EFFECTIVE 7/1/2020 (Deductible applies unless specified as "deductible waived.")

PRESBYTERIAN and BLUE CROSS BLUE SHIELD OF NEW MEXICO (BCBSNM)

New Mexico Public Schools Insurance Authority

This is only a summary that lists the member cost-sharing amounts and provides a brief description of the NMPSIA High Option PPO Health Plan benefits. The Summary Plan Description supersedes any information outlined in this summary.

NMPSIA HIGH OPTION PPO BENEFITS

There is no overall lifetime maximum benefit. However, certain services have maximum annual limits. See below.

This is only a summary that lists the member cost-sharing amounts and provides a brief description of the NMPSIA Low Option PPO Health Plan benefits. The Summary Plan Description supersedes any information outlined in this summary.

NMPSIA LOW OPTION PPO BENEFITS

There is no overall lifetime maximum benefit. However, certain services have maximum annual limits. See below.

BCBSNM nm

This is only a summary that lists the member cost-sharing amounts and provides a brief description of the NMPSIA EPO Health Plan benefits. The Summary Plan Description supersedes any information outlined in this summary.

BLUE PREFERRED EPO (Exclusive Provider Organization) BENEFITS

There is no overall lifetime maximum benefit. However, certain services have maximum annual limits. See below.

NMPSIA MEDICAL PLAN BENEFITS	Member's Share of Covered Charges: In-Network Provider	Member's Share of Covered Charges: Out-of-Network Provider	Member's Share of Covered Charges: In-Network Provider	Member's Share of Covered Charges: Out-of-Network Provider	Member's Share of Covered Charges: Preferred Provider
Calendar Year Deductible	$750 Individual $1,500 Family	$1,500 Individual $3,000 Family	$2,000 Individual $4,000 Family	$4,000 Individual $8,000 Family	$500 Individual $1,000 Family
Annual Out-of-Pocket Limit	$3,750 Individual $7,500 Family	$9,000 Individual $18,000 Family	$3,750 Individual $7,500 Family	$9,000 Individual $18,000 Family	$3,250 Individual $6,500 Family
Office Visit / Exam Charge Office and Home visits/Exams or Consultation (Other services received during the office visits and listed under "Other Services," below, such as therapy, are subject to deductible, copay, and/or coinsurance as listed in the rest of the summary.)	(deductible waived) Office Visit Copay		(deductible waived) Office Visit Copay		(deductible waived) Office Visit Copay
Primary Preferred Provider Office/Home Visit	$30	30%	$35	50%	$25
Specialist /Office/Home Visit	$50	30%	$60	50%	$35
Telehealth (Virtual Video Visits)	$0	Not Covered	$0	Not Covered	$0
Office Surgery (including casts, splints, and dressings)	20%	30%	25%	50%	20%
Allergy Injections (only), Extract Preparation	No Charge (deductible waived)	30%	25%	50%	No Charge (deductible waived)
Therapeutic Injections: Allergy Testing	Office Visit Copay	30%	25%	50%	Office Visit Copay
Routine/Preventive Services Routine Adult Physicals and Gynecological Exams, Routine Tests (including Pap Tests, Cholesterol tests, Urinalysis, Human Papillomavirus (HPV) Screening), Colonoscopies and Mammograms (one covered at 100% annually regardless of diagnosis when in-network), Health Education Counseling (including diabetic and smoking cessation counseling), Family Planning (including insertion/removal of birth control devices, surgical sterilization in office, birth control & therapeutic injections), Immunizations (including travel immunizations); Well-Child Care; Routine Vision or Hearing Screenings through age 17	No Charge (deductible waived)	30% (deductible waived)	No Charge (deductible waived)	50% (deductible waived for routine testing only)	No Charge (deductible waived)
Acupuncture, Chiropractic (Spinal Manipulation), Massage Therapy (if medically necessary), Rolfing, **and Naprapathy** (combined max. benefit of 30 visits/calendar year)	$50 copay (deductible waived)	30%	25%	50%	$35 copay (deductible waived)
Naprapathy - Low Option Plan (Limit $500 per year)		Not Covered	$50 copay (deductible waived)	Not Covered	
Ambulance Services: Ground and Emergency Air Transport	$30 copay (deductible waived)	$30 copay (deductible waived)	25%	25%	$25 copay (deductible waived)
Ambulance Services: Inter-facility Transport	$0 (deductible waived)	$0 (deductible waived)	$0 (deductible waived)	$0 (deductible waived)	$0 (deductible waived)
Autism Spectrum Disorder Diagnosis and Treatment. Up to 90 visits per member per year (in & out-of- network combined) PCP copay for Applied Behavioral Analysis (ABA). Specialist includes outpatient physical therapy occupational therapy & speech therapy.	(deductible waived) PCP $30 copay Specialist $50 copay	30%	(deductible waived) PCP $35 copay Specialist $60 copay	50%	(deductible waived) PCP $25 copay Specialist $35 copay
Biofeedback (for specified medical conditions only)	$50 copay (deductible waived)	30%	25%	50%	$35 copay (deductible waived)
Cardiac and Pulmonary Rehabilitation (office/outpatient)	$50 copay (deductible waived)	30%	25%	50%	$35 copay (deductible waived)
Dental/Facial Accident, Oral Surgery & TMJ/CMJ Services	Varies by services	30%	25%	50%	Varies by service
Emergency Room Treatment Physician and Other Professional Provider Charges	$150 copay plus 25% coinsurance after deductible		$150 copay plus 25% coinsurance after deductible		$150 copay plus 20% after deductible
Hearing Aids and Related Services (Age 21 & older: Routine exams/testing not covered.)	Hearing Aids: No Charge up to $500; thereafter you pay 90% coinsurance in any 36 month period		Hearing Aids: No Charge up to $500; thereafter you pay 90% coinsurance in any 36 month period		Hearing Aids: No Charge up to $500; thereafter you pay 90% coinsurance in any 36 month period
Hearing Aids and Related Services (Under age 21: Exam/testing subject to usual cost-sharing.)	Hearing Aids: No Charge up to $2,200 per hearing impaired ear; thereafter you pay 90% coinsurance in any 36 month period		Hearing Aids: No Charge up to $2,200 per hearing impaired ear; thereafter you pay 90% coinsurance in any 36 month period		Hearing Aids: No Charge up to $2,200 per hearing impaired ear; thereafter you pay 90% coinsurance in any 36 month period
Home Health Care/Home I.V. Services Limitations	20% Unlimited	30% 120 visits/calendar year	25% Unlimited	50% 120 visits/calendar year	20% Unlimited
Hospice Services including respite care (limited to 10 days for each 6-month per hospice period – 2 periods per lifetime) & bereavement counseling (limited to 3 sessions during the hospice benefit period)	No charge (deductible waived)	30%	25%	50%	No charge (deductible waived)
Infertility: Diagnosis Only – No Treatment	Varies by Services	30%	Varies by Services	50%	Varies by Services
Lab, X-Ray, and Other Basic Diagnostic Tests (non-routine) (Office/Freestanding Lab or Radiology)	$30 copay or actual allowable amount, whichever is less, per day (deductible waived)	30%	$35 copay or actual allowable amount, whichever is less, per day (deductible waived)	50%	$25 copay or actual allowable amount, whichever is less, per day (deductible waived)
Lab, X-Ray, and Other Basic Diagnostic Tests (non-routine) (Outpatient Department of Hospital)	$60 copay or actual allowable amount, whichever is less, per day (deductible waived)	30%	$70 copay or actual allowable amount, whichever is less, per day (deductible waived)	50%	$50 copay or actual allowable amount, whichever is less, per day (deductible waived)
High Tech Imaging: MRI, MRA, CT Scan, PET Scan	$600 copay or 20%, whichever is less, per day (deductible waived)	30%	$700 copay or 25%, whichever is less, per day (deductible waived)	50%	$500 copay or 20%, whichever is less, per day (deductible waived)
Professional Interpretation & Reading (Lab, X-Ray, & High Tech)	No Charge	30%	No Charge	50%	No Charge
Prothrombin Time Test	$10 copay (deductible waived)	30%	$10 copay (deductible waived)	50%	$10 copay (deductible waived)
Sleep Study	20%	30%	25%	50%	20%
Inpatient Hospital/Facility Services (High Option copays are waived if you are re-admitted for the same condition within 15 days of discharge or transferred to a rehab or skilled nursing facility within 15 days of discharge from acute care facility.)					(Copays are waived if you are re-admitted for the same condition within 15 days of discharge or transferred to a rehab or skilled nursing facility within 15 days of discharge from acute care facility.)
Medical/Surgical Acute Care, and Maternity-Related Room & Board, Covered Ancillaries, Related Professional charges, Skilled Nursing Facility (max. 60 days/calendar year) Inpatient Physical Rehabilitation	$500 facility copay per admission plus 20%	30%	25%	50%	$500 facility copay per admission plus 20%
Observation Stay including Related Professional Charges	$100 facility copay plus 20%	30%	25%	50%	$100 facility copay plus 20%
Maternity Services		30%		50%	
Physician/Midwife Services (delivery, pre- and post-natal care, including lab, diagnostic testing, and pre-natal genetic testing, if medically necessary)	Office Visit Copay/Initial visit		25%		Office visit copay/Initial visit
Hospital Admission (including routine newborn nursery charges)	$500 copay per pregnancy plus 20%		25%		$500 copay per pregnancy plus 20%
Extended Stay (non-routine) Charges for covered Newborn	$500 facility copay/admission plus 20%		25%		$500 facility copay/admission plus 20%
Home Birth	20%		25%	50%	20%
Mental Health Services		30%		50%	
Office, Home, Outpatient Facility/Physician	$30 copay (deductible waived)		$35 copay (deductible waived)		$25 copay (deductible waived)
Inpatient	$500 copay plus 20%		25%		$500 copay plus 20%
Partial Hospitalization	$250 copay plus 20%		25%		$250 copay plus 20%
Facility-Based Intensive Outpatient Programs (IOP)	$125 copay plus 20%		25%		$125 copay plus 20%
Substance Abuse Rehabilitation (Lifetime-no limit of number of courses of treatment for all services combined)		30%		50%	
Office, Home, Outpatient Facility/Physician (No limit on number of days/calendar year)	$30 copay (deductible waived)		$35 copay (deductible waived)		$25 copay (deductible waived)
Inpatient (No limit on number of days/calendar year combined with Partial Hospitalization)	$500 copay plus 20%		25%		$500 copay plus 20%
Partial Hospitalization[8] (No limit on number of days/calendar year combined with Inpatient)	$250 copay plus 20%		25%		$250 copay plus 20%
Facility-Based Intensive Outpatient Programs (IOP)	$125 copay plus 20%		25%		$125 copay plus 20%
Outpatient Hospital/Facility/Ambulatory Surgery Facility (including Related Professional Charges)	$150 copay plus 20%	30%	25%	50%	$150 copay plus 20%
Residential Treatment Center (RTC): (for adults age 18 & older only) (No limit of number of days/calendar year and not limit on days per admit)	$250 copay plus 20%	30%	25%	50%	$250 copay plus 20%
Short-Term Rehabilitation, Outpatient and Office: Occupational, Physical & Speech Therapy Services	$50 copay (deductible waived) up to $500; thereafter No Charge for the remaining calendar year (Member pays $50 each visit up to a maximum of $500 per calendar year; thereafter plan pays 100% once met for the remaining calendar year.)	30%	25%	50%	$35 copay (deductible waived) up to $350; thereafter No Charge for the remaining calendar year (Member pays $35 each visit up to a maximum of $350 per calendar year; thereafter, plan pays 100% once met for the remaining calendar year.)
Smoking/Tobacco Use Cessation (includes medication, hypnotherapy, acupuncture, related tests, and any counseling programs not eligible under Preventive)	No Charge For Prescription Drugs, see your Express Scripts Plan for details.	50%	No Charge For Prescription Drugs, see your Express Scripts Plan for details.	50%	No Charge For Prescription Drugs, see your Express Scripts Plan for details.
Supplies, Durable Medical Equipment, Prosthetics & Functional Orthotics (Support hose limited to 12 pair (or 24 hose) Mastectomy Bras up to 6 per calendar year.) Prior Authorization needed for services over $1,000	20%	30%	25%	50%	20%
Insulin Pump Supplies (insertion sets, reservoirs)	No Charge (deductible waived)	30%	No Charge (deductible waived)	50%	No Charge (deductible waived)
Therapy: Chemotherapy and Radiation Therapy	No Charge (deductible waived)	30%	25%	50%	No Charge (deductible waived)
Therapy: Dialysis	20%	30%	25%	50%	20%
Transplant Services: Maximums apply to donor charges, travel and lodging. Services must be arranged and received at a facility contracted by the medical plan.	Applicable copays based on place and type of service	Not Covered	Applicable copays based on place and type of service	Not Covered	Applicable copays based on place and type of service
Urgent Care (includes all services and supplies such as xray/labs/ physician fees)	$50 copay (deductible waived)	30%	$60 copay (deductible waived)	50%	$45 copay (deductible waived)

Prescription Drugs, Insulin, Diabetic Supplies, Nutritional Products, Smoking/Tobacco Cessation Products: Administered by Express Scripts. Call Express Scripts Customer Service Center: 1-800-498-4904.