State of New Mexico

Benefits Comparison Guide

BENEFITS	PRESBYTERIAN- STATE OF NM 2024		BLUE CROSS BLUE SHIELD-STATE OF NM 2024				CIGNA-STATE OF NM 2024		
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.	Tier 1	Tier 2	HMO	Tier 1 Provider	Tier 2 Provider	Tier 3 Provider	OAPIN (HMO)	OAP (PPO)	
	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 orare limit per condition.)	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)	$60 (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	$25 (deductible waived) (up to 25 combined visits per plan yr)	$40(deductible waived) (up to 25 combined visits per plan yr)	$35 (deductible waived) (up to 25 combined visits per plan yr)	$40 (deductible waived) (up to 25 visits combined per plan yr)	$50 (deductible waived) (up to 25 visits combined per plan yr)	50% (up to 25 visits combined per plan yr)	$35 (deductible waived) (up to 25 visits combined per plan yr)	$40 (deductible waived) (up to 25 visits combined per plan yr)	50% (up to 25 visits combined per plan yr)
Naprapathic Services, Massage Therapy	$55 (deductible waived) $0 (behavioral health) (up to 25 combined visits per plan yr)	$55 (deductible waived) $0 (behavioral health) (up to 25 combined visits per plan yr)	$60 (deductible waived) $0 (behavioral health) (up to 25 combined visits per plan yr)	$65 (deductible waived) $0 (behavioral health) (up to 25 combined visits per plan yr)	$75 (deductible waived) $0 (behavioral health) (up to 25 combined visits per plan yr)	50% (up to 25 visits per plan yr) $0 (behavioral health)	$60 (deductible waived) $0 (behavioral health) (up to 25 visits per plan yr)	$65 (deductible waived) $0 (behavioral health) (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	CVS caremark -STATE OF NM 2024 (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	Specialty Medications (30 day supply) must move to mail order after 2 fill at retail			$60 Generic $85 Preferred Brand $125 Non-preferredBrand *Contact Prudent RX to confirm eligibility for co-pay assistance				$60 Generic $85 Preferred Brand $125 Non-preferred Brand *Contact Prudent RX to confirm eligibility for co-pay assistance		
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.									

January 1 - December 31, **2024**

DELTA DENTAL PPO-STATE OF NM 2024

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 2024

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	