State of New Mexico

Benefits Comparison Guide

	A	B	C	D	E	F	G	H	I	J
1	**BENEFITS**	**PRESBYTERIAN- STATE OF NM 2022**		**BLUE CROSS BLUE SHIELD-STATE OF NM 2022**				**CIGNA-STATE OF NM 2022**		
2		**Tier 1**	**Tier 2**	**HMO**	**Tier 1 Provider**	**Tier 2 Provider**	**Tier 3 Provider**	**OAPIN (HMO)**	**OAP (PPO)**	
3	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.	**Click for Premium Rate**		**Click for Premium Rates**	**Click for Premium Rates**			**Click for Premium Rates**	**Click for Premium Rates**	
4		**Preferred Network**	**National HMO Network**	**IN-Network**	**Blue Preferred Plus (NBP)**	**Preferred (PPO)**	**Nonpreferred (OON)**	**IN-Network**	**PREFERRED PROVIDER**	**NONPREFERRED PROVIDER**
5	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**
6	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**
7	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**
8	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%**
9	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%**
10	Telehealth	**$0**	**$0**	**$0**	**$0**	**$0**	**50%**	**$0**	**$0**	**Not Covered**
11	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)**
12	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)**
13	Laboratory	**$20**	**$20**	**25%**	**30%**	**40%**	**50%**	**25%**	**30%**	**50%**
14	X-Rays	**$100**	**$100**	**25%**	**30%**	**40%**	**50%**	**25%**	**30%**	**50%**
15	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%**
16	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%**
17	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%**
18	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%**
19	Routine Nursery Care for Newborns	**No Copay**	**No Copay**	**No Copay**	**No Copay**	**No Copay**	**50%**	**No copay**	**No Copay**	**$50%**
20	Emergency Room Visit	**20% coinsurance after deductible**	**20% coinsurance after deductible**	**$300**	**$325**	**$325**	**$325**	**$300**	**$325**	**$325**
21	Urgent Care Center	**$100 All Inclusive**	**$100 All Inclusive**	**$60**	**$65**	**$75**	**$75 (after PPO deductible)**	**$60**	**$65**	**$75**
22	Mental Health/Substance Abuse OutPatient	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**50%**
23	Mental Health/Substance Abuse InPatient	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**50%**
24	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)**
25	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)**
26	Durable Medical Equipment	**20% coinsurance after deductible**	**20% coinsurance after deductible**	**25%**	**25%**	**$35**	**45%**	**25%**	**28%**	**45%**
27	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**
28	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%**
29	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%**
30	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%**
31	Hospice	**No Copay**	**No Copay**	**No Copay**	**No Copay**	**No Copay**	**50%**	**No copay**	**No copay**	**50%**

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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 Famiy 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.**									

DELTA DENTAL PPO-STATE OF NM 2022

Services	PPO Provider	Premier Provider	Non-Participating Provider
Diagnostic & Preventive Services	100% (not subject to deductible)	100% (not subject to deductible)	100% (not subject to deductible)
Basic Services	80% Plan Pays	80% Plan Pays	55% Plan Pays
Major Services	60% Plan Pays	60% Plan Pays	35% Plan Pays

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 STATE OF NEW MEXICO 2022

SERVICES	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
		Tri-focal Lenses: $80
Frame-Every 24 Months	$150 retail allowance, plus 20% off overage	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	