New Mexico Public Schools Insurance Authority
Side-by-Side Medical Plan Benefit Comparison Chart

Medical Summaries of Benefits Comparison These are only summaries that list the member cost-sharing amounts and provides a brief description of NMPSIA Health Plan medical benefits.
NOTE: 2021 and 2022 Benefit Summaries are both displayed here

The High and Low Option Plans are available under BlueCross BlueShield of New Mexico (BCBSNM), Cigna Health and Presbyterian Health Plan. The Exclusive Provider Organization (EPO) is only offered by BlueCross BlueShield of New Mexico.
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NMPSIA Health Plan Benefits There is no overall lifetime maximum benefit. However, certain services have maximum annual limits. **(Deductible applies unless specified as "deductible waived")** See below:	High Option PPO Benefits Member's Share of Covered Charges In-Network Provider	 Out-Of-Network Provider	Low Option PPO Benefits Member's Share of Covered Charges In-Network Provider	 Out-Of-Network Provider	EPO Benefits Member's Share of Covered Charges Preferred Provider	NMPSIA Health Plan Benefits There is no overall lifetime maximum benefit. However, certain services have maximum annual limits. **(Deductible applies unless specified as "deductible waived")** See below:
2021 Calendar Year Deductible Individual Family	$750 $1,500	$1,500 $3,000	$2,000 $4,000	$4,000 $8,000	$500 $1,000	**2021 Calendar Year Deductible** Individual Family
2022 Calendar Year Deductible Individual Family	$750 $1,500	$1,500 $3,000	$2,000 $4,000	$4,000 $8,000	$500 $1,000	**2022 Calendar Year Deductible** Individual Family
2021 Calendar Year Annual Out-Of-Pocket Limit (Includes copayments, coinsurance, and deductibles) Individual Family	$3,750 $7,500	$9,000 $18,000	$3,750 $7,500	$9,000 $18,000	$3,250 $6,500	**2021 Calendar Year Annual Out-Of-Pocket Limit** (Includes copayments, coinsurance, and deductibles) Individual Family
2022 Calendar Year Annual Out-Of-Pocket Limit (Includes copayments, coinsurance, and deductibles) Individual Family	$4,100 $8,200	$9,500 $19,000	$4,100 $8,200	$9,500 $19,000	$500 $1,000	**2022 Annual Year Out-Of-Pocket Limit** (Includes copayments, coinsurance, and deductibles) Individual Family
2021 Calendar Year 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.) **Primary Preferred Provider Office/Home Visit** **Specialist/Office/Home Visit** **Telehealth** (Cost varies dependent on specific plan details - see your health plan for more information)	Office Visit Copay *(deductible waived)* $30 $50 Varies	 30% 30% Not Covered	Office Visit Copay *(deductible waived)* $35 $60 Varies	 50% 50% Not Covered	Office Visit Copay (deductible waived) $25 $35 Varies	**2021 Calendar Year 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.) **Primary Preferred Provider Office/Home Visit** **Specialist/Office/Home Visit** **Telehealth** (Cost varies dependent on specific plan details - see your health plan for more information)
2022 Calendar Year 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.) **Primary Preferred Provider Office/Home Visit** **Specialist/Office/Home Visit** **Telehealth** (Cost varies dependent on specific plan details - see your health plan for more information)	Office Visit Copay *(deductible waived)* $25 $50 Varies	 40% 40% Not Covered	Office Visit Copay *(deductible waived)* $30 $60 Varies	 50% 50% Not Covered	Office Visit Copay *(deductible waived)* $25 $35 Varies	**2022 Calendar Year 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.) **Primary Preferred Provider Office/Home Visit** **Specialist/Office/Home Visit** **Telehealth** (Cost varies dependent on specific plan details - see your health plan for more information)
2021 Calendar Year Office Surgery (Including casts, splints, and dressings)	20%	30%	25%	50%	20%	**2021 Calendar Office Surgery** (Including casts, splints, and dressings)
2022 Calendar Year Office Surgery (Including casts, splints, and dressings)	20%	40%	25%	50%	20%	**2022 Calendar Office Surgery** (Including casts, splints, and dressings)
2021 Calendar Year Allergy injections (only), Extract Preparation	No Charge *(deductible waived)*	30%	25%	50%	No Charge *(deductible waived)*	**2021 Calendar Allergy injections** (only), Extract Preparation
2022 Calendar Year Allergy injections (only), Extract Preparation	No Charge *(deductible waived)*	40%	25%	50%	No Charge *(deductible waived)*	**2022 Calendar Allergy injections** (only), Extract Preparation
2021 Calendar Year Therapeutic injections: Allergy Testing	Office Visit Copay	30%	25%	50%	Office Visit Copay	**2021 Calendar Therapeutic injections:** Allergy Testing
2022 Calendar Year Therapeutic injections: Allergy Testing	Office Visit Copay	40%	25%	50%	Office Visit Copay	**2022 Calendar Therapeutic injections**: Allergy Testing
2021 Calendar Year 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 and therapeutic injections), Immunizations (including travel immunizations); Well-Child Care; Routine Vision or Hearing Screenings	No Charge *(deductible waived)*	30% *(deductible waived)*	No Charge *(deductible waived)*	50% *(deductible waived for routine testing only)*	No Charge *(deductible waived)*	**2021 Calendar 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 and therapeutic injections), Immunizations (including travel immunizations); Well-Child Care; Routine Vision or Hearing Screenings
2022 Calendar Year 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 and therapeutic injections), Immunizations (including travel immunizations); Well-Child Care; Routine Vision or Hearing Screenings	No Charge *(deductible waived)*	40% *(deductible waived)*	No Charge *(deductible waived)*	50% *(deductible waived for routine testing only)*	No Charge *(deductible waived)*	**2022 Calendar 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 and therapeutic injections), Immunizations (including travel immunizations); Well-Child Care; Routine Vision or Hearing Screenings
Acupuncture, Chiropractic (Spinal Manipulation), Massage Therapy (If medically necessary) **Naprapathy and Rolfing**	$50 copay *(deductible waived);* (combined max. benefit of 30 visits/calendar year)	50% Naprapathy and Rolfing Not Covered	25% (combined max. benefit of 30 visits per calendar year) $60 copay *(deductible waived)* ; (Limit $500 per year)	50% Naprapathy and Rolfing Not Covered	$35 copay *(deductible waived);* (combined max. benefit of 30 visits/calendar year)	**Acupuncture, Chiropractic (Spinal Manipulation), Massage Therapy** (If medically necessary) **Naprapathy and Rolfing**
2021 Calendar Year Ambulance Service: Ground and Emergency Air Transport	$30 copay *(deductible waived)*		25% coinsurance after deductible		$25 *(deductible waived)*	**2021 Calendar Year Ambulance Service:** Ground and Emergency Air Transport
2022 Calendar Year Ambulance Service: Ground and Emergency Air Transport	$50 copay *(deductible waived)*		25% coinsurance after deductible		$25 *(deductible waived)*	**2022 Calendar Year Ambulance Service:** Ground and Emergency Air Transport
Ambulance Services: Inter-facility Transport	$0 *(deductible waived)*		$0 *(deductible waived)*		$0 *(deductible waived)*	**Ambulance Services**: Inter-facility Transport
2021 Calendar Year Autism Spectrum Disorder 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.	PCP $30 copay Specialist $50 copay *(deductible waived)*	30%	PCP $35 copay Specialist $60 copay *(deductible waived)*	50%	PCP $25 copay Specialist $35 copay *(deductible waived)*	**2021 Calendar Year Autism Spectrum Disorder** 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.
2022 Calendar Year Autism Spectrum Disorder 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.	PCP $25 copay Specialist $50 copay *(deductible waived)*	40%	PCP $30 copay Specialist $60 copay *(deductible waived)*	50%	PCP $25 copay Specialist $35 copay *(deductible waived)*	**2022 Calendar Year Autism Spectrum Disorder** 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.
2021 Calendar Year Biofeedback (For specified medical conditions only)	$50 copay *(deductible waived)*	30%	25%	50%	$35 copay *(deductible waived)*	**2021 Calendar Year Biofeedback** (For specified medical conditions only)
2022 Calendar Year Biofeedback (For specified medical conditions only)	$50 copay *(deductible waived)*	40%	25%	50%	$35 copay *(deductible waived)*	**2022 Calendar Year Biofeedback** (For specified medical conditions only)

New Mexico Public Schools Insurance Authority
Side-by-Side Medical Plan Benefit Comparison Chart

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NMPSIA Health Plan Benefits There is no overall lifetime maximum benefit. However, certain services have maximum annual limits. **(Deductible applies unless specified as "deductible waived")** See below:	High Option PPO Benefits Member's Share of Covered Charges In-Network Provider	 Out-Of-Network Provider	Low Option PPO Benefits Member's Share of Covered Charges In-Network Provider	 Out-Of-Network Provider	EPO Benefits Member's Share of Covered Charges Preferred Provider	NMPSIA Health Plan Benefits There is no overall lifetime maximum benefit. However, certain services have maximum annual limits. **(Deductible applies unless specified as "deductible waived")** See below:
2021 Calendar Year Cardiac and Pulmonary Rehabilitation (Office/Outpatient)	$50 copay *(deductible waived)*	30%	25%	50%	$35 copay *(deductible waived)*	**2021 Calendar Year Cardiac and Pulmonary Rehabilitation** (Office/Outpatient)
2022 Calendar Year Cardiac and Pulmonary Rehabilitation (Office/Outpatient)	$50 copay *(deductible waived)*	40%	25%	50%	$35 copay *(deductible waived)*	**2022 Calendar Year Cardiac and Pulmonary Rehabilitation** (Office/Outpatient)
2021 Calendar Year Dental/Facial Accident, Oral Surgery & TMJ/CMJ Services	Varies by Services	30%	25%	50%	Varies by Services	**2021 Calendar Year Dental/Facial Accident, Oral Surgery & TMJ/CMJ Services**
2022 Calendar Year Dental/Facial Accident, Oral Surgery & TMJ/CMJ Services	Varies by Services	40%	25%	50%	Varies by Services	**2022 Calendar Year Dental/Facial Accident, Oral Surgery & TMJ/CMJ Services**
2021 Calendar Year Emergency Room Treatment Physician and other professional provider charges	$150 copay plus 20% coinsurance after deducible		$150 copay plus 25% coinsurance after deducible		$150 copay plus 20% coinsurance after deducible	**2021 Calendar Year Emergency Room Treatment** Physician and other professional provider charges
2022 Calendar Year Emergency Room Treatment Physician and other professional provider charges	$450 copay after deductible		$450 copay after deductible		$150 copay plus 20% coinsurance after deducible	**2022 Calendar Year Emergency Room Treatment** Physician and other professional provider charges
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** (Age 21 & older: Routine exams testing not covered)
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	**Hearing Aids and Related Services** (**Under age 21:** Exam testing subject to usual cost-sharing)
2021 Calendar Year Home Health Care/Home I.V. Services Limitations	20% Unlimited	30% 120 visits per calendar year	25% Unlimited	50% 120 visits per calendar year	20% Unlimited	**2021 Calendar Year Home Health Care/Home I.V. Services** Limitations
2022 Calendar Year Home Health Care/Home I.V. Services Limitations	20% Unlimited	40% 120 visits per calendar year	25% Unlimited	50% 120 visits per calendar year	20% Unlimited	**2022 Calendar Year Home Health Care/Home I.V. Services** Limitations
2021 Calendar Year 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)*	**2021 Calendar Year 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)
2022 Calendar Year 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)*	40%	25%	50%	No charge *(deductible waived)*	**2022 Calendar Year 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)
2021 Calendar Year Infertility: Diagnosis Only - No Treatment	Varies by services	30%	Varies by services	50%	Varies by services	**2021 Calendar Year Infertility: Diagnosis Only - No Treatment**
2022 Calendar Year Infertility: Diagnosis Only - No Treatment	Varies by services	40%	Varies by services	50%	Varies by services	**2022 Calendar Year Infertility: Diagnosis Only - No Treatment**
2021 Calendar Year Lab, X-Ray, and other Basic Diagnostic Tests - non-routine (Office/Freestanding Lab or Radiology Facility)	$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)*	**2021 Calendar Year Lab, X-Ray, and other Basic Diagnostic Tests** - non-routine (Office/Freestanding Lab or Radiology Facility)
2022 Calendar Year Lab, X-Ray, and other Basic Diagnostic Tests - non-routine (Office/Freestanding Lab or Radiology Facility)	$30 copay or actual allowable amount, whichever is less per day *(deductible waived)*	40%	$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)*	**2022 Calendar Year Lab, X-Ray, and other Basic Diagnostic Tests** - non-routine (Office/Freestanding Lab or Radiology Facility)
2021 Calendar Year 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)*	**2021 Calendar Year Lab, X-Ray, and other Basic Diagnostic Tests** - non-routine (Outpatient Department of Hospital)
2022 Calendar Year 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)*	40%	$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)*	**2022 Calendar Year Lab, X-Ray, and other Basic Diagnostic Tests** - non-routine (Outpatient Department of Hospital)
2021 Calendar Year 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)*	**2021 Calendar Year High Tech Imaging: MRI, MRA, CT Scan, PET Scan**
2022 Calendar Year High Tech Imaging: MRI, MRA, CT Scan, PET Scan	$600 copay or 20%, whichever is less per day *(deductible waived)*	40%	$700 copay or 25%, whichever is less per day *(deductible waived)*	50%	$500 copay or 20%, whichever is less per day *(deductible waived)*	**2022 Calendar Year High Tech Imaging: MRI, MRA, CT Scan, PET Scan**
2021 Calendar Year Prothrombin Time Test	$10 copay *(deductible waived)*	30%	$10 copay *(deductible waived)*	50%	$10 copay *(deductible waived)*	**2021 Calendar Year Prothrombin Time Test**
2022 Calendar Year Prothrombin Time Test	$10 copay *(deductible waived)*	40%	$10 copay *(deductible waived)*	50%	$10 copay *(deductible waived)*	**2022 Calendar Year Prothrombin Time Test**
2021 Calendar Year Sleep Study	20%	30%	25%	50%	20%	**2021 Calendar Year Sleep Study**
2022 Calendar Year Sleep Study	20%	40%	25%	50%	20%	**2022 Calendar Year Sleep Study**
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 an acute care facility			**Inpatient Hospital/Facility Services** (Low and EPO 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 an acute care facility			
2021 Calendar Year 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/admission plus 20%	30% coinsurance after deductible	25%	50%	$500 facility copay/admission plus 20%	**2021 Calendar Year 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**
2022 Calendar Year 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**	20% coinsurance after deductible	40% coinsurance after deductible	25%	50%	$500 facility copay/admission plus 20%	**2022 Calendar Year 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**
2021 Calendar Year Observation Stay including Related Professional Charges	$100 facility copay plus 20%	30%	25%	50%	$100 facility copay plus 20%	**2021 Calendar Year Observation Stay** including Related Professional Charges
2022 Calendar Year Observation Stay including Related Professional Charges	$100 facility copay plus 20%	40%	25%	50%	$100 facility copay plus 20%	**2022 Calendar Year Observation Stay** including Related Professional Charges

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Maternity Services			**Maternity Services**			
2021 Calendar Year Physicians Midwife Services (Delivery, pre- and post-natal care, including lab, diagnostic testing, and pre-natal genetic testing, if medically necessary)	$30 Office Visit Copay/Initial Visit	30%	25%	50%	$25 Office Visit Copay/Initial Visit	**2021 Calendar Year Physicians Midwife Services** (Delivery, pre- and post-natal care, including lab, diagnostic testing, and pre-natal genetic testing, if medically necessary)
2022 Calendar Year Physicians Midwife Services (Delivery, pre- and post-natal care, including lab, diagnostic testing, and pre-natal genetic testing, if medically necessary)	$25 Office Visit Copay/Initial Visit	40%	25%	50%	$25 Office Visit Copay/Initial Visit	**2022 Calendar Year Physicians Midwife Services** (Delivery, pre- and post-natal care, including lab, diagnostic testing, and pre-natal genetic testing, if medically necessary)
2021 Calendar Year Hospital Admission (Including routine newborn nursery charges)	$500 copay per pregnancy plus 20%	30%	25%	50%	$500 copay per pregnancy plus 20%	**2021 Calendar Year Hospital Admission** (Including routine newborn nursery charges)
2022 Calendar Year Hospital Admission (Including routine newborn nursery charges)	20% coinsurance after deductible	40%	25%	50%	$500 copay per pregnancy plus 20%	**2022 Calendar Year Hospital Admission** (Including routine newborn nursery charges)
2021 Calendar Year Extended Stay (non-routine) Charges for covered Newborn	$500 facility copay/admission plus 20%	30%	25%	50%	$500 facility copay/admission plus 20%	**2021 Calendar Year Extended Stay** (non-routine) Charges for covered Newborn
2022 Calendar Year Extended Stay (non-routine) Charges for covered Newborn	20% coinsurance after deductible	40%	25%	50%	$500 facility copay/admission plus 20%	**2022 Calendar Year Extended Stay** (non-routine) Charges for covered Newborn
2021 Calendar Year Home Birth	20%	30%	25%	50%	20%	**2021 Calendar Year Home Birth**
2022 Calendar Year Home Birth	20%	40%	25%	50%	20%	**2022 Calendar Year Home Birth**
Mental Health Services			**Mental Health Services**			
2021 Calendar Year Office, Home, Outpatient Facility/Physician	$30 copay *(deductible waived)*	30%	$35 copay *(deductible waived)*	50%	$25 copay *(deductible waived)*	**2021 Calendar Year Office, Home, Outpatient Facility/Physician**
2022 Calendar Year Office, Home, Outpatient Facility/Physician	No Charge	No Charge	No Charge	No Charge	No Charge	**2022 Calendar Year Office, Home, Outpatient Facility/Physician**
2021 Calendar Year Inpatient	$500 copay plus 20%	30%	25%	50%	$500 copay plus 20%	**2021 Calendar Year Inpatient**
2022 Calendar Year Inpatient	No Charge	No Charge	No Charge	No Charge	No Charge	**2022 Calendar Year Inpatient**
2021 Calendar Year Partial Hospitalization	$250 copay plus 20%	30%	25%	50%	$250 copay plus 20%	**2021 Calendar Year Partial Hospitalization**
2022 Calendar Year Partial Hospitalization	No Charge	No Charge	No Charge	No Charge	No Charge	**2022 Calendar Year Partial Hospitalization**
2021 Calendar Year Facility-Based Intensive Outpatient Programs (IOP)	$125 copay plus 20%	30%	25%	50%	$125 copay plus 20%	**2021 Calendar Year Facility-Based Intensive Outpatient Programs (IOP)**
2022 Calendar Year Facility-Based Intensive Outpatient Programs (IOP)	No Charge	No Charge	No Charge	No Charge	No Charge	**2022 Calendar Year Facility-Based Intensive Outpatient Programs (IOP)**
Substance Abuse Rehabilitation (Lifetime-no limit on number of courses of treatment for all services combined)			**Substance Abuse Rehabilitation** (Lifetime - no limit on number of courses of treatment for all services combined			
2021 Calendar Year Office, Home, Outpatient Facility/Physician (No limit on number of days/calendar year)	$30 copay *(deductible waived)*	30%	$35 copay *(deductible waived)*	50%	$25 copay *(deductible waived)*	**2021 Calendar Year Office, Home, Outpatient Facility/Physician** (No limit on number of days/calendar year)
2022 Calendar Year Office, Home, Outpatient Facility/Physician (No limit on number of days/calendar year)	No Charge	No Charge	No Charge	No Charge	No Charge	**2022 Calendar Year Office, Home, Outpatient Facility/Physician** (No limit on number of days/calendar year)
2021 Calendar Year Inpatient (No limit on number of days/calendar year)	$500 copay plus 20%	30%	25%	50%	$500 copay plus 20%	**2021 Calendar Year Inpatient** (No limit on number of days/calendar year)
2022 Calendar Year Inpatient (No limit on number of days/calendar year)	No Charge	No Charge	No Charge	No Charge	No Charge	**2022 Calendar Year Inpatient** (No limit on number of days/calendar year)
2021 Calendar Year Partial Hospitalization (No limit on number of days/calendar year combined with Inpatient)	$250 copay plus 20%	30%	25%	50%	$250 copay plus 20%	**2021 Calendar Year Partial Hospitalization** (No limit on number of days/calendar year combined with Inpatient)
2022 Calendar Year Partial Hospitalization (No limit on number of days/calendar year combined with Inpatient)	No Charge	No Charge	No Charge	No Charge	No Charge	**2022 Calendar Year Partial Hospitalization** (No limit on number of days/calendar year combined with Inpatient)
2021 Calendar Year Facility-Based Intensive Outpatient Programs (IOP)	$125 copay plus 20%	30%	25%	50%	$125 copay plus 20%	**2021 Calendar Year Facility-Based Intensive Outpatient Programs (IOP)**
2022 Calendar Year Facility-Based Intensive Outpatient Programs (IOP)	No Charge	No Charge	No Charge	No Charge	No Charge	**2022 Calendar Year Facility-Based Intensive Outpatient Programs (IOP)**
2021 Calendar Year Outpatient Hospital/Facility/Ambulatory Surgery Facility (Including Related Professional Charges)	$150 copay plus 20%	30%	25%	50%	$150 copay plus 20%	**2021 Calendar Year Outpatient Hospital/Facility/Ambulatory Surgery Facility** (Including Related Professional Charges)
2022 Calendar Year Outpatient Hospital/Facility/Ambulatory Surgery Facility (Including Related Professional Charges)	20% coinsurance after deductible	40%	25%	50%	$150 copay plus 20%	**2022 Calendar Year Outpatient Hospital/Facility/Ambulatory Surgery Facility** (Including Related Professional Charges)
2021 Calendar Year Residential Treatment Center (RTC): (For adults age 18 & older only) (No limit on number of days/calendar year and no limit on days/admit)	$250 copay plus 20%	30%	25%	50%	$250 copay plus 20%	**2021 Calendar Year Residential Treatment Center (RTC):** (For adults age 18 & older only) (No limit on number of days/calendar year and no limit on days/admit)
2022 Calendar Year Residential Treatment Center (RTC): (For adults age 18 & older only) (No limit on number of days/calendar year and no limit on days/admit)	No Charge	No Charge	No Charge	No Charge	No Charge	**2022 Calendar Year Residential Treatment Center (RTC):** (For adults age 18 & older only) (No limit on number of days/calendar year and no limit on days/admit)
2021 Calendar Year 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	30%	25%	50%	$35 copay *(deductible waived)* up to $350; thereafter No Charge for the remaining calendar year	**2021 Calendar Year Short-Term Rehabilitation, Outpatient and Office: Occupational, Physical & Speech Therapy Services**
2022 Calendar Year 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	40%	25%	50%	$35 copay *(deductible waived)* up to $350; thereafter No Charge for the remaining calendar year	**2022 Calendar Year Short-Term Rehabilitation, Outpatient and Office: Occupational, Physical & Speech Therapy Services**
Smoking/Tobacco Use Cessation (Includes medication, hypnotherapy, acupuncture, related tests, and any counseling programs not eligible under Routine/Preventive Services)	No Charge For Prescription Drugs, see your Express Scripts Plan for details	50% For Prescription Drugs, see your Express Scripts Plan for details	No Charge For Prescription Drugs, see your Express Scripts Plan for details	50% For Prescription Drugs, see your Express Scripts Plan for details	No Charge For Prescription Drugs, see your Express Scripts Plan for details	**Smoking/Tobacco Use Cessation** (Includes medication, hypnotherapy, acupuncture, related tests, and any counseling programs not eligible under Routine/Preventive Services)

New Mexico Public Schools Insurance Authority
Side-by-Side Medical Plan Benefit Comparison Chart

Medical Summaries of Benefits Comparison These are only summaries that list the member cost-sharing amounts and provides a brief description of NMPSIA Health Plan medical benefits.
NOTE: 2021 and 2022 Benefit Summaries are both displayed here

The High and Low Option Plans are available under BlueCross BlueShield of New Mexico (BCBSNM), Cigna Health and Presbyterian Health Plan. The Exclusive Provider Organization (EPO) is only offered by BlueCross BlueShield of New Mexico.
The Summary Plan Descriptions supersede any information outlined in this summary.

NMPSIA Health Plan Benefits There is no overall lifetime maximum benefit. However, certain services have maximum annual limits. **(Deductible applies unless specified as "deductible waived")** See below:	High Option PPO Benefits Member's Share of Covered Charges		Low Option PPO Benefits Member's Share of Covered Charges		EPO Benefits Member's Share of Covered Charges	NMPSIA Health Plan Benefits There is no overall lifetime maximum benefit. However, certain services have maximum annual limits. **(Deductible applies unless specified as "deductible waived")** See below:
	In-Network Provider	Out-Of-Network Provider	In-Network Provider	Out-Of-Network Provider	Preferred Provider	
2021 Calendar Year 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%	**2021 Calendar Year 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
2022 Calendar Year 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%	40%	25%	50%	20%	**2022 Calendar Year 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
2021 Calendar Year Insulin Pump Supplies (Insertion sets, reservoirs)	No Charge *(deductible waived)*	30%	No Charge *(deductible waived)*	50%	No Charge *(deductible waived)*	**2021 Calendar Year Insulin Pump Supplies** (Insertion sets, reservoirs)
2022 Calendar Year Insulin Pump Supplies (Insertion sets, reservoirs)	No Charge *(deductible waived)*	40%	No Charge *(deductible waived)*	50%	No Charge *(deductible waived)*	**2022 Calendar Year Insulin Pump Supplies** (Insertion sets, reservoirs)
2021 Calendar Year Therapy: Chemotherapy and Radiation Therapy	No Charge *(deductible waived)*	30%	25%	50%	No Charge *(deductible waived)*	**2021 Calendar Year Therapy: Chemotherapy and Radiation Therapy**
2022 Calendar Year Therapy: Chemotherapy and Radiation Therapy	No Charge *(deductible waived)*	40%	25%	50%	No Charge *(deductible waived)*	**2022 Calendar Year Therapy: Chemotherapy and Radiation Therapy**
2021 Calendar Year Therapy: Dialysis	20%	30%	25%	50%	20%	**2021 Calendar Year Therapy: Dialysis**
2022 Calendar Year Therapy: Dialysis	20%	40%	25%	50%	20%	**2022 Calendar Year Therapy: Dialysis**
Transplant Services Maximums apply to donor charges, travel, and lodging. Services must be received at a facility that contracts with the plan or with a national transplant network approved by the 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	**Transplant Services** Maximums apply to donor charges, travel, and lodging. Services must be received at a facility that contracts with the plan or with a national transplant network approved by the plan.
2021 Calendar Year Urgent Care (Includes all services and supplies such as x-ray/labs/ physician fees)	$50 copay *(deductible waived)*	30%	$60 copay *(deductible waived)*	50%	$45 copay *(deductible waived)*	**2021 Calendar Year Urgent Care** (Includes all services and supplies such as x-ray/labs/ physician fees)
2022 Calendar Year Urgent Care (Includes all services and supplies such as x-ray/labs/ physician fees)	$50 copay *(deductible waived)*	40%	$60 copay *(deductible waived)*	50%	$45 copay *(deductible waived)*	**2022 Calendar Year Urgent Care** (Includes all services and supplies such as x-ray/labs/ physician fees)
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			**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			