

New Mexico's 2017 EHB Benchmark Plan Options

Row Number	Benefit	Largest Small Group Plans			State Employee Plans			FEHBP Plans			Largest HMO Plan
		<i>Presbyterian PresElect</i>	<i>Lovelace Classic PPO [2014 Benchmark]</i>	<i>UnitedHealthcare Choice Plus</i>	<i>BCBS NM PPO</i>	<i>BCBS NM HMO</i>	<i>Presbyterian HMO</i>	<i>BCBS Standard Option</i>	<i>BCBS Basic Option</i>	<i>GEHA Standard Option</i>	<i>Presbyterian Individual Silver C</i>
1	Primary Care Visit to Treat an Injury or Illness	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
2	Specialist Visit	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
3	Other Practitioner Office Visit (Nurse, Physician Assistant)	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
4	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
5	Outpatient Surgery Physician/Surgical Services	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
6	Hospice Services	Covered. Respite care is limited to 5 consecutive days for every 60 days on hospice care. No more than two respite care stays during a hospice benefit period.	Covered	Covered	Covered. Respite care is limited to 5 consecutive days for every 60 days on hospice care. No more than two respite care stays during a hospice benefit period.	Covered. Respite care is limited to 5 consecutive days for every 60 days on hospice care. No more than two respite care stays during a hospice benefit period.	Covered. Respite care lifetime max of 2 sessions of up to 10 days for each hospice benefit period.	Covered. Inpatient hospice benefits are provided for up to 30 consecutive days. Each inpatient stay must be separated by at least 21 days of traditional home hospice care.	Covered. Inpatient hospice benefits are provided for up to 30 consecutive days. Each inpatient stay must be separated by at least 21 days of traditional home hospice care.	Covered. Pays up to \$15,000 for a combination of inpatient and outpatient care.	Covered. Respite care limited to 5 continuous days for every 60 days of hospice care. No more than 2 respite care stays available during a hospice benefit period.
7	Non-Emergency Care When Traveling Outside the U.S.	Not Covered. Emergent and urgent care only.	Covered	Not Covered. Emergency care only.	Not Covered. Emergency care only.	Not Covered. Emergency care only.	Covered	Covered	Covered	Covered	Not covered except for emergency and urgent care services.
8	Routine Dental Services (Adult)	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Covered	Covered	Covered	Not Covered
9	Infertility Treatment	Covered for diagnosis and treatment, including drugs and injections for physical conditions causing infertility except as required to reverse prior voluntary sterilization surgery. Artificial insemination is covered for up to three inseminations. In vitro, GIFT and ZIFT fertilization are not covered	Covered. Excludes in vitro fertilization and costs connected with collection, preparation, storage of sperm for artificial insemination, including donor fees, reversal of voluntary sterilization surgery	Covered only to treat or correct underlying causes of fertility	Covered only for diagnostic testing, surgical treatments and hormone replacement	Covered only for diagnostic testing, surgical treatments and hormone replacement	Covered only for diagnostic testing, surgical treatments and hormone replacement	Covered. Diagnosis and treatment, except assisted reproductive technology (ART) and assisted insemination procedures, cryopreservation or storage of sperm, eggs, or embryos, infertility drugs used in conjunction with ART and assisted insemination	Covered. Diagnosis and treatment, except assisted reproductive technology (ART) and assisted insemination procedures, cryopreservation or storage of sperm, eggs, or embryos, infertility drugs used in conjunction with ART and	Covered. Diagnosis and treatment, except services after voluntary sterilizations, fertility drugs, genetic counseling pre-implantation genetic diagnosis, assisted reproductive technology and procedure, cost of donor sperm or egg	Not Covered

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								procedures.	assisted insemination procedures.		
10	Long-Term/Custodial Nursing Home Care	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
11	Private-Duty Nursing	Not Covered	Not Covered	Covered only on an inpatient basis when skilled nursing is not available from the hospital	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
12	Routine Eye Exam (Adult)	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Covered	Not Covered
13	Urgent Care Centers or Facilities	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
14	Home Health Care Services	Covered.	Covered. Limited to 100 visits per year	Covered	Covered. Limited to 100 visits per year.	Covered	Covered	Covered. Limited to two hours per day. Must be provided by an RN or LPN and be ordered by a physician. Limited to 50 visits per person per year.	Covered. Limited to two hours per day. Must be provided by an RN or LPN and be ordered by a physician. Limited to 25 visits per person per year.	Covered. Limited to 50 in-home visits per person per year, not to exceed up to two hours per day. Must be provided by an RN or LPN and be ordered by a physician.	Covered. Limited to 100 visits per year
15	Emergency Room Services	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
16	Emergency Transportation/Ambulance	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
17	Inpatient Hospital Services (e.g., Hospital Stay)	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
18	Inpatient Physician and Surgical Services	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
19	Bariatric Surgery	Covered	Covered.	Covered	Covered	Covered	Covered	Covered.	Covered.	Covered	Covered

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20	Cosmetic Surgery	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
21	Skilled Nursing Facility	Covered. Limited to 60 days per year.	Covered. Limited to 60 days per year.	Covered	Covered	Covered	Covered	Not covered unless member has Medicare Part A.	Not covered unless member has Medicare Part A.	Covered for first 14 days following transfer from acute inpatient confinement. Limited to \$700 per day.	Covered. Limited to 60 days per year.
22	Prenatal and Postnatal Care	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
23	Delivery and All Inpatient Services for Maternity Care	Covered	Covered	Covered	Covered	Covered	Covered	Covered. . Does not cover abortions, genetic testing of the father, birthing/parenting classes	Covered. Does not cover abortions, genetic testing of the father, birthing/parenting classes	Covered. Does not cover abortions, or home uterine monitoring devices	Covered
24	Mental/Behavioral Health Outpatient Services	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
25	Mental/Behavioral Health Inpatient Services	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
26	Substance Abuse Disorder Outpatient Services	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
27	Substance Abuse Disorder Inpatient Services	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
28	Generic Drugs	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
29	Preferred Brand Drugs	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
30	Non-Preferred Brand Drugs	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
31	Specialty Drugs	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered

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32	Outpatient Rehabilitation Services	Covered	Covered	Covered	Covered	Covered	Covered	Covered up to 75 visits per person per year	Covered up to 50 visits per person per year	Covered. Up to 60 visits per person per calendar year combined with habilitative.	Covered
33	Habilitation Services	Not Covered	Covered	Covered	Covered	Covered	Covered	Not Covered	Not Covered	Covered. Up to 60 visits per person per calendar year combined with rehabilitative.	Covered
34	Chiropractic Care	Covered. \$1,500 annual maximum combined with acupuncture, massage therapy, and biofeedback	Covered. Limited to 20 visits per year	Covered	Covered. Limited to 25 visits per year combined with acupuncture.	Covered. Limited to 25 visits per year combined with acupuncture.	Covered. Limited to 25 visits per year combined with acupuncture.	Covered. Limited to 12 visits per person per year.	Covered. Limited to 20 visits per person per year.	Covered. Limited to 12 visits per person per year.	Covered. Limited to 20 visits per year for acupuncture and chiropractic combined
35	Durable Medical Equipment	Covered. \$5,000 annual maximum	Covered	Covered	Covered	Covered	Covered	Covered except for exercise and bathroom equipment, lifts, car seats, air conditioners, communications equipment, equipment for cosmetic purposes, and topical hyperbaric oxygen therapy.	Covered except for exercise and bathroom equipment, lifts, car seats, air conditioners, communications equipment, equipment for cosmetic purposes, and topical hyperbaric oxygen therapy.	Covered except for computer devices or program, air purifiers, air conditioners, heating pads, cold therapy units, whirlpool, exercise devices, lifts, wigs, bone simulators, devices to eliminate bed wetting.	Covered
36	Hearing Aids	Covered for children up to 18 or 21, limited to \$2,200 every 36 months	Covered for dependent children only	Covered for children up to 18 or 21	Covered. Limited to \$2,500 per hearing impaired ear every 36 months for member age 22 and older.	Covered. Limited to \$2,500 per hearing impaired ear every 36 months for member age 22 and older.	Covered. Limited to \$2,500 per hearing impaired ear every 36 months.	Covered for children up at age 22 limited to \$2,500 per year. Covered for adults age 22 and over, limited to \$2,500 every 3 years.	Covered for children up at age 22 limited to \$2,500 per year. Covered for adults age 22 and over, limited to \$2,500 every 3 years.	Covered, benefit payable per person every five years.	Covered for children up to 18 or 21
37	Diagnostic Test (X-Ray and Lab Work)	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
38	Imaging (CT/PET Scans, MRIs)	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
39	Preventive Care/ Screening/Immunization	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
40	Routine Foot Care	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

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41	Acupuncture	Covered. \$1,500 annual maximum combined with acupuncture, massage therapy, and biofeedback	Covered	Covered	Covered. Limited to 25 visits per year combined with spinal manipulation.	Covered. Limited to 25 visits per year combined with spinal manipulation.	Covered. Limited to 25 visits per year combined with spinal manipulation.	Covered. Limited to 24 visits per calendar year.	Covered. Limited to 10 visits per calendar year.	Covered. Limited to 20 procedures per calendar year.	Covered. Limited to 20 visits per year for acupuncture and chiropractic combined
42	Weight Loss Programs	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
43	Routine Eye Exam for Children	Not Covered	Covered.	Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Covered
44	Eye Glasses for Children	Not Covered	Covered	Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Covered
45	Dental Check-Up for Children	Not Covered	Covered.	Covered	Not Covered	Not Covered	Not Covered	Covered	Covered	Covered	Covered
46	TMJ Services	Covered	Covered	Covered	Covered	Covered	Covered	Not Covered	Not Covered	Not Covered	Covered
47	Dental Services Resulting From Accident	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
48	Dental Anesthesia	Covered	Covered	Covered	Not Covered	Covered	Covered	Covered	Covered	Covered	Covered