

State of New Mexico
Benefits Comparison Guide

A	B PRESBYTERIAN- STATE OF NM 2022		C	D BLUE CROSS BLUE SHIELD-STATE OF NM 2022			E	G		H	I	J
BENEFITS	Tier 1		Tier 2	HMO	Tier 1 Provider	Tier 2 Provider	Tier 3 Provider	OAPIN (HMO)		OAP (PPO)		
<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>	Click for Premium Rate		Click for Premium Rates			Click for Premium Rates			Click for Premium Rates		Click for Premium Rates	
	Preferred Network	National HMO Network	IN-Network	Blue Preferred Plus (NBP)	Preferred (PPO)	Nonpreferred (OON)	IN-Network	PREFERRED PROVIDER	NONPREFERRED PROVIDER			
	Deductibles	\$350 / \$700 / \$1050	\$500 / \$1000 / \$1,500	\$425 / \$850 / \$1,275	\$500 / \$1,000 / \$1,500	\$700 / \$1400 / \$2100	\$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	\$4250 / \$8500 / \$12,750	\$4,000 / \$8,000 / \$12,000	\$4,000 / \$8,000 / \$12,000	\$5600 / \$11,200 / \$16,800	\$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	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited		
Primary Care Provider	\$25 (deductible waived)	\$40 (deductible waived)	\$35 (deductible waived)	\$40 (deductible waived)	\$50 (deductible waived)	50%	\$35 (deductible waived)	\$40 (deductible waived)	50%			
Specialist Provider	\$45 (deductible waived)	\$75 (deductible waived)	\$50 (deductible waived)	\$60 (deductible waived)	\$70 (deductible waived)	50%	\$50 (deductible waived)	\$60 (deductible waived)	50%			
Telehealth	\$0	\$0	\$0	\$0	\$0	50%	\$0	\$0	Not Covered			
Preventive Services/Immunization	\$0 (deductible waived)	\$0 (deductible waived)	\$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)	\$0 (deductible waived)	\$0 (deductible waived)	50% (deductible waived)	\$0 (deductible waived)	\$0 (deductible waived)	50% (deductible waived)			
Laboratory	\$20	\$20	25%	30%	40%	50%	25%	30%	50%			
X-Rays	\$100	\$100	25%	30%	40%	50%	25%	30%	50%			
Inpatient Hospital	20% coinsurance after deductible	20% coinsurance after deductible	\$700 per admission	\$1,250 per admission	\$1,750 per admission	50%	\$700 per admission	\$1,250 per admission	50%			
MRI, MRA, CAT Scan, and PET Scan	\$250 per test per day	\$250 per test per day	25% up to maximum of \$250 per test	25% up to maximum of \$300 per test	35% up to maximum of \$300 per test	50%	\$250 copay per type of scan per day, and plan pays 100%	\$300 copay per type of scan per day	50%			
Outpatient Surgery	\$500 copay	\$500 copay	25% \$250 per visit	25% \$500 per visit	35% \$700 per visit	50%	\$250 copay/visit, plus 25% coinsurance	\$500 copay/visit, plus 25% coinsurance	50%			
Maternity Hospitalization	\$1000 per admission	\$1000 per admission	\$500 per admission	\$1,000 per admission	\$1,400 per admission	50%	\$500 per admission	\$1,000 per admission	50%			
Routine Nursery Care for Newborns	No Copay	No Copay	No Copay	No Copay	No Copay	50%	No copay	No Copay	\$50%			
Emergency Room Visit	20% coinsurance after deductible	20% coinsurance after deductible	\$300	\$325	\$325	\$325	\$300	\$325	\$325			
Urgent Care Center	\$100 All Inclusive	\$100 All Inclusive	\$60	\$65	\$75	\$75 (after PPO deductible)	\$60	\$65	\$75			
Mental Health/Substance Abuse OutPatient	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	50%			
Mental Health/Substance Abuse InPatient	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	50%			
Chiropractic, Acupuncture	\$50 (deductible waived) (up to 25 combined visits per plan yr)	\$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)	\$70 (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)	\$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)	\$75 (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	20% coinsurance after deductible	20% coinsurance after deductible	25%	25%	\$35	45%	25%	28%	45%			
Chemotherapy and Radiation Therapy	Plan pays 100% after deductible	Plan pays 100% after deductible	No Copay in Physicians Office	\$55 per visit (deductible waived)	\$65 per visit (deductible waived)	50%	Prior Authorization (PA) required	Prior Authorization (PA) required	Prior Authorization (PA) required			
Home HealthCare	\$45 copay per visit	\$75 copay per visit	\$45 copay per visit	\$55 (deductible waived)	\$65 per visit	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 (36 months)	No copay up to \$2500 per ear; once every 3 yrs (36 months)	No copay up to \$2500 per ear; once every 3 yrs (36 months)	No copay up to \$2500 per ear; once every 3 yrs (36 months)	No copay up to \$2500 per ear; once every 3 yrs (36 months)	50% No copay (deductible waived)	(age 22 and older \$5,000 maximum per 36 months)	(age 22 and older \$5,000 maximum per 36 months)	50%			
Physical, Occupational, & Speech Therapy	\$25 (deductible waived)	\$40 (deductible waived)	\$35 (deductible waived)	\$40 (deductible waived)	\$50 (deductible waived)	50%	\$35 (deductible waived)	\$40 (deductible waived)	50%			
Hospice	No Copay	No Copay	No Copay	No Copay	No Copay	50%	No copay	No copay	50%			

	A	B	C	D	E	F	G	H	I	J
33	EXPRESS SCRIPTS, INC. -STATE OF NM 2022 (Pharmacy Benefit Manager)									
34				Retail (30 Day Supply)***				Mail Order (90 Day Supply)		
36	Out of Pocket			Combined prescription and medical OOP maximum						
37	Deductible**			\$50 individual/ \$100 Family only on Non-Generics (applies to Medical annual OOP Max)						
38	Generic			\$6.00				\$17.00		
39	Brand (Preferred)			30% (\$35 min/ \$95 max)				\$120.00		
40	Brand (Non-Preferred)			40% (\$60 min/ \$130 max)				\$155.00		
41	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		
42	**DEDUCTIBLE: \$50 PER INDIVIDUAL/\$100 FAMILY APPLIES TO Formulary and Non-Formulary Only									
43	***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).									
44	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.									

