

**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 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 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 PPO NEW MEXICO

	<u>In-Network</u>	<u>Out of Network</u>
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

	<u>IN-NETWORK</u>	<u>OUT-OF-NETWORK</u>
Eye Exam - every 12 months	Paid in Full after \$10 Copay	<i>Reimbursement - up to:</i> Eye Exam: \$40
Lenses - every 12 months	Paid in full at \$15 Co-pay	
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)	Single-Vision Lenses: \$40
Contacts every 12 months	No Co-pay Required	Tri-focal Lenses: \$80
- Evaluation/Fitting/Follow-up	Non-Collection Contacts: \$60 allowance, plus 15% off overage /¹	Elective Contacts: \$105
- In lieu of allowance	Davis Vision Collection Contacts /²: Covered in Full no co-pay required	Frame: \$50.00
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	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