

Western Refining High Deductible Plan

Summary of 2011 HDHP PPO Benefits

Administered by:



Blue Cross and Blue Shield
of New Mexico

This is a summary only that lists the deductible, out-of-pocket limits, and member coinsurance percentage amounts, and provides a brief description of Western Refining High Deductible Health Plan (HDHP) PPO benefits.

Western Refining HDHP PPO Plan Benefits	Member's Share of Covered Charges	
	Preferred Provider ¹	Nonpreferred Provider ¹
Calendar Year Deductible (Family deductible is an aggregate of three times the individual deductible amount.)	\$2,400 (\$7,200 Family)	\$4,800 (\$14,400 Family)
Annual Out-of-Pocket Limit – (Includes deductible and coinsurance amounts only - NOT penalty amounts or noncovered charges. Family limit is an aggregate of three times the individual out-of-pocket limit amount.) ²	\$2,400 Individual \$7,200 Family Coverage	\$7,800 Individual \$23,400 Family Coverage
Office Services (nonroutine)	Plan pays 100%	30%
Office Visits	Plan pays 100%	30%
Office Surgery (including casts, splints, and dressings)	Plan pays 100%	30%
Allergy Injections, Tests, Serum	Plan pays 100%	30%
Mental Health and Chemical Dependency (outpatient/office)	Plan pays 100% ⁴	30% ⁴
Preventive Services Routine Adult Physicals and Gynecological Exams (ages 18 and older), Related Testing (includes routine Pap tests, mammograms, cholesterol tests, urinalysis, etc.), Routine Vision & Hearing Exams and Immunizations, Colonoscopies, and PSA tests. Well-Child Care; Routine Vision & Hearing Exams, Routine Testing, and Immunizations	Plan pays 100% (deductible waived)	Adults & children age 7 & older: 30% (deductible waived) Children through age 6 Plan pays 100% (deductible waived)
Lab, X-Ray, EKG, and Other Diagnostic Tests	Plan pays 100%	30%
MRI, CT Scan, PET Scan	Plan pays 100% ⁴	30% ⁴
Ambulance Services: Ground and Emergency Air Transport	Plan pays 100% ³	
Cardiac and Pulmonary Rehabilitation, Outpatient	Plan pays 100% ⁴	30% ⁴
Spinal Manipulation (max. \$1,500/year)	Plan pays 100%	30%
Dental/Facial Accident, Oral Surgery, TMJ/CMJ Services, and Removal of Impacted Wisdom Teeth	Plan pays 100% ⁴ Plan pays 100% ⁴	30% ⁴ Plan pays 100% ⁴
Emergency Room Treatment	Plan pays 100% ³	
Hearing Aids and Related Services (max. \$1,000 every 36 mos.)	Plan pays 100%	
Home Health Care/Home I.V. Services (max. 100 visits/year)	Plan pays 100%	30%
Home Infusion Therapy	Plan pays 100%	30%
Hospice Services	Plan pays 100%	30%
Inpatient Hospital/Facility Services (See "Short-Term Rehabilitation" for physical rehabilitation and skilled nursing facility admissions. See "Transplant Services," if applicable.)		
Medical/Surgical, Mental Health/Chemical Dependency and Maternity-Related Room and Board and Covered Ancillaries	Plan pays 100% ⁵	30% ⁵
Routine Nursery Care for Covered Newborns	Plan pays 100%	30%
Maternity Services , including Routine Pediatrician Care for Covered Newborns	Plan pays 100% ⁵	30% ⁵

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Western Refining HDHP PPO Plan Benefits		Member's Share of Covered Charges		
		Preferred Provider ¹	Nonpreferred Provider ¹	
Short-Term Rehabilitation: Occupational, Physical, and Speech Therapy; including Inpatient Physical Rehabilitation		Plan pays 100% ^{4,5}	30% ^{4,5}	
Skilled Nursing Facility (max. 90 days/year)		Plan pays 100% ^{4,5}	30% ^{4,5}	
Supplies, Durable Medical Equipment, Prosthetics and Orthotics		Plan pays 100% ^{4,6}	30% ^{4,6}	
Surgery, Inpatient or Outpatient (For transplants, see "Transplant Services," below)		Plan pays 100% ^{4,5}	30% ^{4,5}	
Therapy: Chemotherapy, Dialysis, and Radiation		Plan pays 100%	30%	
Transplant Services				
Cornea, Kidney, and Bone Marrow		Plan pays 100% ^{4,5}	30% ^{4,5}	
Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney - \$10,000 maximum for travel per diem in-network only)				
Urgent Care Facility		Plan pays 100%	30%	
Prescription Drugs, Insulin, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods¹				
All covered nonpreventive drugs and other items are subject to the deductible (Exception: Preventive drugs are not subject to deductible, although the coinsurance you pay is applied to the PPO deductible/out-of-pocket limit and will be waived once the PPO deductible/out-of-pocket limit is met. Certain drugs, special medical foods, and enteral nutritional products require preauthorization or benefits will be denied.) ^{1,4,7}				
Retail Pharmacy Program (up to a 34-day supply or 180 units, whichever is less.)	Generic Drugs & Brand-Name Drugs	Plan pays 100% after PPO deductible is met ^{1,4,7}		
Mail-Order Plan (up to a 90-day supply or 360 units, whichever is less.)				
Nonprescription enteral nutritional products and special medical foods (up to a 30-day supply/30-day period, needs preauthorization.)		Plan pays 100% after PPO deductible is met ^{1,4,7}		
Preventive Drugs Only	Type of Prescription	Percentage of covered charge you pay (coinsurance), if the percentage is between the minimum and maximum member share amounts ⁷	Minimum Member Share ⁷	Maximum Member Share ⁷
Preventive Drug Retail Pharmacy Program (up to a 34-day supply or 180 units, whichever is less.) ⁷	Generic Drug	10%	\$0	\$5
	Preferred Brand	(deductible waived; however, your share is applied to the PPO deductible and out-of-pocket limit)	\$15	\$50
	Nonpreferred Brand		\$30	\$100
Preventive Drug Mail-Order Plan (up to a 90-day supply or 360 units, whichever is less.) ⁷	Generic Drug	10%	\$0	\$10
	Preferred Brand	(deductible waived; however, your share is applied to the PPO deductible and out-of-pocket limit)	\$30	\$100
	Nonpreferred Brand		\$60	\$200

Note: BCBSNM provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims, except as may be specified in the Administrative Services Agreement.

FOOTNOTES:

- 1 The Individual or Family deductible (as applicable) must be met before benefit payments are made for most services, including for nonpreventive medications and items covered under the drug plan. Preventive care services are **not** subject to the deductible. When one person in a family meets an individual deductible amount, that person's preferred provider/drug plan (or nonpreferred provider) services start paying at 100 percent (or 70 percent for nonpreferred provider services). **Exception:** Preventive drugs are not applied to the deductible.
- 2 After a member or family reaches the applicable out-of-pocket limit, BCBSNM pays 100 percent of that member's or family's preferred provider/drug plan or nonpreferred provider covered charges, whichever is applicable. Amounts paid under the drug plan are subject to the preferred provider/drug plan limit. Nonpreferred provider out-of-pocket amounts apply to the preferred provider level out-of-pocket limit, but **not** vice versa. When one person in a family meets the nonpreferred provider out-of-pocket limit, that person's nonpreferred provider claims begin paying at 100 percent of covered charges. If the other family members meet the remaining nonpreferred provider family out-of-pocket limit amount, their nonpreferred provider claims begin paying at 100 percent of the covered charge.
- 3 Initial treatment of a medical emergency is paid at Preferred Provider level. Follow-up treatment and treatment that is not for an emergency is paid at Nonpreferred Provider level if a nonpreferred provider is used.
- 4 Certain services are not covered if preauthorization is not obtained from BCBSNM. See the *Summary Plan Description* for a list of services requiring preauthorization.
- 5 Preauthorization is required for inpatient admissions. You pay a \$300 penalty for covered medical/surgical facility services if preauthorization is not obtained. Some services, such as transplants and physical rehabilitation, require additional preauthorization. If you do not receive preauthorization for these individually identified procedures and services, benefits for any related admissions will be denied. See the *Summary Plan Description* for details.
- 6 Rental benefits will not exceed the purchase price of a new unit. In addition to all equipment costing \$500 or more, specific equipment, prosthetics, appliances, and orthotics require preauthorization or services will not be covered.
- 7 Prescription drugs and other items covered only under the drug plan (e.g., diabetic supplies) must be purchased at a pharmacy that participates in the Retail Pharmacy/Specialty Pharmacy or Mail Order Service programs. **Note:** Under the drug plan, if you prefer a brand-name drug that has a generic equivalent, you will pay the difference in cost between the generic and brand name, plus the generic drug coinsurance amount.
- 8 Effective January 1, 2010, all dollar, day, and/or visit limitations for mental health services and the maximum number of benefit periods for chemical dependency are being removed. These services will be subject to medical necessity review and all general limitations and exclusions will be applied. Residential treatment centers are not covered.

IMPORTANT: Deductible amounts and coinsurance percentages are applied to BCBSNM's covered charges, which may be less than the provider's billed charges. Preferred providers will not charge you the difference between the covered charge and the billed charge for covered services; nonpreferred providers may.