	PRESBYTERIAN - HMO	BLUE CROSS BLUE SHIELD NM - HMO	BLUE CROSS BLUE SHIELD NM - PPO	
BENEFITS			PREFERRED PROVIDER	NONPREFERRED PROVIDER
Deductibles	$325/$650/$975	$325/$650/$975	$500 / $1,000 / $1,500	$2,800 / $5,600 / $8,400
Out of Pocket (combined Pharmacy & Medica	$3500/$7000/$10500	$3500/$7000/$10500	$3,500 / $7,000 / $10,500	$7,000 / $14,000 / $21,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited	
Primary Care Provider	$25.00 (deductible waived)	$25.00 (deductible waived)	$30 (deductible waived)	50%
Specialist Provider	$40.00	$40.00	$50.00	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	$500.00 per admission	$500.00 per admission	$1,000.00 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	$25.00 Initial Visit Only	$25.00 Initial Visit Only	$30 Initial Visit Only	50%
Maternity Hospitalization	$500.00	$500.00	$1,000.00	50%
Routine Nursery Care for Newborns	No Copay	No Copay	No Copay	50%
Emergency Room Visit	$175.00	$175.00	$175.00	$175.00
Urgent Care Center	$50.00	$50.00	$50.00	$50.00
Mental Health Out Patient	$25.00	$25.00	$30.00	50%
Mental Health In Patient	$500.00	$500.00	$1,000.00	50%
Chiropractic, Acupuncture	$40.00 (up to 25 combined visits per plan year)	$40.00 (up to 25 combined visits per plan year)	$50.00 (up to 25 visits combined per plan year)	50% (up to 25 visits combined per plan year)
Naprapathic Services	$50.00 (up to $500 per plan year)	$50.00 (up to $500 per plan year)	$50.00 (up to $500 per plan yer)	50% (up to $500 per plan yer)
Durable Medical Equipment	20%	20%	25%	40%
Chemotherapy and Radiation Therapy	No Copay in Physicians Office	No Copay in Physicians Office	$50.00	50%
Home HealthCare	$40.00 Physician, no copay for nursing services	$40.00 Physician, no copay for nursing services	$50.00	50%
Hearing Aids	No copay up to $2500 per yr per ear, once every 3 yrs	No copay up to $2500 per yr per ear, once every 3 yrs	No copay up to $2500 per yr per ear, once every 3 yrs	No copay up to $2500 per yr per ear, once every 3 yrs
Physical, Occupational, & Speech Therapy	$40.00	$40.00	$50.00	50%
Hospice	No Copay	No Copay	No Copay	50%

Express Scripts Inc - Pharmacy Benefit Manager				
	COPAY COINS	Retail 30 Day Supply Maintenance meds 3 retail fills, then home delivery required or pay Home Delivery price for 30 day fill	Home Delivery 90 Day Supply	Specialty Medications Accredo Pharmacy 2 retail fills allowed, then Home Delivery Required
Generic	$5.00	$5.00	$15.00	$60.00
Brand	30%	$30 minimum $90 maximum	$95.00	$85.00
Brand Non-Preferred	40%	$55 minimum $125 maximum	$125.00	$125.00

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

Pharmacy out of pocket is combined with medical to meet total medical out of pocket

If you obtain a brand name medication when a generic is available, you are responsible for the generic copay plus the cost difference between brand and the generic.

This does not apply to specialty medications.

Delta Dental PPO New Mexico

	In-Network	Out of Network
Diagnostic & Preventitive Services	100 % (not subject to deductible)	100% **
Basic Services	80 %	55% **
Major Services	60%	35%**
Orthodontic Services		
Children up to 18	75% up to $2000 lifetime maximum	
Adults 18 and Over	60% up to $1750 lifetime maximum	
Calendar Year Deductible	$50 per person, $150 per family	
Calendar Year Maximum	$1750 per enrolled person	

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

*The payment percentages shown for Out=Of Network services are based on the Maximum approved Fees applicable only to Out of Network Dentists

Vision Service Plan

	In-Network	Out of Network
Exam every 12 months	$10	Up to $35.00
Prescription Lenses every 12 months	$15	Single Vision up to $25.00
(Single Vision, Lined bifocal, Lined Trifocal,		Lined Bifocals up to $40
Polycarbonate lenses for dependent children)		Lined Trifocal up to $55
Frame every 24 months	Up to $130 = 20% off out of pocket expense	Frame up to $35
Contacts every 12 months	$110 allowance when contacts are chosen instead of glasses	Contacts up to $110

Please contact Vision Service Plan for specific details at 1-800-877-7195