

Summary of PNM Resources' Health Care Benefits — Retirees — 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	
Plan Features				
Annual Deductible • Individual • Family	\$350 \$1,050	\$500 \$1,500	\$2,100 \$4,300	\$350 \$1,050
Out of Pocket Maximum • Individual • Family	\$3,000 \$6,000	\$4,000 \$8,000	\$5,000 \$10,000	\$3,000 \$6,000
Limitations on Pre-Existing Conditions	None	None	None	None
Overall Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited
Other Lifetime Maximums • Hospice care • Infertility • Outpatient physical, speech & occupational therapy (combined) • Skilled Nursing Facilities & inpatient rehabilitation facilities	<ul style="list-style-type: none"> • \$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. • \$5,000 in medical/surgical benefits. Additional \$5,000 in prescription drug benefits. • \$3,500/condition • 30 days/condition 			<ul style="list-style-type: none"> • \$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. • \$5,000 in medical/surgical benefits. Additional \$5,000 in prescription drug benefits. • \$3,500/condition • 30 days/condition
Other Maximums • 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>Other Maximums</p> <ul style="list-style-type: none"> • Travel related to organ and tissue transplants • Home health care • Medical supplies & durable medical equipment from a non-preferred provider • Orthotics & prosthetics from a non-preferred provider (combined) • Spinal manipulation/ chiropractic • 	<ul style="list-style-type: none"> • \$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) • 100-visits/calendar year. • \$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. • \$1,000/calendar year — for non-preferred providers. No annual max. for preferred providers. Breast prosthetics are not subject to max. • \$1,500/calendar year — for preferred providers. No coverage/benefits for non-preferred providers. 	<ul style="list-style-type: none"> • \$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. • 100-visits/calendar year. • \$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. • \$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. • \$1,500/calendar year — for preferred providers. (X-rays and physical therapy are not subject to max.). 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>									
Penalties for Failure to Call:									
<ul style="list-style-type: none"> For Prior Approval of specific expenses, surgeries & procedures For Admission Review of a Hospital admission or other facility admission 		<ul style="list-style-type: none"> Denial of benefits \$300 penalty/admission or denial of benefits if admission is not Medically Necessary 						<ul style="list-style-type: none"> Denial of benefits \$300 penalty/admission 	
Services With A Copay									
For In-Network/ Preferred Provider Care		Preferred Provider	Non-Preferred Provider¹	Preferred Provider	Non-Preferred Provider¹	Preferred Provider	Non-Preferred Provider¹	In-Network	Out-of-Network
Doctor's Office Visit — PPP & Other Providers <ul style="list-style-type: none"> PPO Primary Provider (PPP) Other preferred and non-preferred Doctors Includes regular office visits, as well as covered diabetes education, family planning and gynecological services & prenatal visits <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>		PPP: 100% after a \$15 copay <i>No deductible</i> Other Preferred Providers: 100% after \$30 copay <i>No deductible</i>	70%	PPP: 100% after a \$20 copay <i>No deductible</i> Other Preferred Providers: 100% after \$40 copay <i>No deductible</i>	60%	PPP: 100% after a \$25 copay <i>No deductible</i> Other Preferred Providers: 100% after \$50 copay <i>No deductible</i>	50%	100% after \$15 copay <i>No deductible</i>	70%
Doctor's Office Visit — Specialist <ul style="list-style-type: none"> Includes regular office visits, as well as covered diabetes education, family planning and gynecological services & prenatal visits 		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 ¹	Preferred Provider	Non-Preferred Provider ¹	Preferred Provider	Non-Preferred Provider ¹	In-Network	Out-of-Network
Emergency Room/ Observation Room – Facility Charges, Emergency Only	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>
Urgent Care	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%
Wellness/Preventive Visits – <ul style="list-style-type: none"> • Annual physical • Annual Ob/Gyn • Well-child care • Adult & child immunizations • Mammogram • Colonoscopy • Diabetes management 	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 ¹	Preferred Provider	Non-Preferred Provider ¹	Preferred Provider	Non-Preferred Provider ¹	In-Network	Out-of-Network
Abortion²	90%	70%	80%	60%	75%	50%	90%	70%
Acupuncture <i>Up to \$1,500/year</i>	90%	Not Covered	80%	Not Covered	75%	Not Covered	90%	Not Covered
Allergy Injections, Tests, Serum	90%	70%	80%	60%	75%	50%	90%	70%
Ambulance² <ul style="list-style-type: none"> • Ground/Emergency Air • Non-emergency Air 	90%	90%	80%	80%	75%	75%	90%	90%
	90%	70%	80%	60%	75%	50%	90%	70%
Cardiac Rehabilitation – Outpatient²	90%	70%	80%	60%	75%	50%	90%	70%
Cochlear Implants²	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 ¹	Preferred Provider	Non-Preferred Provider ¹	Preferred Provider	Non-Preferred Provider ¹		
Dental Related/TMJ Services & Oral Surgery² <ul style="list-style-type: none"> • Facility charges for dental services • Oral surgery • Treatment of TMJ <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%
Diagnostic Services² <ul style="list-style-type: none"> • Lab • X-ray • Other diagnostic tests — EKG, EEG, PET & CT scans, ultrasounds, etc. 	90%	70%	80%	60%	75%	50%	90%	70%
Durable Medical Equipment² <i>Limitations apply. See "Other Maximums."</i>	90%	70%	80%	60%	75%	50%	90%	70%
Emergency Room/ Observation Room — Non-Emergency	90%	70%	80%	60%	75%	50%	90%	70%
Emergency Room — Physician & Other Professional Provider Charges	90%	90%	80%	80%	75%	75%	90%	<i>Emergency: 90%</i> <i>Non-emergency: 70%</i>
Eyeglasses/Contacts After Cataract Surgery or Keratoconus Correction² <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 ¹	Preferred Provider	Non-Preferred Provider ¹	Preferred Provider	Non-Preferred Provider ¹	In-Network	Out-of-Network	
Home Health Care/Home Intravenous Services² <i>Up to 100 visits/year</i>	90%	70%	80%	60%	75%	50%	90%	70%	
Hospice Care² <i>Up to \$7,500/lifetime</i>	90%	70%	80%	60%	75%	50%	90%	70%	
Hospital Inpatient^{2,3} <ul style="list-style-type: none"> • Medical/surgical, maternity related • Room & board • Covered ancillaries • Routine nursery care for newborns • Intensive care, cardiac care unit 	90%	70%	80%	60%	75%	50%	90%	70%	
Infertility^{2,3} — Physician/Facility <i>Up to \$5,000/lifetime</i>	Based on services	70%	Based on services	60%	Based on services	50%	Based on services	70%	
Mastectomy & Reconstructive Surgery^{2,3}	90%	70%	80%	60%	75%	50%	90%	70%	
Maternity Services <ul style="list-style-type: none"> • Including delivery & routine pediatrician care for covered newborns • Also see "Hospital" <i>Initial visit may require a copay.</i>	90%	70%	80%	60%	75%	50%	90%	70%	
Medical Supplies² <i>Limitations apply. See "Other Maximums."</i>	90%	70%	80%	60%	75%	50%	90%	70%	
Mental Health — Outpatient²	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		In-Network	Out-of-Network
Services With Coinsurance <i>(cont'd)</i>	Preferred Provider	Non-Preferred Provider ¹	Preferred Provider	Non-Preferred Provider ¹	Preferred Provider	Non-Preferred Provider ¹		
Mental Health — Inpatient^{2,3}	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%
Orthotics, Functional² <i>Limitations apply. See “Other Maximums.”</i>	90%	70%	80%	60%	75%	50%	90%	70%
Prosthetics² <i>Limitations apply. See “Other Maximums.”</i>	90%	70%	80%	60%	75%	50%	90%	70%
Pulmonary Rehabilitation — Outpatient²	90%	70%	80%	60%	75%	50%	90%	70%
Short-Term Rehabilitation & Therapy — Outpatient² • 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%
Short-Term Rehabilitation & Therapy — Inpatient^{2,3} • 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%
Spinal Manipulation/ Chiropractic <i>Up to \$1,500/year</i>	90%	Not Covered	80%	Not Covered	75%	Not Covered	<i>Spinal Manipulation:</i> 90% <i>Office Visit:</i> 100% after a \$20 copay <i>No deductible</i>	Not Covered

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 ¹	Preferred Provider	Non-Preferred Provider ¹	Preferred Provider	Non-Preferred Provider ¹		
Substance Abuse Treatment — Outpatient² • 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%
Substance Abuse Treatment — Inpatient^{2,3} • 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%
Surgery^{2,3} — Inpatient or Outpatient	90%	70%	80%	60%	75%	50%	90%	70%
Therapy — Chemotherapy, Dialysis & Radiation²	90%	70%	80%	60%	75%	50%	90%	70%
Transplants^{2,3} <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)
Generic	\$4 copay	\$8 copay
Brand-name when generic is available	\$4 copay plus cost difference between brand and generic	\$8 copay plus cost difference between brand and generic
Brand-name on Formulary List	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
Brand-name not on Formulary List	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
Immunosuppressive drugs & specialty pharmaceuticals	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.*

Dental Coverage

		DeltaPremier Dentist (Nationwide)	Non-Participating Dentist (Nationwide)
Plan Features			
Annual Deductible			
<ul style="list-style-type: none"> • Individual • Family 		\$50 \$150	\$50 \$150
Benefit Maximums			
<ul style="list-style-type: none"> • Annual — per individual; applies to all expenses <i>except</i> orthodontia • Lifetime Orthodontic — per individual; applies <i>only</i> to orthodontic benefits 		\$1,000 \$2,500	
Covered Expenses			
Preventive Services			
<ul style="list-style-type: none"> • Cleanings (Prophylaxis) or Periodontal Cleaning— up to twice each calendar year • Fluoride, topical application — only for children under age 19; up to twice each calendar year • Oral Exams, routine — up to twice each calendar year • Palliative Treatment (emergency treatment for pain) • Space Maintainers • X-rays, bitewing — up to twice each calendar year • X-rays, full-Mouth — once every five years 		100% No deductible applies	100% ¹ No deductible applies
Restorative & Basic Services			
<ul style="list-style-type: none"> • Anesthesia, general • Extractions & other oral surgery • Fillings & regular restorative services • Gum Treatments (periodontics) • Prescription drugs — only when dentally necessary. you must pay up front and file a claim for reimbursement • Root canals (endodontics) • Sealants — only for children under age 19 and only to unrestored molars and bicuspids. Up to one treatment per tooth per calendar year and no more than two treatments per tooth per lifetime 		80% After deductible	80% ¹ After deductible

		DeltaPremier Dentist (Nationwide)	Non-Participating Dentist (Nationwide)
Covered Expenses (cont'd)			
Major Services <ul style="list-style-type: none"> • Bridges, fixed or removable • Crowns & cast restorations • Dentures, full or partial 		50% After deductible	50% ¹ After deductible
Orthodontic Services <ul style="list-style-type: none"> • For children under age 19 • For adults age 19 & over — only when dentally necessary, needed for future dental health and not cosmetic in nature 		50% After deductible	50% ¹ After deductible
<i>1 With a non-participating dentist, you are responsible for paying your coinsurance amount, if any, as well as any amount billed by the dentist that is over Delta Dental's Allowable Fee. With a DeltaPremier dentist, you are NOT responsible for paying amounts over the Allowable Fee.</i>			

Vision Coverage

	Vision Service Plan (VSP)	
Plan Features & Covered Expenses	From A VSP Provider	From A Non-VSP Provider
Annual Deductible	None	None
Examinations <i>Once every 12 months</i>	Plan pays: 100% after \$15 copay	Plan pays: up to \$35 after \$15 copay
Lenses <ul style="list-style-type: none"> • Single Vision • Bifocal • Trifocal • Progressive <i>Once every 12 months. Benefits are per complete set, not per lens.</i>	Plan pays: 100% after \$25 copay <i>(all lens types)</i>	Plan pays: <ul style="list-style-type: none"> • Up to \$25 (after \$25 copay) • Up to \$40 (after \$25 copay) • Up to \$55 (after \$25 copay) • No Coverage for Progressive
Frame <i>Once every 24 months</i>	Plan pays up to \$145 frame allowance (One \$25 copay applies to both lenses & frames)	Plan pays up to \$45 (One \$25 copay applies to both lenses & frames)
Contact Lenses <ul style="list-style-type: none"> • Elective • Medically Necessary <i>Once every 12 months. Contact lenses are in lieu of all other lens and frame benefits.</i>	Plan pays: <ul style="list-style-type: none"> • Up to \$145 • 100% after \$25 copay 	Plan pays: <ul style="list-style-type: none"> • Up to \$105 • Up to \$210 after \$25 copay
Laser Vision Correction <ul style="list-style-type: none"> • Screening • Surgery & pre- and post-operative care 	<ul style="list-style-type: none"> • Plan pays 100% • Plan provides a discount on fees. Discounts vary, but average 15% 	Not available
Low Vision Services & Supplies <i>(must be approved by VSP in advance)</i> <ul style="list-style-type: none"> • Supplemental testing • Supplemental aids <i>There is a maximum benefit of \$1,000 every 24 months for all low vision services and materials.</i>	Plan pays: <ul style="list-style-type: none"> • 100% • 75% of pre-approved amount 	Plan pays: <ul style="list-style-type: none"> • Up to \$125 • Up to 75% of pre-approved amount