State of New Mexico
Benefits Comparison Guide

	A	B	C	D	E	F	G
1	**SHORT PLAN YEAR 2026**	**PRESBYTERIAN- STATE OF NM Short Plan Year 2026**		**BLUE CROSS BLUE SHIELD-STATE OF NM Short Plan Year 2026**			
2	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
3		Click for Premium Rate		Click for Premium Rates	Click for Premium Rates		
4		Preferred Network	NM and Multiplan Nationwide Network	IN-Network	Blue Preferred Plus (NBP)	Preferred (PPO)	Nonpreferred (OON)
5	Deductibles	$175 / $350 / $525	$250 / $500/ $750	$212.50 / $425 / $637.50	$250 / $1,000 / $1,500	$350/ $700/ $1050	$1500 / $3000 / $4500
6	Out of Pocket (combined Pharmacy & Medical)	$1875 / $3750 / $5625	$2125 / $4250/ $6375	$2000 / $4000 / $6000	$2000 / $4000 / $6000	$2800/ $8600/ $5400	$4500 / $9,000 / $13500
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
8	Primary Care Provider	$25 (deductible waived)	$40 (deductible waived)	$35 (deductible waived)	$40 (deductible waived)	$50 (deductible waived)	50%
9	Specialist Provider	$45 (deductible waived)	$75 (deductible waived)	$50 (deductible waived)	$60 (deductible waived)	$70 (deductible waived)	50%
10	Telehealth	$0	$0	$0	$0	$0	50%
11	Preventive Services/Immunization	$0 (deductible waived)	$0 (deductible waived)	$0 (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)
13	Laboratory	$20	$20	25%	30%	40%	50%
14	X-Rays	$100	$100	25%	30%	40%	50%
15	Inpatient Hospital	20% coinsurance after deductible	20% coinsurance after deductible	$700 per admission	$1,250 per admission	$1,750 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%
17	Outpatient Surgery	$500 copay	$500 copay	25% $250 per visit	25% $500 per visit	35% $700 per visit	50%
18	Maternity Hospitalization	$1000 per admission	$1000 per admission	$500 per admission	$1,000 per admission	$1,400 per admission	50%
19	Routine Nursery Care for Newborns	No Copay	No Copay	No Copay	No Copay	No Copay	50%
20	Emergency Room Visit	20% coinsurance after deductible	20% coinsurance after deductible	$300	$325	$325	$325
21	Urgent Care Center	$100 All Inclusive	$100 All Inclusive	$60	$65	$75	$75 (after PPO deductible)
22	Mental Health/Substance Abuse OutPatient	$0	$0	$0	$0	$0	$0
23	Mental Health/Substance Abuse InPatient	$0	$0	$0	$0	$0	$0

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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)
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)
26	Durable Medical Equipment	20% coinsurance after deductible	20% coinsurance after deductible	25%	25%	$35	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%
28	Home HealthCare	$45 copay per visit	$75 copay per visit	$45 copay per visit	$55 (deductible waived)	$65 per visit	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)
30	Physical, Occupational, & Speech Therapy	$25 (deductible waived)	$40 (deductible waived)	$35 (deductible waived)	$40 (deductible waived)	$50 (deductible waived)	50%
31	Hospice	No Copay	No Copay	No Copay	No Copay	No Copay	50%
32							

	CVS CAREMARK Short Plan Year 2026 (Pharmaceutical Benefits Manager)		
33			
34	Out of Pocket	Retail (30 Day Supply)	Mail Order (90 Day Supply)
35	Deductible	Combined Prescription and Medical OOP Maximum	Combined Prescription and Medical OOP Maximum
36	Deductible	$25 individual/$50 family (applies to brand-name medications only; applies to OOP Maximum)	$25 individual/$50 family (applies to brand-name medications only; applies to OOP Maximum)
37	Generic	$6	$17
38	Brand (preferrred)	30% ($35 min/$95 max)	$120
39	Brand (non-preferred)	40% ($60 min/$130 max)	$155
40	Specialty Medication (30 day supply) - must move to mail order after 2 fills at retail	$60 Generic $85 Preferred Brand $125 Non-Preferred Brand; Prudent RX to confirm eligibility for co-pay assistance	Contact

	STAY WELL HEALTH CENTER @ 1100 Saint Frances Drive, #1000, Santa Fe NM	
33		
34	Services	
35	Prevention & Wellness	Health Screening & Testing, Lab Services, Physical and Wellness Visits, Patient Advocacy
36	Diagnosis & Treatment	Illness, Aches & Pains
37	Monitoring & Management	Diabetes, Depression, Hypertension, High Cholesterol, Anxiety, Weight Management, Help to Quit Smoking, Vascular Disease, Thyroid Disorder, Asthma
38	Patient Advocacy	Care Coordination, Specialist Coordination, Crisis Support, Community Resource Navigation, Elder-Care Support, Hospital Discharge Support
39	Services	Cost
40	OFFICE VISIT COPAY; ONSITE LABS & MEDICATIONS; CHRONIC DISEASE MANAGEMENT; PATIENT ADVOCACY SERVICES; CONCIERGE-STYLE CARE; PATIENT PORTAL WELLNESS & NUTRITION COACHING	no charge

	DELTA DENTAL PPO-STATE OF NM 2026			
41				
42	Services	PPO Provider	Premier Provider	Non-Participating Provider
43	Diagnostic & Preventive Services	100% (not subject to deductible)	100% (not subject to deductible)	100% (not subject to deductible)
44	Basic Services	you pay 20%	you pay 20%	you pay 45%
45	Major Services	you pay 40%	you pay 40%	you pay 65%
46	Short Plan Year Year Deducibles: $25 per person, $75 per family Deductible does not apply to Diagnostic, Preventive or Orthodontic Services			
47	Orthodontic Services: Children up to 18 - you pay 25% up to $2,000 Lifetime Maximum; you pay 50% out of network; and over - you pay 40% up to $1,750 Lifetime Maximum (no age limit)			Adults 18
48	Short Plan Year Maximum - Calendar Year: $875 per enrolled person - short plan year			

	Metlife Dental - State of NM Short Plan Year 2026		
41			
42	Coverage Type	In-Network	Out-of-Network
43	Type A: Preventive	100% covered	100% covered
44	Type B: Basic Restorative	80% covered	55% covered
45	Type C: Major Restorative	60% covered	35% covered
46	Type D: Orthodontia	60% (adult) / 75% (child)	60% (adult) / 50% (child)
47	Deductible	$25 individual / $75 family	$25 individual / $75 family
48	Short Plan Year Maximum Benefit	$875 per person	$875 per person

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49	Please contact Delta Dental for service descriptions or further details at 1-877-395-9420				Orthodontia Lifetime Maximum	$1750 (adult) / $2000 (child) per person	$1750 (adult) / $2000 (child) per person
50	Davis Vision State of NM Short Plan Year 2025						
51	Frequency:	Exam - 12 months	Frame - 24 months	Spectacle Lenses - 12 months	Contact lenses - 12 months		
52	Vision Care Services			In-Network		Out-of-Network	
53	Eye Exam			Exam $10 copay; Retinal Imaging up to $39		Exam up to $40; Retinal Imaging not covered	
54	Contact Lens Fit and Follow-Up			Fitting & Follow-Up Care for Standard - Covered in Full; Fitting & Follow-Up Care for Specialty Lens - $60 allowance plus 15% savings		Up to $40	
55	Frame			$0 copay: $150 allowance toward any frame from provider plus 20% off any balance		Up to $50	
56	Spectacle Lenses			$15 (single vision, bifocal, trifocal, lenticular)		Up to $40 single vision; up to $60 bifocal; Up to $80 trifocal; Up to $100 lenticular	
57	Contact Lenses			$0 copay: $150 allowance toward any contacts from provider's supply plus 15% off balance		Up to $105	
58	Medically Necessary Contact Lenses			Covered in full with prior approval		Up to $210	
59	Options & Upgrades			Please review the Davis Vision Summary of Benefits and Coverage for a complete list of all options and upgrades with cost			