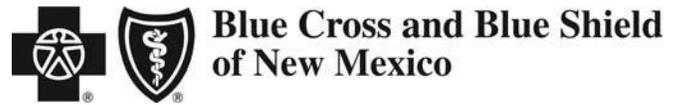


City of Las Cruces EPO*

Plan Highlights



Highlights the copayments, deductible and out-of-pocket limit amounts; member coinsurance percentage amounts; and provides a brief description of City of Las Cruces EPO health care plan benefits.

| EPO Benefits — This plan does not cover services received from nonpreferred providers, except in an emergency. | | Member's Share of Covered Charges From a Preferred Provider |
|--|-------------------------|--|
| Annual Deductible – All services are subject to deductible unless noted otherwise. | | \$300/Individual - \$600/Two-Person - \$900/Family |
| Annual Out-of-Pocket Limit - Includes medical deductible, coinsurance, copayments, and prescription drug copayments; NOT penalty amounts, or noncovered charges ² | | \$3,500/Individual - \$7,000/Two-Person - \$10,500/Family |
| Lifetime Maximum Benefit | | Unlimited; certain services have calendar year or benefit period limitations, as listed below. |
| Primary Preferred Provider (PPP) Office Services * | | \$20 copay/visit (Deductible waived) |
| Office Visit**, Medication Management ** | | |
| Office Surgery (including casts, splints, and dressings) | | |
| Mental Health/Chemical Dependency Services (outpatient/office) | | \$40 copay/visit |
| Specialty Physician Office Services | | |
| Office Visit**, Medication Management**, Office Evaluations** | | |
| Office Surgery (including casts, splints, and dressings) | | |
| Preventive Care (Outpatient/office adult medical care/routine exams; well child care; routine lab and x-rays, vision and hearing screening; mammogram, routine colonoscopy) | | No Charge (Deductible waived) |
| Acupuncture Treatment and Spinal Manipulation (max. 20 visits/year combined) | | \$40 copay/visit |
| Allergy Services (Office visit and testing) | Primary Provider | \$20 copay/visit |
| | Specialist | \$40 copay/visit |
| Allergy Serum and Allergy Injections | | No charge (Deductible waived) |
| Ambulance Services | | \$30 per trip/ground or \$100 per trip/air ³ |
| Applied Behavioral Analysis for Autism Spectrum Disorders for Children (A preauthorized treatment plan is required.) | | Usual copays or coinsurance based on place of treatment and type of service ³ |
| Cardiac and Pulmonary Rehabilitation (outpatient) | | \$40 copay/visit ³ |
| Dental/Facial Accidents, Oral Surgery, TMJ/CMJ Services | | Usual copays or coinsurance based on place of treatment and type of service ^{3,4} |
| Emergency and Urgent Care Services | | \$250 copay/ER visit \$250 copay/visit \$75 copay/visit |
| Emergency Room (includes all related ER services) | | |
| Observation Room (including pregnancy) | | |
| Urgent Care Facility | | |
| Hearing Aids and Related Services for Adults and Children: Hearing aids are paid at 100% (Deductible waived) of covered charges up to a maximum of 2 hearing aids during any 3-year period ; exams and testing are subject to usual cost-sharing provisions. | | |
| Home Health Care (prescribed home nursing care, physician, and therapy care – 100 visits/year) | | \$40 copay/visit |
| Hospice Services | | No charge (Deductible waived) |
| Lab Tests, X-Rays, EKGs, & Other Diagnostic Services (including tests done in office, outpatient facility, freestanding facility, ambulatory surgery facility, or any other place of treatment) | | 20% coinsurance ³ |
| MRI, CT Scans, and PET Scans | | \$200 copay/test ³ |

* A Primary Preferred Provider (PPP) is a preferred physician or other professional provider in one of the following categories of practice: Family or General Practice, Internal Medicine, Pediatrics, Obstetrics and Gynecology, and Gynecology Only.

*** NOTE: BCBSNM EPO members can access contracted Blue Cross and Blue Shield providers anywhere within the U.S. and in more than 200 countries outside the U.S.**

See footnotes on back.

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|--|--|
| EPO Benefits – This plan does not cover services received from nonpreferred providers, except in an emergency. | Member's Share of Covered Charges From a Preferred Provider |
|--|--|

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|--|--|
| Inpatient Hospital/Facility Services | |
| Medical/Surgical, Mental Health/Chemical Dependency (including Partial Hospitalization), Residential Treatment Center (RTC), Maternity-Related Room and Board, and Covered Ancillaries | \$500 copay/admission ⁴ |
| Maternity – initial visit to diagnose pregnancy | Office copay for initial visit |
| Maternity – prenatal & post delivery exams, inpatient delivery | \$500 copay/admission ⁴ |
| Newborn Care – must be enrolled within 31 days of birth | \$500 copay/admission ⁴ |
| Naprapathy (max. \$500/year) | \$50 copay/visit |
| Outpatient Facility, Physician/Surgeon (including surgical procedures related to pregnancy and family planning; and nonroutine colonoscopies) | 20% coinsurance ³ |
| Short-Term Rehabilitation: Outpatient/Office Occupational, Physical, and Speech Therapy (max. 60 visits/year for all services combined) | \$40 copay/visit |
| Skilled Nursing Facility | \$500 copay/admission ⁴ |
| Supplies, Equipment, Prosthetics, and Orthotics | 20% coinsurance ⁵ |
| Therapy: Chemotherapy, Dialysis, and Radiation Therapy | No charge |
| Transplant Services (Must use facilities that contract with BCBSNM or through the national BCBS transplant network.) | |
| Cornea, Kidney, Bone Marrow | Usual copays or coinsurance based on place of treatment and type of service ^{3,4} |
| Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney: \$10,000 maximum for travel and per diem | |

| Prescription Drugs, Insulin, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods | | | | |
|--|---------------------|--|---|------------------------------|
| Prescription drug copayments are applied to the medical plan-of-pocket limit; they are not subject to the deductible. Certain drugs, special medical foods, and enteral nutritional products require preauthorization or benefits will be denied. | Generic Drug | Brand-Name Drug | | |
| | | If a generic equivalent is available and you or your doctor order the brand-name drug, you pay: | If there is no generic equivalent available: | |
| | | | On Drug List | Not on Drug List |
| Retail Pharmacy Program (up to a 30-day supply or 120 units, whichever is less) | \$5 | \$5 plus difference in covered charge between the brand-name and the generic equivalent | 30% (\$30/min, \$90/max) | 40% (\$55/min, \$125/max) |
| Mail-Order Service (up to a 90-day supply or 360 units, whichever is less) | | \$15 | \$95 | \$125 |
| Specialty Pharmacy Drug | | \$135 per prescription | | |
| Nonprescription enteral nutritional products and special medical foods | | 50% of covered charges ³ | | |

FOOTNOTES:

1 The deductible must be met before benefit payments are made for most services. **Note:** A deductible is not required for preventive services, PPP office visits, Hospice, and Allergy injections.

2 After a member (or family) reaches the out-of-pocket limit during a single calendar year, BCBSNM pays 100 percent of that member's (or family's) covered charges for the remainder of the calendar year.

3 Certain services are not covered if preauthorization is not obtained from BCBSNM. See a benefit booklet for details.

4 Preauthorization is required for inpatient admissions. You pay a \$400 penalty for covered facility services if preauthorization is not obtained. Some services, such as transplants, require additional preauthorization. If you do not receive preauthorization for these individually identified procedures and services, benefits for any related admissions will be denied.

5 Rental benefits for medical equipment and other items will not exceed the purchase price of a new unit.

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.

Blue Cross and Blue Shield of New Mexico (BCBSNM) is a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.