)</i>	Preferred Provider	Non-Preferred Provider <sup>1</sup>	Preferred Provider	Non-Preferred Provider <sup>1</sup>	Preferred Provider	Non-Preferred Provider <sup>1</sup>	In-Network	Out-of-Network	
<b>Mental Health — Inpatient<sup>2,3</sup></b>	100% after \$15 copay <i>No deductible</i>	70%	100% after \$20 copay <i>No deductible</i>	60%	100% after \$25 copay <i>No deductible</i>	50%	100% after \$15 copay <i>No deductible</i>	70%	
<b>Orthotics, Functional<sup>2</sup></b> <i>Limitations apply. See “Other Maximums.”</i>	90%	70%	80%	60%	75%	50%	90%	70%	
<b>Prosthetics<sup>2</sup></b> <i>Limitations apply. See “Other Maximums.”</i>	90%	70%	80%	60%	75%	50%	90%	70%	
<b>Pulmonary Rehabilitation — Outpatient<sup>2</sup></b>	90%	70%	80%	60%	75%	50%	90%	70%	
<b>Short-Term Rehabilitation &amp; Therapy — Outpatient<sup>2</sup></b> • Physical, occupational & speech therapy & rehabilitation services • Outpatient, office & home-based <i>Limitations apply. See “Other Lifetime Maximums.”</i>	90%	70%	80%	60%	75%	50%	90%	70%	
<b>Short-Term Rehabilitation &amp; Therapy — Inpatient<sup>2,3</sup></b> • Physical, occupational & speech therapy & rehabilitation services • Skilled Nursing Facility or rehabilitation facility <i>Limitations apply. See “Other Lifetime Maximums.”</i>	90%	70%	80%	60%	75%	50%	90%	70%	
<b>Spinal Manipulation/ Chiropractic</b> <i>Up to \$1,500/year</i>	90%	Not Covered	80%	Not Covered	75%	Not Covered	<i>Spinal Manipulation: 90%</i>  <i>Office Visit: 100% after a \$20 copay No deductible</i>	Not Covered	

	Blue Cross and Blue Shield of New Mexico						Presbyterian Health Plan	
	Premium Option		Standard Option		Value Option		In-Network	Out-of-Network
Services With Coinsurance <i>(cont'd)</i>	Preferred Provider	Non-Preferred Provider <sup>1</sup>	Preferred Provider	Non-Preferred Provider <sup>1</sup>	Preferred Provider	Non-Preferred Provider <sup>1</sup>		
<b>Substance Abuse Treatment — Outpatient<sup>2</sup></b> • Includes chemical dependency, drug abuse & alcoholism treatment ”	100% after \$15 copay <i>No deductible</i>	70%	100% after \$20 copay <i>No deductible</i>	60%	100% after \$25 copay <i>No deductible</i>	50%	100% after \$15 copay <i>No deductible</i>	70%
<b>Substance Abuse Treatment — Inpatient<sup>2,3</sup></b> • Includes chemical dependency, drug abuse & alcoholism treatment	100% after \$15 copay <i>No deductible</i>	70%	100% after \$20 copay <i>No deductible</i>	60%	100% after \$25 copay <i>No Deductible</i>	50%	100% after \$15 copay <i>No Deductible</i>	70%
<b>Surgery<sup>2,3</sup> — Inpatient or Outpatient</b>	90%	70%	80%	60%	75%	50%	90%	70%
<b>Therapy — Chemotherapy, Dialysis &amp; Radiation<sup>2</sup></b>	90%	70%	80%	60%	75%	50%	90%	70%
<b>Transplants<sup>2,3</sup></b> <i>Limitations apply. See “Other Maximums.”</i>	90%	Not Covered	80%	Not Covered	75%	Not Covered	90%	Not Covered

1 Percentage shown for non-preferred providers are the percentage of covered charges payable after deductible.

2 Certain services are not covered if prior approval is not obtained. See your Summary Plan Description for a complete list of specific expenses, surgeries and procedures that require prior approval.

3 Admission review is required for inpatient admissions or financial penalty applies. Some services, such as transplants and physical rehabilitation, require additional approval or benefits may be denied entirely. See your Summary Plan Description for details.

Prescription Drugs

You must use Preferred/In-Network pharmacies – All plans  
 No Benefits for Non-preferred/Out-of-network pharmacies (except emergencies)

	Retail (up to a 30-day supply)	Mail-order (up to a 90-day supply)
<b>Generic</b>	\$4 copay	\$8 copay
<b>Brand-name when generic is available</b>	\$4 copay plus cost difference between brand and generic	\$8 copay plus cost difference between brand and generic
<b>Brand-name on Formulary List</b>	You pay 30% of the total cost, minimum of \$30/maximum of \$70	You pay 30% of the total cost, minimum of \$60/maximum of \$140
<b>Brand-name not on Formulary List</b>	You pay 40% of the total cost, minimum of \$60/maximum of \$120	You pay 40% of the total cost, minimum of \$120/maximum of \$240
<b>Immunosuppressive drugs &amp; specialty pharmaceuticals</b>	You pay 15% up to a maximum copay of \$250 per prescription	You pay 15% up to a maximum copay of \$250 per prescription

*Special Notes for the BCBS program: For covered non-prescription enteral nutritional products and special medical foods, the copay is 50%.*

*\* Includes immunosuppressive drugs following transplant surgery. Specialty pharmaceuticals are a list of drugs including injectibles and oral or inhalation forms. It includes, but is not limited to, growth hormones, low molecular weight heparins, interferon, immunologic agents and anti-tumor necrosis factors.*