

**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%	50%
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 year; 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 PPO NEW MEXICO

	<u>In-Network</u>	<u>Out of Network</u>
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 further details at 1-877-395-9420

DAVIS VISION

IN-NETWORK

Eye Exam - every 12 months
Lenses - every 12 months

Paid in Full after \$10 Copay
Paid in full at \$15 Copay

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
- Evaluation/Fitting/Follow-up
- In lieu of allowance

No Copay Required
Non-Collection Contacts: \$60 allowance, plus 15% off overage /¹
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 independent providers' offices and is subject to change.

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