

# Western Refining

## Summary of 2011 Benefits – PPO Plan

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's PPO Health Care Plan benefits.

Western Refining PPO Plan Benefits – Certain services have maximum annual limits.	Member's Share of Covered Charges	
	Preferred Provider <sup>1</sup>	Nonpreferred Provider <sup>1</sup>
<b>Calendar Year Deductible (per individual)</b> – Family deductible is aggregate of three times individual amount chosen. Deductible does not apply to services subject to a copayment. <sup>1</sup>	\$250 (\$750/family)	\$500 (\$1,500/family)
<b>Annual Out-of-Pocket Limit</b> – Includes coinsurance only - NOT copays, deductible, penalty amounts, or noncovered charges. <sup>2</sup>	\$2,000 (\$6,000 family)	\$4,000 (\$12,000 family)
<b>Office Visits, Medical Exams, and Initial Maternity Visits</b>	\$25 copay/visit	50%
Related office services and lab, x-ray, diagnostic services	Plan pays 100%	50%
Office Surgery (including casts, splints, and dressings)	\$25 copay/visit	50%
Allergy Injections, Tests, Serum	20%	50%
<b>Mental Health and Chemical Dependency</b> (outpatient/office)	\$25 copay/visit <sup>4</sup>	50% <sup>4</sup>
<b>Preventive Services</b> Routine Adult Physicals and Gynecological Exams, Related Testing (includes routine Pap tests, mammograms, cholesterol tests, urinalysis, etc.), Routine Vision & Hearing Exams, Immunizations, Routine Colonoscopies (outpatient/office), and PSA tests. Well-Child Care; Routine Testing, Routine Vision & Hearing Exams and Immunizations	Adults & children age 7 & older: \$25 copay/visit  Children through age 6 Plan pays 100% <i>(deductible waived)</i>	Adults & children age 7 & older: 50% <i>(deductible waived)</i>  Children through age 6 Plan pays 100% <i>(deductible waived)</i>
<b>X-Ray, EKG, Diagnostic Tests</b>	20%	50%
<b>Lab Tests</b>	Plan pays 100%	50%
<b>MRI, CT Scan, PET Scan</b>	20% <sup>4</sup>	50% <sup>4</sup>
<b>Ambulance Services: Ground and Emergency Air Transport</b>	20% <i>(deductible waived)</i>	
<b>Cardiac and Pulmonary Rehabilitation, Outpatient</b>	20% <sup>4</sup>	50% <sup>4</sup>
<b>Spinal Manipulation</b> (max. \$1,500/year)	20%	50%
<b>Dental/Facial Accident, Oral Surgery , TMJ/CMJ Services</b>	20% <sup>4</sup>	50% <sup>4</sup>
<b>Emergency Room Treatment</b>	\$100 copay/visit (ER physician = deductible and coinsurance) <sup>3</sup>	
<b>Hearing Aids &amp; Related Services</b> (max. \$1,000/year every 36 mos.)	100%	100%
<b>Home Health Care/Home I.V. Services</b> (max. 100 visits/year)	Plan pays 100%	50%
<b>Home Infusion</b>	Plan pays 100%	50%
<b>Hospice Services</b>	Plan pays 100%	50%
<b>Inpatient Hospital/Facility Services</b> (See "Short-Term Rehabilitation" for physical rehabilitation and skilled nursing facility admissions.)		
Medical/Surgical, Mental Health/Chemical Dependency and Maternity-Related Room and Board and Covered Ancillaries	20% <sup>5</sup>	50% <sup>5</sup>
Routine Nursery Care for Covered Newborns	20%	50%

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

**See footnotes on back.**

Western Refining PPO Plan Benefits – Certain services have maximum annual limits.		Member's Share of Covered Charges			
		Preferred Provider <sup>1</sup>		Nonpreferred Provider <sup>1</sup>	
<b>Removal of Impacted Wisdom Teeth</b>		20% <sup>4</sup> <i>(deductible waived)</i>		20% <sup>4</sup> <i>(deductible waived)</i>	
<b>Short-Term Rehabilitation:</b> Occupational, Physical, and Speech Therapy; including Inpatient Physical Rehabilitation		20% <sup>4,5</sup>		50% <sup>4,5</sup>	
<b>Skilled Nursing Facility</b> (90 days/year)		20% <sup>5</sup>		50% <sup>5</sup>	
<b>Supplies, Durable Medical Equipment, Prosthetics and Orthotics</b>		20% <sup>4,6</sup>		50% <sup>4,6</sup>	
<b>Surgery, Inpatient or Outpatient</b> (This includes invasive diagnostic tests. For transplants, see "Transplant Services," below)		20% <sup>4,5</sup>		50% <sup>4,5</sup>	
<b>Therapy: Chemotherapy, Dialysis, and Radiation</b>		20%		50%	
<b>Transplant Services</b>					
<b>Cornea, Kidney, and Bone Marrow</b>		Subject to same deductible, copay, and coinsurance provisions as are other services, based on place of treatment & type of service <sup>4,5</sup>		50% <sup>4,5</sup>	
<b>Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney (\$10,000 maximum for travel and per diem)</b>					
<b>Urgent Care Facility</b>		\$50 copay/visit		50%	
<b>Prescription Drugs, Insulin, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods</b>					
Covered drugs and other items are subject to a separate \$50 calendar year deductible per family (Exception: Deductible does not apply to Generic Drugs or Preventive Drugs). Certain drugs, special medical foods, and enteral nutritional products require preauthorization or benefits will be denied. <sup>4</sup>		Type of Prescription	Percentage of covered charge you pay (coinsurance), if the percentage is between the minimum and maximum member share amounts <sup>7</sup>	Minimum Member Share <sup>7</sup>	Maximum Member Share <sup>7</sup>
<b>Retail Pharmacy Program</b> (up to a 30-day supply or 120 units, whichever is less.) <sup>7</sup>		Generic Drug	20%	\$0	\$10
		Preferred Brand		\$20	\$50
		Nonpreferred Brand		\$40	\$100
<b>Mail-Order Plan</b> (up to a 90-day supply or 360 units, whichever is less.) <sup>7</sup>		Generic Drug	20%	\$0	\$20
		Preferred Brand		\$40	\$100
		Nonpreferred Brand		\$80	\$200
<b>Nonprescription enteral nutritional products and special medical foods</b> (up to a 30-day supply/30-day period, needs preauthorization.) <sup>4</sup>		50% <sup>4</sup>			
<b>Preventive Drug Retail Pharmacy Program</b> (up to a 30-day supply or 120 units, whichever is less.) <sup>7</sup>		Generic Drug	10% <i>(deductible waived)</i>	\$0	\$5
		Preferred Brand		\$15	\$50
		Nonpreferred Brand		\$30	\$100
<b>Preventive Drug Mail-Order Plan</b> (up to a 90-day supply or 360 units, whichever is less.) <sup>7</sup>		Generic Drug	10% <i>(deductible waived)</i>	\$0	\$10
		Preferred Brand		\$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 on next page.

**FOOTNOTES:**

1 The deductible must be met before benefit payments are made (excluding ambulance services, services subject to a copayment or paid in full, drug plan charges, and removal of impacted wisdom teeth). Drug plan charges are subject to a separate annual family deductible that must be met each calendar year before the Plan begins paying benefits for nonpreventive drugs. Nonpreferred Provider deductible amounts apply to the Preferred Provider level deductible, but **not** vice versa.

2 After a member reaches the applicable out-of-pocket limit, BCBSNM pays 100 percent of most of that member's covered Preferred or Nonpreferred Provider charges, whichever is applicable, for the rest of the calendar year. (Note: Drug plan charges do not apply to the out-of-pocket limit). Nonpreferred Provider out-of-pocket amounts apply to the Preferred Provider level out-of-pocket limit, but **not** vice versa.

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 for medical equipment and other items 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 choose to purchase a brand drug that has a generic equivalent, you will pay the difference in cost between the generic and brand drug, plus your deductible and generic drug coinsurance. The \$50 drug plan deductible does not apply to generic drugs or the preventive drug list.

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, copayments, 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.**

**See footnotes on back.**