

Please visit [www.mybenefitsnm.com](http://www.mybenefitsnm.com) to review the current Summaries of Benefits and Coverage (SBCs) and Plan Documents. All information on the benefit grid is illustrative only and does not substitute for the Summary Plan Descriptions.

**Blue Cross Blue Shield, Presbyterian Health Plan and UnitedHealthcare - State of New Mexico**

BENEFITS	HMO Clear Cost Platinum		HMO Basic Gold		PPO Basic Gold			PPO HDHP Silver	
	Tier I Providers	Tier II** Providers	Tier I Providers	Tier II** Providers	In-Network Tier I Providers	In-Network Tier II Providers	Out-of-Network Tier III Providers	In-Network Providers	Out-of-Network Providers
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.									
Deductible	\$0 Individual/ \$0 Two-Party/ \$0 Family	\$300 Individual/ \$600 Two-Party/ \$900 Family	\$500 Individual/ \$1,000 Two-Party/ \$1,500 Family	\$700 Individual/ \$1,400 Two-Party/ \$2,100 Family	\$500 Individual/ \$1,000 Two-Party/ \$1,500 Family	\$700 Individual/ \$1,400 Two-Party/ \$2,100 Family	\$3,000 Individual/ \$6,000 Two-Party/ \$9,000 Family	\$3,000 Individual/ \$6,000 Two-Party/ \$6,000 Family	\$4,500 Individual/ \$9,000 Two-Party/ \$9,000 Family
Out of Pocket Maximum (Combined Medical & Pharmacy)	\$3,500 Individual/ \$7,000 Two-Party/ \$10,500 Family	\$4,250 Individual/ \$8,500 Two-Party/ \$12,750 Family	\$4,000 Individual/ \$8,000 Two-Party/ \$12,000 Family	\$5,000 Individual/ \$10,000 Two-Party/ \$15,000 Family	\$4,000 Individual/ \$8,000 Two-Party/ \$12,000 Family	\$6,000 Individual/ \$12,000 Two-Party/ \$18,000 Family	\$9,000 Individual/ \$18,000 Two-Party/ \$27,000 Family	\$8,500 Individual/ \$10,150 Two-Party/ \$10,150 Family	\$12,000 Individual/ \$24,000 Two-Party/ \$24,000 Family
Lifetime Maximum (Certain services may be subject to plan year and/or lifetime maximum limits per condition)	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Primary Care Provider	\$20	\$30	\$30	\$40	\$30	\$40	50% after deductible	30% after deductible	50% after deductible
Specialist Provider	\$40 *	\$60	\$60 *	\$80	\$60 *	\$80	50% after deductible	30% after deductible	50% after deductible
Telehealth	\$0	\$0	\$0	\$0	\$0	\$0	50% after deductible	\$0	50% after deductible
Preventive Services/ Immunization	\$0	\$0	\$0	\$0	\$0	\$0	50% after deductible	\$0	50% after deductible
Well Child Services/ Immunization	\$0	\$0	\$0	\$0	\$0	\$0	50% after deductible	\$0	50% after deductible
Laboratory	\$20 *	\$30	\$30 *	\$40	30% after deductible *	35% after deductible	50% after deductible	30% after deductible	50% after deductible
X-rays	\$75 *	\$100	\$100 *	\$120	30% after deductible *	35% after deductible	50% after deductible	30% after deductible	50% after deductible
Inpatient Hospital (except MH/SUD)	\$750 per admission *	\$1,250 per admission	30% after deductible *	30% after deductible	30% after deductible *	35% after deductible	50% after deductible	30% after deductible	50% after deductible
MRI, MRA, CAT Scan and PET Scan	\$75 *	\$100	30% after deductible; up to \$250 *	30% after deductible; up to \$250	30% after deductible; up to \$300 *	35% after deductible; up to \$300	50% after deductible	30% after deductible	50% after deductible

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Outpatient Surgery	\$75 *	\$100	30% after deductible *	30% after deductible	30% after deductible *	35% after deductible	50% after deductible	30% after deductible	50% after deductible
Maternity Hospitalization	\$750 per admission *	\$1,250 per admission	30% after deductible *	30% after deductible	30% after deductible *	35% after deductible	50% after deductible	30% after deductible	50% after deductible
Routine Nursery Care for Newborns	\$0	\$0	\$0	\$0	\$0	\$0	50% after deductible	30% after deductible	50% after deductible
Emergency Room Services	\$250 (waived if admitted)		\$350 (waived if admitted)		\$350 (waived if admitted)			30% after deductible (In-Network deductible applies)	
Urgent Care Center	\$50 *	\$70	\$80 *	\$100	\$80 *	\$100	50% after deductible	30% after deductible	50% after deductible
Mental Health / Substance Abuse Outpatient	\$0	\$0	\$0	\$0	\$0	\$0	50% after deductible	0% after deductible	50% after deductible
Mental Health / Substance Abuse Inpatient	\$0	\$0	\$0	\$0	\$0	\$0	50% after deductible	0% after deductible	50% after deductible
Chiropractic (limited to 25 visits combined / plan year)	\$20 *	\$30	\$30 *	\$40	\$30 *	\$40	50% after deductible	30% after deductible	50% after deductible
Acupuncture (limited to 25 visits combined / plan year)	\$40 *	\$60	\$60 *	\$80	\$60 *	\$80	50% after deductible	30% after deductible	50% after deductible
Naprapathic Services, Massage Therapy (limited to 25 visits combined / plan year). No copay applies for behavioral health for HMOs and PPO in-network	\$40 *	\$60	\$60 *	\$80	\$60 *	\$80	50% after deductible	30% after deductible	50% after deductible

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Durable Medical Equipment	20% *	20%	30% after deductible *	30% after deductible	30% after deductible *	35% after deductible	50% after deductible	30% after deductible	50% after deductible
Chemotherapy & Radiation Therapy	Specialist copay applies for office visits, other outpatient place of service 20%	Specialist copay applies for office visits, other outpatient place of service 20%	Specialist copay applies for office visits, other outpatient place of service 30% after deductible	Specialist copay applies for office visits, other outpatient place of service 30% after deductible	Specialist copay applies for office visits, other outpatient place of service 30% after deductible	Specialist copay applies for office visits, other outpatient place of service 35% after deductible	50% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
Home Health Care	\$40 *	\$60	\$60 *	\$80	\$60 *	\$80	50% after deductible	30% after deductible	50% after deductible
Hearing Aids	No copay, up to \$2,500 per ear every 36 months *	No copay, up to \$2,500 per ear every 36 months	No copay, up to \$2,500 per ear every 36 months *	No copay, up to \$2,500 per ear every 36 months	No copay, up to \$2,500 per ear every 36 months *	No copay, up to \$2,500 per ear every 36 months	50% after deductible, up to \$2,500 per ear every 36 months	30% after deductible, up to \$2,500 per ear every 36 months	50% after deductible, up to \$2,500 per ear every 36 months
Physical, Occupational, and Speech Therapy	\$20	\$30	\$30	\$40	\$30	\$40	50% after deductible	30% after deductible	50% after deductible
Hospice	0%	0%	0% after deductible	0% after deductible	0% after deductible	0% after deductible	50% after deductible	30% after deductible	50% after deductible

\* For UHC/UMR, Tier I copays and coinsurance apply to all in-network facilities and for specialists where tiering does not apply.

\*\* The BCBSNM HMO is only available in New Mexico and does not have a Tier II. For PHP, Tier I only applies to New Mexico, outside New Mexico Tier II applies to members accessing the national network. For UHC/UMR, tiering is available nationwide.