

Medical

Blue Cross Blue Shield

PPO	Employee per Pay Period**	City per Pay Period**
Coverage		
Employee Only	\$78.73	\$118.09
Employee +Spouse (DP)	\$157.46	\$236.19
Employee + Child(ren)	\$149.59	\$224.38
Family	\$228.32	\$342.47

EPO

Employee Only	\$86.49	\$129.74
Employee +Spouse (DP)	\$172.99	\$259.48
Employee + Child(ren)	\$164.34	\$246.51
Family	\$250.83	\$376.25

premiums listed include an administration fee

Dental

Delta Dental

Coverage	Employee per Pay Period	City per Pay Period
Employee Only	\$4.89	\$7.34
Employee +Spouse (DP)	\$9.27	\$13.91
Employee + Child(ren)	\$12.32	\$18.48
Family	\$18.84	\$28.27

Vision

VSP – Vision Service Plan* (Voluntary 100% employee paid)

Coverage	Employee per Pay Period
Employee Only	\$2.01
Employee +Spouse (DP)	\$4.02
Employee + Child(ren)	\$5.15
Family	\$8.22

Life, Short-Term, & Long Term Disability

Coverage	Employee per Pay Period	City per Pay Period
Employee Basic Life	\$0.00	\$1.94
Dependent Life	\$0.43	\$0.65
Short Term Disability	\$9.83	\$0.00
Long-Term Disability	\$1.64	\$0.00

Voluntary Term Life Insurance – 5 additional levels of life insurance for employee only; cost based on age and annual earnings; 100% employee funded.
Flexible Spending Account(s) – Pre-tax benefit; available for medical and/or dependent care expenditures as approved by the IRS.
Health Savings Account(s) – Pre-tax benefit; available to employees enrolled in the Presbyterian HDHP only as approved by the IRS.

**City of Las Cruces
MEDICAL PLAN COMPARISON
PLAN YEAR 01/01/2014 - 12/31/2014**

BENEFITS	BCBSNM-EPO (01/01/2014 - 12/31/2014)		BCBSNM-PPO (01/01/2014 - 12/31/2014)	
	PREFERRED PROVIDER	NONPREFERRED PROVIDER	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Deductibles	\$300 / \$600 / \$900	\$700 / \$1,400 / \$2,100	\$3,500 / \$7,000 / \$10,500	\$2,800 / \$5,600 / \$8,400
Out of Pocket	\$3,500 / \$7,000 / \$10,500	\$3,500 / \$7,000 / \$10,500	\$7,000 / \$14,000 / \$21,000	\$7,000 / \$14,000 / \$21,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Primary Care Provider	\$20.00 (deductible waived)	\$30 (deductible waived)	\$50.00	50%
Specialist Provider	\$40.00	\$50.00	\$0 (deductible waived)	50% (deductible waived)
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	\$1,000.00 per admission	\$200 copay/per test	50%
MRI/PET/CT Scans	\$200 copay/per test	\$200 copay/per test	20%	50%
Outpatient Surgery	20%	20%	\$30 Initial Visit Only	50%
Maternity Physician Services	\$20.00 Initial Visit Only	\$30 Initial Visit Only	\$1,000.00	50%
Maternity Hospitalization	\$500.00	\$1,000.00		50%
Routine Nursery Care for Newborns	No Copay	No Copay		50%
Emergency Room Visit	\$175.00	\$175.00		\$175.00
Urgent Care Center	\$50.00	\$50.00		\$50.00
Mental Health Outpatient/Office	\$20.00 (deductible waived)	\$30.00		50%
Mental Health Inpatient	\$500.00	\$1,000.00		50%
Chiropractic, Acupuncture	\$40.00	\$50.00		50%
Naprapathic Services	(up to 20 visits combined/per year)	(up to 20 visits combined/per year)		(up to 20 visits combined/per year)
Durable Medical Equipment	\$50.00 (up to \$500 per plan year)	\$50.00 (up to \$250 per plan year)		50% (up to \$250 per plan year)
Chemotherapy and Radiation Therapy	20%	25%		40%
Home HealthCare	No Copay in Physicians Office	\$50.00		50%
Hearing Aids	\$40.00 Physician, no copay for nursing services	\$50.00		50%
Physical, Occupational & Speech Therapy	Two hearing aids during a 3 year period - PAY 100% (NO COPAY, NO DED)	Two hearing aids during a 3 year period PAY 100% (NO COPAY, NO DED)		50%
Hospice	\$40.00	\$50.00		50%
	No Copay	No Copay		50%

** Items Highlighted in Purple Indicate Changes

Prime Therapeutics/Prime Specialty Pharmacy - New Pharmacy Benefit Manager			
	Generic	Retail	Mail-Order
Brand Name (With Generic Equivalent)	\$5 plus difference in covered charge between the brandname and the generic equivalent.	\$5.00	\$15.00
Brand Name (Preferred)	30% (\$30/min, \$90/max)		N/A
Brand Name (Non-Preferred)	40% (\$55/min, \$125/max)		\$95.00
Specialty		\$135 per prescription	\$125.00