

Summary of Benefits

This is a summary only that lists the deductible, out-of-pocket limit, the coinsurance percentages, and a brief description of Intrepid Mining PPO Plan benefits for both the Basic and the HealthCounts health care plans.

Intrepid Mining PPO Plan Benefits	Benefit Level: Your Share of Covered Charges	
	Preferred Provider (PPO) ¹	Nonpreferred Provider ¹
Calendar Year Deductible: Family deductible is an aggregate amount.	\$250 (\$500/family)	\$500 (\$1,000/family)
Out-of-Pocket Limit: Includes coinsurance only - does not include deductible, copayments, penalty amounts, or noncovered charges.	\$2,000 (\$4,000/family)	\$4,000 (\$8,000/family)
Lifetime Maximum Benefit	\$5,000,000 per member (in addition to specific maximums listed below)	
Office Visit/Exam Copayment (Including Physicals): All other services received during the office visit are subject to deductible and coinsurance as listed below.	HealthCounts: \$15/office visit Basic Plan: \$30/office visit (deductible waived)	40%
Other Office Services: Includes all other services received during an office visit and services of nonpreferred providers, including routine physicals.	10%	40%
Office Surgery (including casts, splints, and dressings)	10% ⁴	40% ⁴
Allergy Injections, Tests, Serum	10%	40%
Routine Vision or Hearing Screenings (only through age 17)	10%	40%
Acupuncture Treatment (max. \$1500/year)	10%	No benefit
Ambulance, Ground and Emergency Air Transport	10% ³	
Cardiac and Pulmonary Rehabilitation, Outpatient	10% ⁴	No benefit
Spinal Manipulation (max. \$1,500/year)	10%	No benefit
Emergency Room Treatment	\$150 facility copayment (waived if admitted) ³	
Home Health Care/Home I.V. Services (max. 100 visits/year)	10% ⁴	40% ⁴
Hospice Services (lifetime max. \$7,500)	10% ⁴	40% ⁴
Inpatient Hospital/Facility Services (See "Short-Term Rehabilitation" for physical rehabilitation and skilled nursing facility admissions or see "Psychotherapeutic Services" for other inpatient treatments. Also, see "Transplant Services," if applicable.)		
Medical/Surgical and Maternity-Related Room and Board, and Covered Ancillaries	10% ⁵	40% ⁵
Routine Nursery Care for Covered Newborns	10%	40%
Lab, X-Ray, EKGs, and Other Diagnostic Tests: Outpatient/Office	Plan pays 100% ⁴ (deductible waived)	40% ⁴
Maternity Services , Including Routine Pediatrician Care for Covered Newborns (Also see "Inpatient Hospital/Facility Services")	10% ⁵ (plus office visit copay for first office visit)	40% ⁵
Prosthetics and Orthotics	10% ^{4,6} (Unlimited benefit)	40% ^{4,6} (Max \$1000/year)

See footnotes on next page

Intrepid Mining PPO Plan Benefits (continued)	Benefit Level: Your Share of Covered Charges	
	Preferred Provider (PPO) ¹	Nonpreferred Provider ¹
Psychotherapeutic Services, Inpatient and Outpatient (Includes mental health services and chemical dependency rehabilitation; maximum benefit of up to 60 days/visits per calendar year for all services combined. Chemical dependency also limited to services received within a maximum of two 12-month benefit periods .)	10% ^{4,5}	Not covered
Short-Term Rehabilitation, Inpatient and Outpatient (Includes services in a rehabilitation facility or skilled nursing facility, and outpatient physical, occupational, and speech therapy services. Benefits limited to a lifetime maximum of up to 60 days/visits per condition for all services combined.)	10% ^{4,5}	Not covered
Supplies and Durable Medical Equipment	10% ^{4,6} (Unlimited benefit)	40% ^{4,6} (Max. \$1000/year)
Surgery, Outpatient	10% after deductible and \$150 facility copayment ^{4,5}	40% ^{4,5}
Therapy: Chemotherapy, Dialysis, and Radiation	10% ⁴	40% ⁴
TMJ/CMJ Services, Dental/Facial Accidents, Oral Surgery	10% ⁴	40% ⁴
Transplant Services (Must be received at a facility that contracts with BCBSNM or with the national BCBS transplant network.)		
Cornea, Kidney, Bone Marrow		
Heart, Heart-Lung, Liver, Lung, Pancreas-Kidney (Subject to a separate \$5,000 out-of-pocket limit per transplant type; no deductible. Additional maximums also apply. See <i>Section 3</i> .)	10% ⁴	No benefit
Prescription Drugs, Insulin, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods: Deductible does not apply and copayments are not applied to out-of-pocket. Intrepid Mining has contracted with a separate program for administration of the prescription drug benefits. The administrator of the prescription drug plan is not an affiliate of BCBSNM.		

- 1 The deductible must be met before benefit payments are made excluding outpatient/office diagnostic tests from a preferred provider, preferred provider office visits for which you pay a fixed-dollar copayment (but including all other services billed during the office visit), emergency room services, drug plan charges, and certain transplant services. Outpatient surgery is subject to deductible, a copayment, and coinsurance
- 2 After you reach the applicable out-of-pocket limit, BCBSNM pays 100 percent of most of your covered preferred or nonpreferred provider charges, whichever is applicable.
- 3 Initial treatment of a medical emergency is paid at the Preferred Provider benefit level. Follow-up treatment and treatment that is not for an emergency is paid at the Nonpreferred Provider level.
- 4 Certain services are not covered if prior approval is not obtained from BCBSNM. A list of services requiring prior approval is in *Section 2*.
- 5 Admission review is required for inpatient admissions. You pay a \$300 penalty for covered facility services if approval is not obtained. Some services, such as transplants and physical rehabilitation, require additional approval. If you do not receive approval for these individually identified procedures and services, benefits for any related admissions will be denied. The \$300 penalty will not apply in such cases. See *Section 2* for details.
- 6 Rental benefits for medical equipment and other items will not exceed purchase price of a new unit.

Deductibles, copayments, and coinsurance percentages are applied to BCBSNM's covered charges, which may be less than billed charges. Nonpreferred providers may bill you the difference between the covered charge and the billed charge for a covered service, in addition to your deductible, copayment, coinsurance, penalty amount (if any), and charges for noncovered services.