

**State of New Mexico
Benefits Comparison Guide
January 1 - December 31, 2021**

A	B	C	D	E	F	G	H
BENEFITS	PRESBYTERIAN - HMO	BLUE CROSS BLUE SHIELD NM - HMO	BLUE CROSS BLUE SHIELD NM - PPO		Cigna-Open Access Plus IN Plan(HMO)	Cigna-Open Access Plus Plan (PPO)®	
			PREFERRED PROVIDER	NONPREFERRED PROVIDER		PREFERRED PROVIDER	NONPREFERRED PROVIDER
<small>This is only a summary that lists the employees' cost-sharing amounts and provides a brief description of the State of NM Group Plan benefits. The Summary Plan Description supersedes any information outlined in this summary.</small>							
Deductibles	\$350 / \$700 / \$1050	\$425 / \$850 / \$1,275	\$500 / \$1,000 / \$1,500	\$3,000 / \$6,000 / \$9,000	\$500 / \$1,000 / \$1,500	\$750 / \$1,500 / \$2250	\$3,000 / \$6,000 / \$9,000
Out of Pocket (combined Pharmacy & Medical)	\$3,750 / \$7,500 / \$11,250	\$4,000 / \$8,000 / \$12,000	\$4,000 / \$8,000 / \$12,000	\$9,000 / \$18,000 / \$27,000	\$5,000 / \$10,000 / \$15,000	\$5,000 / \$10,000 / \$15,000	\$9,000 / \$18,000 / \$27,000
Lifetime Maximum (Certain services are subject to Plan Year and/or lifetime maximums or are limit per condition.)	Unlimited	Unlimited	Unlimited		Unlimited	Unlimited	
Primary Care Provider	\$25 (deductible waived)	\$35 (deductible waived)	\$40 (deductible waived)	50%	\$35 (deductible waived)	\$40 (deductible waived)	50%
Specialist Provider	\$45 (deductible waived)	\$50 (deductible waived)	\$60 (deductible waived)	50%	\$50 (deductible waived)	\$60 (deductible waived)	50%
Preventive Services/Immunization	\$0 (deductible waived)	\$0 (deductible waived)	\$0 (deductible waived)	50% (deductible waived)	\$0 (deductible waived)	\$0 (deductible waived)	50% (deductible waived)
Well Child Services/Immunization	\$0 (deductible waived)	\$0 (deductible waived)	\$0 (deductible waived)	50% (deductible waived)	\$0 (deductible waived)	\$0 (deductible waived)	50% (deductible waived)
Laboratory	20%	25%	30%	50%	25%	30%	50%
X-Rays	20%	25%	30%	50%	25%	30%	50%
Inpatient Hospital	\$600 per admission	\$700 per admission	\$1,250 per admission	50%	\$700 per admission	\$1,250 per admission	50%
MRI, MRA, CAT Scan, and PET Scan	20% up to maximum of \$200 per test	25% up to maximum of \$250 per test	25% up to maximum of \$300 per test	50%	\$250 copay per type of scan per day, plan pays 100% and	\$300 copay per type of scan per day	50%
Outpatient Surgery	20%	25%	25%	50%	\$250 copay/visit, plus 25% coinsurance	\$500 copay/visit, plus 25% coinsurance	50%
Maternity Hospitalization	\$500 per admission	\$500 per admission	\$1,000 per admission	50%	\$500 per admission	\$1,000 per admission	50%
Routine Nursery Care for Newborns	No Copay	No Copay	No Copay	50%	No copay	No Copay	\$50%
Emergency Room Visit	\$275	\$300	\$325	\$325	\$300	\$325	\$325
Telehealth	No Copay	No Copay	No copay	50%	No Copay	No Copay	Not Covered
Urgent Care Center	\$55	\$60	\$65	\$75 (after PPO deductible)	\$60	\$65	\$75
Mental Health/Substance Abuse OutPatient	1st visit \$0/\$25 (deductible waived)	1st visit \$0/\$25 (deductible waived)	1st visit \$0/\$30 (deductible waived)	50%	1st visit \$0/\$25 (deductible waived)	1st visit \$0/\$30 (deductible waived)	50%
Mental Health/Substance Abuse InPatient	\$500 per admission	\$500 per admission	\$1,000 per admission	50%	\$500 per admission	\$1,000 per admission	50%
Chiropractic, Acupuncture	\$50 (deductible waived) (up to 25 combined visits per plan yr)	\$55 (deductible waived) (up to 25 combined visits per plan yr)	\$60 (deductible waived) (up to 25 visits combined per plan yr)	50% (up to 25 visits combined per plan yr)	\$55 (deductible waived) (up to 25 visits combined per plan yr)	\$60 (deductible waived) (up to 25 visits combined per plan yr)	50% (up to 25 visits combined per plan yr)
Naprapathic Services	\$55 (deductible waived) (up to 25 visits per plan yr)	\$60 (deductible waived) (up to 25 visits per plan yr)	\$65 (deductible waived) (up to 25 visits per plan yr)	50% (up to 25 visits per plan yr)	\$60 (deductible waived) (up to 25 visits per plan yr)	\$65 (deductible waived) (up to 25 visits per plan yr)	50% (up to 25 visits per plan yr)
Durable Medical Equipment	23%	25%	28%	45%	25%	28%	45%
Chemotherapy and Radiation Therapy	No Copay in Physicians Office	No Copay in Physicians Office	\$55.00	50%	PA required	PA required	PA required
Home HealthCare	\$45 Physician (deductible waived) no copay for nursing services	\$45 Physician (deductible waived) no copay for nursing services	\$55 (deductible waived)	50%	\$45 Physician (deductible waived) no copay for nursing services	\$55 (deductible waived)	50%
Hearing Aids	No copay up to \$2500 per ear; once every 3 yrs	(no maximum birth to age 22) No copay up to \$2500 per ear; once every 3 yrs	(no maximum birth to age 22) No copay up to \$2500 per ear; once every 3 yrs	50%	(no maximum birth to age 22) (age 22 and older \$5,000 maximum per 36 months)	(no maximum birth to age 22) (age 22 and older \$5,000 maximum per 36 months)	50%
Physical, Occupational, & Speech Therapy	\$25 (deductible waived)	\$35 (deductible waived)	\$40 (deductible waived)	50%	\$35 (deductible waived)	\$40 (deductible waived)	50%
Hospice	No Copay	No Copay	No Copay	50%	No copay	No copay	50%
EXPRESS SCRIPTS, INC. - Pharmacy Benefit Manager							
			Retail (30 Day Supply)***		Mail Order (90 Day Supply)		
Out of Pocket		Combined prescription and medical OOP maximum					
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	
Speciality 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 applicable brand name co-payment 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 PPO NEW MEXICO								
		Diagnostic & Preventive Services	In-Network 100% (not subject to deductible)	Out of Network 100% (not subject to deductible)				
		Basic Services	80%	55%				
		Major Services	60%	35%				
	Calendar Year Deductibles \$50 per person, \$150 per family Deductible does not apply to Diagnostic, Preventive 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 \$1,750.00 per enrolled person - per calendar year							
	Please contact Delta Dental for service descriptions or further details at 1-877-395-9420							
EYEMED								
			IN-NETWORK	OUT-OF-NETWORK				
	EXAM SERVICES							
	Eye Exam -Every 12 Months		Paid in Full after \$10 Copay	Reimbursement - up to:Eye Exam: \$40				
	Retinal Imaging		Up to \$39	Not Covered				
	Lenses -Every 12 Months		Single/Bifocal/Trifocal-Paid in Full at \$15 Co-Pay	Single-Vision Lenses: \$40				
	Frame-Every 24 Months		\$150 retail allowance, plus 20% off overage	Tri-focal Lenses: \$80				
				Up to \$50				
	CONTACT LENS FIT AND FOLLOW-UP							
	Fit and Follow-up - Standard		\$0 copay; paid in full fit and two follow-up visits	Up to \$40				
	Fit and Follow-up - Premium		\$0 copay; 10% off retail price less \$40 allowance	Up to \$40				
	CONTACT LENSES							
	Contacts - Conventional		\$0 copay; 15% off balance over \$150 allowance	Up to \$105				
	Contacts - Disposable		\$0 copay; \$150 allowance	Up to \$105				
	Contacts - Medically Necessary		\$0 copay; paid in full	Up to \$210				
	OTHER							
	Hearing Care from Amplifon Network		Discounts on hearing exam and aids; call 1.877.203.0675					
	LASIK or PRK from U.S. Laser Network		15% off retail or 5% off promo price; call 1.800.988.4221					