At-A-Glance: Comparing the 2017 PPO & HDHP Medical Programs

Medical Program Benefit Comparison	PPO Benefits & Cost Sharing		HDHP + HSA Benefits & Cost-Sharing	
	Preferred Provider (In-Network)	**Nonpreferred Provider (Out-of-Network)**	**Preferred Provider (In-Network)**	**Nonpreferred Provider (Out-of-Network)**
Calendar Year Deductible – All services are subject to deductible unless otherwise indicated below.	$300 Individual $900 Family	$500 Individual $1,500 Family	$1,500 Individual $3,000 Family	$3,000 Individual $6,000 Family
	Family deductible is an aggregate of **three** times the Individual amount, **PPO and Non-PPO deductibles do NOT cross apply.**		Family deductible is an aggregate of **two** times the Individual amount.	
Calendar Year Out-of-Pocket Limit – Does not include penalty amounts, if any, noncovered charges, Out-of-network inpatient facility copays, or amounts over the covered charges. Under PPO and HDHP programs, the PPO and Non-PPO amounts do **not** cross-apply. After a member (or family) reaches the applicable out-of-pocket limit, the Medical Program pays 100 percent of most of that member's (or family's) covered charges for the rest of the year.	$3,000 Individual $9,000 Family	$6,000 Individual $18,000 Family	$3,000 Individual $6,000 Family	$6,000 Individual $12,000 Family
	Out-of-Pocket limit includes deductible, percentage coinsurance, copays, and drug plan copays; but does not include: out-of-network inpatient hospital copay or residential treatment center copay.		Out-of-Pocket limit includes deductible, percentage coinsurance and amounts paid by you under the drug plan.	
Lifetime Maximum Benefit Limit (per member)	Unlimited	Unlimited	Unlimited	Unlimited
Basic Hospital and Physician Services				
Primary Preferred Provider (PPP) **Office Visit/Exam Charge** (Nonroutine)	$30/visit (deductible waived)	40% after deductible	10% after deductible	40% after deductible
Therapeutic injections and diagnostic tests; Office surgery and supplies; Allergy care; Family planning surgery and injections	10% after deductible	40% after deductible	10% after deductible	40% after deductible
Specialist Provider Office Visit/Exam Charge (Nonroutine)	$45/visit (deductible waived)	40% after deductible	10% after deductible	40% after deductible
Therapeutic injections and diagnostic test; Office surgery and supplies; Allergy care; Family planning surgery and injections	10% after deductible	40% after deductible	10% after deductible	40% after deductible
Allergy Injections	No Charge	40% after deductible	10% after deductible	40% after deductible
Routine/Preventive Care (Includes exams, physicals, checkups, lab tests, immunizations, colonoscopies, etc.)				
Well-Baby (Through Age 2)	No Charge	40% (deductible waived)	No Charge	40% (deductible waived)
Well-Child (3-18)	No Charge	40% after deductible	No Charge	40% after deductible
Adult Physicals and Colonoscopies (Ages 19 and Older)				
Lab, X-Ray, and other Testing	No Charge	40% after deductible	No Charge	40% after deductible
Inpatient Hospital Charges/Inpatient Surgery	10% after deductible	$250 + 40% after deductible	10% after deductible	40% after deductible
Inpatient Physician Medical Visits/Consultation	No Charge	40% after deductible	10% after deductible	40% after deductible
Inpatient OB-GYN Maternity Delivery Global Fee	No Charge	40% after deductible	10% after deductible	40% after deductible
Outpatient Hospital/Ambulatory Surgery Center	10% after deductible	40% after deductible	10% after deductible	40% after deductible
Emergency Room Visit (Emergency condition only)	$150/visit (deductible waived)		10% after In-Network deductible	
Physician and Other Professional Provider Charges	10% after In-Network deductible		10% after In-Network deductible	
Independent Lab/X-Ray Facility	10% after deductible	40% after deductible	10% after deductible	40% after deductible
Urgent Care Facility	$30/visit (deductible waived)	40% after deductible	10% after deductible	40% after deductible
- Ancillary Services (Lab tests, X-Rays, Supplies, etc.)	10% after deductible	40% after deductible	10% after deductible	40% after deductible

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Hospice Care Facility (Respite care limited to **10 days** for every 6-month period)	10% (deductible waived)	40% (deductible waived)	10% after deductible	40% after deductible
Short-Term Rehabilitation, Outpatient and Office (Includes physical, occupational, and speech therapy; each therapy is limited to **20 visits**/calendar year) **Acupuncture/Spinal Manipulation/Naprapathy** (Acupuncture is limited to **20 visits**/calendar year; Spinal Manipulation/Naprapathy has a separate combined limit of **20 visits**/calendar year)	$45/visit (deductible waived)	40% after deductible	10% after deductible	40% after deductible
Office Chemotherapy/Radiation Therapy	$45/visit (deductible waived)	40% after deductible	10% after deductible	40% after deductible
Behavioral Health: Mental Health/Chemical Dependency				
Office	$30/visit (deductible waived)	40% after deductible	10% after deductible	40% after deductible
Other Outpatient Treatments; Intensive Outpatient Programs; Partial Hospitalization and Outpatient Suboxone Treatment	10% after deductible	40% after deductible	10% after deductible	40% after deductible
Inpatient	10% after deductible	$250 + 40% after deductible	10% after deductible	40% after deductible
Related Inpatient Physician Claims	10% after deductible	40% after deductible	10% after deductible	40% after deductible
Residential Treatment Center, Includes Physician	10% after deductible	$250 + 40% after deductible	10% after deductible	40% after deductible
PRESCRIPTION DRUGS, INSULIN, VACCINES, DIABETIC SUPPLIES, ENTERAL NUTRITION, SPECIAL MEDICAL FOODS**				
Retail Pharmacy/Specialty Pharmacy Programs (Up to a 30-day supply or 180 units, whichever is less. Some drugs require preauthorization before coverage will be available, Benefits include flu, pneumococcal, and Zostavax vaccines for which no copayment is required.)	**$7**/generic **$35**/brand-name on Drug List **$55**/brand-name drug not on Drug List and for special medical foods/enteral nutrition*		You pay 20% of covered charges after the deductible is met.*	
Mail-Order Program (Up to a 90-day supply or 540 units, whichever is less)	Two copayments as listed above*			
Specialty Pharmacy Drugs	**15%** of covered charge up to a maximum copayment of **$125** per prescription			
*If you require a brand-name drug for which there is a generic equivalent, you will pay the difference in cost plus the generic drug copayment. You must use a participating pharmacy.	Charges payable under the drug plan are **not** subject to the medical plan deductible.		Deductible and out-of-pocket limit provisions apply to charges payable under the drug plan.	

**Prescription drugs and other items covered under the drug plan must be purchased at a pharmacy that participates in the Retail Pharmacy, Specialty Pharmacy or Mail-Order Program.

This document is a basic comparison of the non-Medicare LANS medical programs for 2017. It is not a complete overview and additional exclusions and limitations will apply. This document highlights the major differences among the programs in order to assist you with making a decision about which program best suits your and your family's health care needs. To obtain more details about each plan please refer to the Summary of Benefits provided for each Medical Program available on your benefits homepage http://int.lanl.gov/employees/benefits/.Blue Cross and Blue Shield of New Mexico (BCBSNM) is a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the

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