State of New Mexico
Benefits Comparison Guide
January 1 - December 31, 2019

BENEFITS	PRESBYTERIAN - HMO	BLUE CROSS BLUE SHIELD NM - HMO	BLUE CROSS BLUE SHIELD NM - PPO	
			PREFERRED PROVIDER	NONPREFERRED PROVIDER
Deductibles	$350 / $700 / $1050	$425 / $850 / $1,275	$500 / $1,000 / $1,500	$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 / $16,000 / $23,000
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)	$35 (deductible waived)	$40 (deductible waived)	50%
Specialist Provider	$45 (deductible waived)	$50 (deductible waived)	$60 (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%	25%	30%	50%
X-Rays	20%	25%	30%	50%
Inpatient Hospital	$600 per admission	$700 per admission	$1,250 per admission	50%
MRI/PET/CT Scans	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%
Outpatient Surgery	20%	25%	25%	50%
Maternity Hospitalization	$500 per admission	$500 per admission	$1,000 per admission	50%
Routine Nursery Care for Newborns	No Copay	No Copay	No Copay	50%
Emergency Room Visit	$275	$300	$325	$325
Urgent Care Center	$55	$60	$65	$75
Mental Health Out Patient	$25 (deductible waived)	$25 (deductible waived)	$30 (deductible waived)	50%
Mental Health In Patient	$500 per admission	$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)
Naprapathic Services	$55 - deductible waived (up to $500 per plan yr)	$60 - deductible waived (up to $500 per plan yr)	$65 - deductible waived (up to $500 per plan yr)	50% (up to $500 per plan yr)
Durable Medical Equipment	23%	25%	28%	45%
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 Famiy 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 PPONEW MEXICO

	In-Network	Out of Network
Diagnostic & Preventive Services	100% (not subject to deductible)	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

DAVIS VISION

	IN-NETWORK	OUT-OF-NETWORK
		Reimbursement - up to:
Eye Exam - every 12 months	Paid in Full after $10 Copay	Eye Exam: $40
Lenses - every 12 months	Paid in full at $15 Co-pay	Single-Vision Lenses: $40
Frame - every 24 months	$150 retail allowance, plus 20% off overage /1	Tri-focal Lenses: $80
	$200 retail allowance at Visionworks stores, plus 20% off overage/1	Elective Contacts: $105
	$0 - Davis Vision Exclusive Collection/2 (in lieu of allowance)	Frame: $50.00
Contacts every 12 months	No Co-pay Required	Bi-focal: $60
- Evaluation/Fitting/Follow-up	Non-Collection Contacts: $60 allowance, plus 15% off overage /1	Lenticular Lenses: $100
- In lieu of allowance	Davis Vision Collection Contacts /2: Covered in Full no co-pay required	Visually Required Contacts: $225
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	

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