TRIAD National Security, LLC

Plan Highlights – Medicare Retirees

Administered by:
BlueCross BlueShield of New Mexico

Highlights deductible, copayments, coinsurance, out-of-pocket limits; and provides a brief description of the benefit plan for TRIAD National Security, LLC.

National PPO Medical Program Cost-Sharing Features, Covered Services, and Limitations	Member's Share of Covered Charges	
	Preferred Provider (In-Network)[1]	**Nonpreferred Provider (Out-of-Network)[1]**
Calendar Year Deductible[1] (Family deductible is an aggregate of three times individual amount and may be met by three or more family members.)[1]	$250 Individual $750 Family	$500 Individual $1,500 Family
Calendar Year Out-of-Pocket Limit[2] (Includes deductible, copayments, drug plan copayments and percentage coinsurance amounts; except out-of-network inpatient hospital copayments. Family limit may be met by three or more family members.)	$3,000 Individual $9,000 Family	$6,000 Individual $18,000 Family
Lifetime Maximum Benefit Limit (per member)	Unlimited	Unlimited
Office Visit/Exam Charge Office Visits/Exams or Consultations; Office Surgery (Other office services received during the visit, unless specified otherwise, are subject to deductible and/or coinsurance provisions as listed in the rest of the summary. Includes initial visit to OB/Gyn or midwife to confirm pregnancy; pre-natal and post-natal care is listed under "Hospital/Other" as part of global delivery fee.)	$20/visit (deductible waived)	40% after deductible
Sterilization/surgery (reversal not covered); other related services in office	10% after deductible	40% after deductible
Allergy Injections; Allergy Serum/Extract Prep; and Immunizations (only)	No Charge	40% after deductible
Other Allergy Care (such as allergy testing)	10% after deductible	40% after deductible
Therapeutic Injections	10% after deductible[4]	40% after deductible[4]
Lab, X-Ray, and Other Diagnostic Tests (non-routine/non-preventive)	10% after deductible[4]	40% after deductible[4]
Nutritional Counseling (**3 sessions/lifetime** for certain conditions)	$20/visit (deductible waived)	40% after deductible
PREVENTIVE SERVICES		
Routine adult physicals and gynecological exams; well-child care, vision/hearing screenings; routine mammograms, routine colonoscopies; immunizations; routine pap tests, cholesterol tests, urinalysis.	No Charge	40% after deductible
Family Planning (including devices, insertion, Depo-Provera, etc.)	No Charge	40% after deductible
OTHER MEDICAL / SURGICAL SERVICES		
Acupuncture Treatment (limited to **20 visits**/year)	$20/visit (deductible waived)	40% after deductible
Ambulance: Emergency Transport (Ground and Emergency Air, as needed)	10% after PPO deductible[3]	
Ambulance: Nonemergency Ground Transport (between facilities)	10% after PPO deductible[4]	
Ambulance: Nonemergency Air Transfer (between facilities)	10% after deductible[4]	40% after deductible[4]
Cancer/Congenital Heart Disease Care (Blue Distinction programs only include a lodging per diem benefit of **$50** per person, or **$100**/day for 2-3 persons. Travel and the above per diem allowances combined are limited to **$10,000** per lifetime for each program utilized. If program is not used, benefits are same as for any other service, per place of treatment, provider contract and type of service.)	10% after deductible[4,5]	40% after deductible[4,5]
Cardiac Rehabilitation, Outpatient/Office	$20/visit (deductible waived)[4]	40% after deductible[4]
Chemotherapy, Dialysis, and Radiation Office or Freestanding Clinic Outpatient Hospital	$20/visit (deductible waived)[4] 10% after deductible[4]	40% after deductible[4]
Dental/Facial Accident[3], Oral Surgery, and TMJ/CMJ Services (for limited, non-dental medical conditions; see a benefits booklet for details)	Usual benefit based on type/place of service[4]	40% after deductible[4]

National PPO Medical Program Cost-Sharing Features, Covered Services, and Limitations	Member's Share of Covered Charges	
	Preferred Provider[1] (In-Network)	Nonpreferred Provider[1] (Out-of-Network)
Emergency Room Visit (*emergency* conditions only) Facility Charges Physician and Other Professional Provider Charges	$75/visit (deductible waived)[3] 10% after deductible[3]	
Hearing-Related Services for members 21 years and younger: Office exams and evaluations: cochlear implant; auditory testing Hearing aid services (maximum total benefit of one hearing aid per hearing-impaired ear every three years, including fitting of hearing aid and ear molds)	10% after In-Network deductible	
Hearing-Related Services for members 22 years and older: Office exams and evaluations: cochlear implant; auditory testing Hearing aid services (maximum total benefit of $2,200 during any 3-year period, including fitting of hearing aid and ear molds)	10% after In-Network deductible	
Home Health Care/Home I.V. Services (Private duty nursing **not** covered; care must be from a licensed home health care agency): Home Health care agency services and home I.V. services (Out-of-network limited to **100 visits**/calendar year)	10% after deductible[4]	40% after deductible[4]
Hospice Services including bereavement counseling when such services are provided by hospice (Respite care limited to **10 days** for each 6-month benefit period)	10% (deductible waived)[4]	40% (deductible waived)[4]
HOSPITAL / OTHER		
Medical/Surgical Acute Care, Observation, Medical Detox, Maternity-Related (including routine newborn nursery charges), and **Extended Stay (Non-routine) for Covered Newborn**: Room/Board, and Covered Ancillaries	10% after deductible[5]	$250 +40% after deductible[5]
Birthing Center	10% after deductible	$250 + 40% after deductible
Skilled Nursing Facility and **Inpatient Physical Rehabilitation** (max. **100 days** per calendar year/combined (preferred and nonpreferred combined); in addition, nonpreferred services cannot exceed **70 days** per calendar year)	10% (deductible waived)[5]	40% (deductible waived)[5]
Inpatient **Physician's Medical visit** or **Consultation;** Routine Inpatient **OB/Gyn Global Delivery Fee** (includes pre-natal/post-natal care); Inpatient Newborn Male **Circumcision**	No Charge	40% after deductible
Inpatient **Surgeon, Anesthesiologist, Radiologist, Pathologist,** and **Assistant Surgeon** (including maternity services that are not part of OB/Gyn global delivery fee and complications of pregnancy)	10% after deductible[4]	40% after deductible[4]
Hospital/Other Facility: Outpatient/Ambulatory Surgery Center (includes covered services, whether billed by facility or professional provider, including surgery, diagnostic test, chemotherapy, dialysis, and radiation treatment.)	10% after deductible[4]	40% after deductible[4]
Lab, X-ray, and Other Diagnostic Tests (non-preventive) Including MRI, CT Scans, and PET Scans; Sleep Studies; EKGs, etc. (Office or Freestanding/Independent Facility or Outpatient Hospital)	10% after deductible[4]	40% after deductible[4]
Short-Term Rehabilitation; Outpatient and Office (Includes Physical, Occupational, and Speech therapy services; each are limited to **20 visits**/calendar year. Speech therapy is limited to specified medical conditions; see a benefit booklet for details.)	$20/visit (deductible waived)[4]	40% after deductible[4]
Spinal/Osteopathic Manipulation/Naprapathy (limited to **20 visits**/calendar year/combined)	$20/visit (deductible waived)	40% after deductible
Supplies, Durable Medical Equipment, Prosthetics, Orthotics (Includes insulin pumps and pump supplies; support hose limited to **6 pair**/year; mastectomy bras limited to **3/year**; For diabetic supplies such as needles, test strips, glucagon, etc., see drug plan provision)	10% after deductible[4,6]	40% after deductible[4,6]
Transplant Services: Limitations apply to donor charges and travel and lodging. Must be received at a facility that contracts with BCBSNM or with the national BCBS transplant network.		
Cornea, Kidney, and Bone Marrow	Based on place of treatment and type of service[4,5]	
Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney	10% after deductible[4,5]	Not Covered Out-of-Network
Travel and Lodging: Benefits are available if patient is receiving treatment from a Blue Distinction Center for Specialty Care or case-managed transplants (excluding cornea). Travel for more than 50 miles must be necessary in order to be eligible for coverage under this provision.		
Travel to and from health care facility plus per diem payments as listed. Lodging per diem for patient and/or companion(s)	$10,000/lifetime after PPO deductible[4] $50/Individual or $100 for 2-3 persons after PPO deductible[4]	

National PPO Medical Program Cost-Sharing Features, Covered Services, and Limitations	Member's Share of Covered Charges	
	Preferred Provider[1] (In-Network)	Nonpreferred Provider[1] (Out-of-Network)
Urgent Care Facility	$20/visit (deductible waived)	40% after deductible
Ancillary Services (lab, X-rays, supplies, etc.)	10% after deductible	40% after deductible
BEHAVIORAL HEALTH: Mental Health and Chemical Dependency		
Mental Health Services Office	$20/visit (deductible waived)	40% after deductible
Other Outpatient Treatments; Intensive Outpatient Programs	10% after deductible	40% after deductible
Inpatient; Partial Hospitalization	10% after deductible[5]	$250 + 40% after deductible[5]
Related Physician Claims	10% after deductible	40% after deductible
Chemical Dependency Rehabilitation Office	$20/visit (deductible waived)	40% after deductible
Other Outpatient Treatments; Intensive Outpatient Programs; Outpatient Methadone	10% after deductible	40% after deductible
Inpatient; Partial Hospitalization	10% after deductible[5]	$250 + 40% after deductible[5]
Related Physician Claims	10% after deductible	40% after deductible
Residential Treatment Center for Chemical Dependency and Mental Health Includes Physician	10% after deductible[5,7]	$250 facility copay plus 40% after deductible[5,7]

DRUG PLAN: Prescription Drugs, Insulin, Diabetic Supplies, Nutritional Products, Specified Vaccines[8]				
Members must use a participating pharmacy. Enteral nutritional products, compounded medications, special medical foods, and other drugs require preauthorization or benefits will be denied.	**Generic Drug**	**Brand-Name Drug[8]**		
		If a generic equivalent is available and you order the brand-name drug, you pay:	**On Drug List**	**Not on Drug List**
Retail Pharmacy Program (up to a 30-day supply or 180 units, whichever is less) benefits include Flu, Pneumococcal, and Shingles vaccines, for which **no copayment** is required.	$15	$15 plus difference in covered charge between the brand-name and the generic equivalent	$30	$45
Mail-Order Service (up to a 60- or 90-day supply or 540 units, whichever is less)	$30	$30 plus difference in covered charge between the brand-name and the generic equivalent	$60	$90
Nonprescription enteral nutritional products and special medical foods (up to a 30-day supply per 30-day period; requires preauthorization	$45 retail/$90 mail-order			
Pharmacy Benefits are administered by: Express Scripts. They can be reached at 1-800-838-4590.				

FOOTNOTES:

[1] All services – excluding items covered under the drug plan – are subject to deductible unless otherwise indicated in the Summary of Benefits (i.e., "deductible waived"). When applicable, the deductible must be met before benefit payments are made. Charges for Preferred Provider services do not cross-apply to the Nonpreferred Provider deductible, nor vice versa.

[2] After a member (or family) reaches the applicable out-of-pocket limit, the Medical Program pays 100 percent of that member's (or family's) covered charges for the rest of the calendar year (except for out-of-network inpatient hospital copayments, and residential treatment center copayments). Deductible, coinsurance, and copayments for Preferred Provider services do not cross-apply to the Nonpreferred Provider limit, nor vice versa.

[3] Initial treatment of a medical emergency is paid at the Preferred Provider benefit level. Follow-up treatment from a Nonpreferred Provider and treatment that is not for an emergency is paid at the Nonpreferred Provider level.

[4] Certain services are **not covered** if preauthorization is not obtained from BCBSNM (or the BCBSNM Behavioral Health Unit). A list of services requiring preauthorization and a description of when obtaining preauthorization is **your** responsibility is in Section 4 of the Benefit Booklet. Some services may require a written request for preauthorization in order to be covered. (Nonemergency ambulance services are covered **only** when it is medically necessary to transfer the patient from one facility to another.)

[5] Preauthorization is required for inpatient admissions.

[6] Rental benefits for medical equipment and other items will not exceed purchase price of a new unit.

[7] TRIAD has authorized the Claims Administrator to approve, when used as a cost-effective alternative to inpatient hospitalization, residential treatment center services for patients being treated for chemical dependency and mental health.

[8] Pharmacy Benefits are administered by Express Scripts. Prescription drugs and other items covered under the drug plan must be purchased at a pharmacy that participates in the Retail Pharmacy/Specialty Pharmacy or Mail-Order Programs. Some prescription drugs require preauthorization before coverage will be available. If you require a brand-name drug for which there is a generic equivalent, you will pay the difference in cost between the brand-name drug and the generic drug, plus the generic drug copayment.

Deductibles, 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.

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.

This is a summary only – please refer to the Summary of Benefits and Coverage (SBC) document and Benefit Booklet for more details.