State of New Mexico
Benefits Comparison Guide
January 1 - December 31, 2018

BENEFITS	PRESBYTERIAN - HMO	BLUE CROSS BLUE SHIELD NM - HMO	BLUE CROSS BLUE SHIELD NM - PPO	
			PREFERRED PROVIDER	NONPREFERRED PROVIDER
Deductibles	$350/$675/$1000	$350/$675/$1000	$500/$1000/$1500	$2800/$5600/$8400
Out of Pocket (combined Pharmacy & Medical)	$3500/$7000/$10500	$3500/$7000/$10500	$3,500 / $7,000 / $10,500	$7,000 / $14,000 / $21,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited (Certain services are subject to Plan Year and/or lifetime maximums or are limit per condition.)	
Primary Care Provider	$25 (deductible waived)	$25 (deductible waived)	$30 (deductible waived)	50%
Specialist Provider	$45 (deductible waived)	$45 (deductible waived)	$55 (deductible waived)	50%
Adult Preventive Services	$0 (deductible waived)	$0 (deductible waived)	$0 (deductible waived)	50% (deductible waived)
Well Child Services	$0 (deductible waived)	$0 (deductible waived)	$0 (deductible waived)	50% (deductible waived)
Laboratory	20%	20%	20%	50%
X- Ray	20%	20%	20%	50%
Inpatient Hospital	$500 per admission	$500 per admission	$1,000 per admission	50%
MRI/PET/CT Scans	20% up to maximum of $200 per test	20% up to maximum of $200 per test	20% up to maximum of $200 per test	50%
Outpatient Surgery	20%	20%	20%	50%
Maternity Physician Services	$25 Initial Visit Only	$25 Initial Visit Only	$30 Initial Visit Only	50%
Maternity Hospitalization	$500	500 Per Admission	$1,000	50%
Routine Nursery Care for Newborns	No Copay	No Copay	No Copay	50%
Emergency Room Visit	$250	$250	$250	$250
Urgent Care Center	$50	$50	$50	$50
Mental Health Out Patient	$25 (deductible waived)	$25 (deductible waived)	$30 (deductible waived)	50%
Mental Health In Patient	500 Per Admission	500 Per Admission	1000 Per Admission	50%
Chiropractic, Acupuncture	$45 (deductible waived) (up to 25 combined visits per plan yr)	$45 (deductible waived) (up to 25 combined visits per plan yr)	$55 (deductible waived) (up to 25 visits combined per plan yr)	50% (up to 25 visits combined per plan yr)
Naprapathic Services	$50 - deductible waived (up to $500 per plan yr)	$50 - deductible waived (up to $500 per plan yr)	$50 - deductible waived (up to $500 per plan yr)	50% (up to $500 per plan yr)
Durable Medical Equipment	20%	20%	25%	40%
Chemotherapy and Radiation Therapy	No Copay in Physicians Office	No Copay in Physicians Office	$55.00	50%
Home HealthCare	$45 Physician (deductible waived) no copay for nursing services	$45 Physician (deductible waived) no copay for nursing services	$55 (deductible waived)	50%
Hearing Aids	No copay up to $2500/yr per ear; once every 3 yrs	No copay up to $2500/yr per ear; once every 3 yrs	No copay up to $2500/yr per ear; once every 3 yrs	No copay up to $2500/yr per ear; once every 3 yrs
Physical, Occupational, & Speech Therapy	$45 (deductible waived)	$45 (deductible waived)	$55 (deductible waived)	50%
Hospice	No Copay	No Copay	No Copay	50%

EXPRESS SCRIPTS, INC. - Pharmacy Benefit Manager

	Retail (30 Day Supply)***	Mail Order (90 Day Supply)
Out of Pocket	$3,500 single/ $10,500 family (accumulated with Medical OOP towards annual max)	
Deductible**	$50 Individual/ $100 Family only on Non-Generics (applies to Medical annual OOP Max)	
Generic	$6.00	$17.00
Brand (Preferred)	30% ($35 min/ $95 max)	$120.00
Brand (Non-Preferred)	40% ($60 min/ $130 max)	$155.00
Specialty Medications (30 day supply) must move to mail order after 2 fill at retail	$60 Generic $85 Preferred Brand $125 Non-preferred Brand	$60 Generic $85 Preferred Brand $125 Non-preferred Brand

****DEDUCTIBLE: $50 PER INDIVIDUAL/$100 FAMILY APPLIES TO Formulary and Non-Formulary Only**

*****Three retail fills are allowed on maintenance medications before your copay will increase to the mail order copays shown above (for a 30 day supply).**

Note: If you obtain a brand name drug when a generic equivalent is available, you are responsible for the generic co-payments plus the cost difference between the brand-name drug and the generic drug. This does not apply to specialty medications.

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DELTA DENTAL PPONEW MEXICO

	In-Network	Out of Network
Diagnostic & Preventive Services	100% (not subject to deductible)	100%
Basic Services	80%	55%
Major Services	60%	35%

Calendar Year Deductibles

$50 per person, $150 per family

Deductible does not apply to Diagnostic, Preventive Services or Orthodontic Services

Orthodontic Services

Children up to 18 - 75% up to $2,000.00 lifetime maximum

Adults 18 and Over - 60% up to $1,750.00 lifetime maximum

Benefit Annual Maximum - Calendar Year

$1,750 per enrolled person/per calendar year

Please contact Delta Dental for service descriptions or futher details at 1-877-395-9420

DAVIS VISION

	IN-NETWORK
Eye Exam - every 12 months	Paid in Full after $10 Copay
Lenses - every 12 months	Paid in full at $15 Co-pay
Frame - every 24 months	$150 retail allowance, plus 20% off overage /1
	$200 retail allowance at Visionworks stores, plus 20% off overage/1
	$0 - Davis Vision Exclusive Collection/2 (In lieu of allowance)
Contacts every 12 months	No Co-pay Required
- Evaluation/Fitting/Follow-up	Non-Collection Contacts: $60 allowance, plus 15% off overage /1
- In lieu of allowance	Davis Vision Collection Contacts /2: Covered in Full no co-pay required
Contact Lenses	Non-Collection Allowance: Up to $150 allowance plus 15% off overage /1
	Davis Vision Collection /2 (In lieu of allowance): Paid in Full
	- Disposable up to 8 boxes/multi-packs
	- Planned replacement 4 boxes/multi-packs

OUT-OF-NETWORK

Reimbursement - up to:

Eye Exam: $40

Single-Vision Lenses: $40

Tri-focal Lenses: $80

Elective Contacts: $105

Frame: $50.00

Bi-focal: $60

Lenticular Lenses: $100

Visually Required Contacts: $225

1/ Additional discounts not applicable at Costco, Sam's Club or Walmart locations

2/ Collection is available at participating indiepndent providers offices and is subject to change.

Please contact Davis Vision for service descriptions or further details at 1-800-999-5431