State of New Mexico
CY15 Health Benefits Comparison

BENEFITS	PRESBYTERIAN - HMO	BLUE CROSS BLUE SHIELD NM - HMO	BLUE CROSS BLUE SHIELD NM - PPO	
			PREFERRED PROVIDER	NONPREFERRED PROVIDER
Deductibles	$325/$650/$975	$325/$650/$975	$500 / $1,000 / $1,500	$2,800 / $5,600 / $8,400
Out of Pocket (combined Pharmacy & Medical)	$3500/$7000/$10500	$3500/$7000/$10500	$3,500 / $7,000 / $10,500	$7,000 / $14,000 / $21,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited (Certain services are subject to Plan Year and/or lifetime maximums or are limited per condition.)	
Primary Care Provider	$25.00 (deductible waived)	$25.00 (deductible waived)	$30 (deductible waived)	50%
Specialist Provider	$40.00	$40.00	$50.00	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%	20%	20%	50%
X- Ray	20%	20%	20%	50%
Inpatient Hospital	$500.00 per admission	$500.00 per admission	$1,000.00 per admission	50%
MRI/PET/CT Scans	20% up to maximum of $200 per test	20% up to maximum of $200 per test	20% up to maximum of $200 per test	50%
Outpatient Surgery	20%	20%	20%	50%
Maternity Physician Services	$25.00 Initial Visit Only	$25.00 Initial Visit Only	$30 Initial Visit Only	50%
Maternity Hospitalization	$500.00	$500.00	$1,000.00	50%
Routine Nursery Care for Newborns	No Copay	No Copay	No Copay	50%
Emergency Room Visit	$175.00	$175.00	$175.00	$175.00
Urgent Care Center	$50.00	$50.00	$50.00	$50.00
Mental Health Out Patient	$25.00	$25.00	$30.00	50%
Mental Health In Patient	$500.00	$500.00	$1,000.00	50%
Chiropractic, Acupuncture	$40.00 (up to 25 combined visits per plan year)	$40.00 (up to 25 combined visits per plan year)	$50.00 (up to 25 visits combined per plan year)	50% (up to 25 visits combined per plan year)
Naprapathic Services	$50.00 (up to $500 per plan year)	$50.00 (up to $500 per plan year)	$50.00 (up to $500 per plan year)	50% (up to $500 per plan year)
Durable Medical Equipment	20%	20%	25%	40%
Chemotherapy and Radiation Therapy	No Copay in Physicians Office	No Copay in Physicians Office	$50.00	50%
Home HealthCare	$40.00 Physician, no copay for nursing services	$40.00 Physician, no copay for nursing services	$50.00	50%
Hearing Aids	No copay up to $2500 per yr per ear, once every 3 yrs	No copay up to $2500 per yr per ear, once every 3 yrs	No copay up to $2500 per yr per ear, once every 3 yrs	No copay up to $2500 per yr per ear, once every 3 yrs
Physical, Occupational, & Speech Therapy	$40.00	$40.00	$50.00	50%
Hospice	No Copay	No Copay	No Copay	50%

Express Scripts Inc - Pharmacy Benefit Manager				
		Retail	Retail	Home Delivery
		Min	Max	
Generic	$5.00	NA	NA	$15.00
Brand	30%	$30	$90.00	$95.00
Brand Non-Preferred	40%	$55.00	$125.00	$125.00
Specialty	Copay	$75 PER SCRIPT/PER MONTH	$75 PER SCRIPT/PER MONTH	$75 PER SCRIPT/PER MONTH
	SPECIALTY MEDICATIONS - MUST USE MAIL ORDER AFTER 2 RETAIL FILLS			

DEDUCTIBLE: $50 PER INDIVIDUAL/$100 FAMILY APPLIES TO Formulary and Non-Formulary Only
Pharmacy deductible is combined with medical deductible to meet total medical deductible

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Delta Dental PPO New Mexico		
	In- Network	Out of Network
*Diagnostic & Preventive Services	100% (not subject to deductible)	100% **
*Basic Services	80%	55% **
*Major Services	60%	35% **
Orthodontic Services		
Children up to 18	75% up to $2000 lifetime maximum	
Adults 18 and Over	60% up to $1750 lifetime maximum	
Calendar Year Deductible	$50 per person, $150 per family	
Calendar Year Maximum	$1750 per enrolled person	

*Please contact Delta Dental for service descriptions or further details at 1-877-395-9420

** The payment percentages shown for Out-Of Network services are based on the Maximum approved Fees applicable only to Out Of Network Dentists

Vision Service Plan		
	In- Network	Out of Network
Exam every 12 months	$10	Up to $35
Prescription Lenses every 12 months	$15	Single Vision up to $25
(Single Vision, Lined bifocal, Lined Trifocal,		Lined Bifocals up to $40
Polycarbonate lenses for dependent children)		Lined Trifocal up to $55
Frame every 24 months	Up to $130 + 20% off out of pocket expense	Frame up to $35
Contacts every 12 months	10 allowance when contacts are chosen instead of glas	Contacts up to $110

Please contact Vision Service Plan for specific details at 1-800-877-7195