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

These are only summaries that list the member cost-sharing amounts and provides a brief description of NMPSIA Health Plan medical benefits.
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")***	**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**
See below:	**In-Network Provider**	**Out-Of-Network Provider**	**In-Network Provider**	**Out-Of-Network Provider**	**Preferred Provider (Narrow Network)**
Calendar Year Deductible **Individual** **Family**	**$750** **$1,500**	**$1,500** **$3,000**	**$2,000** **$4,000**	**$4,000** **$8,000**	**$500** **$1,000**
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**	**$3,250** **$6,500**
Office Visit/Exam Charge Office and Home Visits/Exams or Consultation *(Other services received during the office visits listed 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** *(Virtual video visit access. * **Cost varies dependent on specific plan details - see your health plan for more information.**)*	**Office Visit Copay** ***(deductible waived)*** **$25** **$50** **$0***	 **40%** **40%** **Not Covered**	**Office Visit Copay** ***(deductible waived)*** **$30** **$60** **$0***	 **50%** **50%** **Not Covered**	**Office Visit Copay** ***(deductible waived)*** **$25** **$35** **$0***
Office Surgery *(Including casts, splints, and dressings)*	**20%**	**40%**	**25%**	**50%**	**20%**
Allergy injections (*only*), Extract Preparation	**No Charge** ***(deductible waived)***	**40%**	**25%**	**50%**	**No Charge** ***(deductible waived)***
Therapeutic Injections: Allergy Testing	**$25**	**40%**	**25%**	**50%**	**$25**
Routine/Preventive Services *(included but not limited to the following)* Routine Adult Physicals and Gynecological Exams, Routine Tests *(including Pap Tests, Cholesterol tests, Urinalysis, Human Papillomavirus (HPV) Screening);* Colonoscopies (*one covered at 100% annually regardless of diagnosis when in-network);* **Mammograms** ***(no charge for breast imaging);*** 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)***
Acupuncture and Massage Therapy *(when medically necessary)* *(combined max. benefit of 30 visits/calendar year)* **Naprapathy and Rolfing** *(when medically necessary)* *(combined max. benefit of 30 visits/calendar year)*	**$50 copay** ***(deductible waived)***	**40%** **Naprapathy and Rolfing Not Covered**	**25%** **$50 copay** *(deductible waived)* **(Limit $500 per year)**	**50%** **Naprapathy and Rolfing Not Covered**	**$35 copay** ***(deductible waived)***
Chiropractic (Spinal Manipulation) *(when medically necessary)* *(combined max. benefit of 30 visits/calendar year)*	**$25 copay** ***(deductible waived)***	**40%**	**$30 copay** ***(deductible waived)***	**50%**	**$25 copay** ***(deductible waived)***
Ambulance Service: Ground and Emergency Air Transport	**$50 copay** ***(deductible waived)***		**25% coinsurance after deductible**		**$25** ***(deductible waived)***
Ambulance Services: Inter-facility Transport	**$0** ***(deductible waived)***		**$0** ***(deductible waived)***		**$0** ***(deductible waived)***

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

These are only summaries that list the member cost-sharing amounts and provides a brief description of NMPSIA Health Plan medical benefits.
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")***	**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**
See below:	**In-Network Provider**	**Out-Of-Network Provider**	**In-Network Provider**	**Out-Of-Network Provider**	**Preferred Provider (Narrow Network)**
Autism Spectrum Disorder Applied Behavioral Analysis (ABA). Specialist includes outpatient physical therapy, occupational therapy & speech therapy.	**No Charge**	**40%**	**No Charge**	**50%**	**No Charge**
Biofeedback *(For specified medical conditions only)*	**$50 copay** ***(deductible waived)***	**40%**	**25%**	**50%**	**$35 copay** ***(deductible waived)***
Cardiac and Pulmonary Rehabilitation (Office/Outpatient)	**$50 copay** ***(deductible waived)***	**40%**	**25%**	**50%**	**$35 copay** ***(deductible waived)***
Dental/Facial Accident, Oral Surgery & TMJ/CMJ Services	**Varies by Services**	**40%**	**25%**	**50%**	**Varies by Services**
Emergency Room Treatment Physician and other professional provider charges	**$450 copay** ***(deductible waived)***		**$450 copay** **after deductible**		**$150 copay** **plus 20% coinsurance** **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**	**40%** **120 visits per calendar year**	**25%** **Unlimited**	**50%** **120 visits per 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)***	**40%**	**25%**	**50%**	**No charge** ***(deductible waived)***
Infertility: Diagnosis <u>Testing</u> Only - No Treatment	**Varies by services**	**40%**	**Varies by services**	**50%**	**Varies by services**
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)***
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)***

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

These are only summaries that list the member cost-sharing amounts and provides a brief description of NMPSIA Health Plan medical benefits.
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")***	**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**
See below:	**In-Network Provider**	**Out-Of-Network Provider**	**In-Network Provider**	**Out-Of-Network Provider**	**Preferred Provider (Narrow Network)**
High Tech Imaging: MRI, MRA, CT Scan, PET Scan ***(No charge for breast imaging)***	**$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)***
Professional Interpretation & Reading (Lab, X-Ray, & High Tech)	**No Charge**	**40%**	**No Charge**	**50%**	**No Charge**
Prothrombin Time Test	**$10 copay** ***(deductible waived)***	**40%**	**$10 copay** ***(deductible waived)***	**50%**	**$10 copay** ***(deductible waived)***
Sleep Study	**20%**	**40%**	**25%**	**50%**	**20%**
Inpatient Hospital/Facility Services	(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.)				
Medical/Surgical Acute Care and Maternity-Related Room & Board *(Covered Ancillaries and 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%**
Observation Stay including Related Professional Charges	**$100 facility copay plus 20%**	**40%**	**25%**	**50%**	**$100 facility copay plus 20%**
Maternity Services					
Physicians Midwife Services *(Delivery, pre- and post-natal care, including lab, diagnostic testing, and pre-natal genetic testing, when medically necessary)*	**$25 Office Visit Copay/Initial Visit**	**40%**	**25%**	**50%**	**$25 Office Visit Copay/Initial Visit**
Hospital Admission *(Including routine newborn nursery charges)*	**20% coinsurance after deductible**	**40%**	**25%**	**50%**	**$500 copay per pregnancy plus 20%**
Extended Stay - (non-routine) ***Charges for covered Newborn***	**20% coinsurance after deductible**	**40%**	**25%**	**50%**	**$500 facility copay/admission plus 20%**
Home Birth	**20%**	**40%**	**25%**	**50%**	**20%**
Mental Health Services					
Office, Home, Outpatient Facility/Physician	**No Charge**	**40%**	**No Charge**	**50%**	**No Charge**
Inpatient	**No Charge**	**40%**	**No Charge**	**50%**	**No Charge**
Partial Hospitalization	**No Charge**	**40%**	**No Charge**	**50%**	**No Charge**
Facility-Based Intensive Outpatient Programs (IOP)	**No Charge**	**40%**	**No Charge**	**50%**	**No Charge**

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

These are only summaries that list the member cost-sharing amounts and provides a brief description of NMPSIA Health Plan medical benefits.
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")***	**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**
See below:	**In-Network Provider**	**Out-Of-Network Provider**	**In-Network Provider**	**Out-Of-Network Provider**	**Preferred Provider (Narrow Network)**
Substance Abuse Rehabilitation (Lifetime-no limit on number of courses of treatment for all services combined)					
Office, Home, Outpatient Facility/Physician *(No limit on number of days/calendar year)*	**No Charge**	**40%**	**No Charge**	**50%**	**No Charge**
Inpatient *(No limit on number of days/calendar year)*	**No Charge**	**40%**	**No Charge**	**50%**	**No Charge**
Partial Hospitalization *(No limit on number of days/combined with Inpatient)*	**No Charge**	**40%**	**No Charge**	**50%**	**No Charge**
Facility-Based Intensive Outpatient Programs (IOP)	**No Charge**	**40%**	**No Charge**	**50%**	**No Charge**
Residential Treatment Center					
Residential Treatment Center (RTC): *(For adults age 18 & older only)* *(No limit on number of days/and no limit on days/admit)*	**No Charge**	**40%**	**No Charge**	**50%**	**No Charge**
Outpatient Hospital/Facility/Ambulatory Surgery Facility *(Including Related Professional Charges)*	**20% coinsurance after deductible**	**40%**	**25%**	**50%**	**$150 copay plus 20%**
Short-Term Rehabilitation **Outpatient and Office: Occupational, Physical & Speech Therapy Services**	**$25 copay** ***(deductible waived)*** **up to $250; thereafter No Charge for the remaining calendar year**	**40%**	**$30** **(deductible waived)**	**50%**	**$25 copay** ***(deductible waived)*** **up to $250; thereafter No Charge for the remaining calendar year**
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 CVS Plan for details**	**50% For Prescription Drugs, see your CVS Plan for details**	**No Charge For Prescription Drugs, see your CVS Plan for details**	**50% For Prescription Drugs, see your CVS Plan for details**	**No Charge For Prescription Drugs, see your CVS Plan for details**
Supplies, Durable Medical Equipment, Prosthetics & Functional Orthotics ***Prior Authorization needed for services over $1,000*** *(Support hose limited to 12 pair (or 24 hose) and Mastectomy Bras up to 6 per calendar year)* ***Prosthetics and/or orthotics are not subject to financial penalties or greater restrictions than other medical services.***	**20%**	**40%**	**25%**	**50%**	**20%**
Insulin Pump Supplies and Glucose Meters *(Insertion sets and reservoirs)*	**No Charge** ***(deductible waived)***	**40%**	**No Charge** ***(deductible waived)***	**50%**	**No Charge** ***(deductible waived)***
Therapy: Chemotherapy and Radiation Therapy	**No Charge** ***(deductible waived)***	**40%**	**25%**	**50%**	**No Charge** ***(deductible waived)***

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

These are only summaries that list the member cost-sharing amounts and provides a brief description of NMPSIA Health Plan medical benefits.
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")***	**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**
See below:	**In-Network Provider**	**Out-Of-Network Provider**	**In-Network Provider**	**Out-Of-Network Provider**	**Preferred Provider (Narrow Network)**
Therapy: Dialysis	**20%**	**40%**	**25%**	**50%**	**20%**
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**
Urgent Care *(Includes all services and supplies such as the facility's x-ray, labs, physician fees)*	**$50 copay** ***(deductible waived)***	**40%**	**$60 copay** ***(deductible waived)***	**50%**	**$45 copay** ***(deductible waived)***

Prescription Drugs, Insulin, Diabetic Supplies, Nutritional Products, Smoking/Tobacco Cessation Products:
Administered by CVS Caremark. **Call CVS Caremark Customer Service Center: 1-877-787-0652.**
(No charge for drugs used to treat behavioral health conditions)

Prescription Drug Annual Out-Of-Pocket Limit *(Includes copayments and coinsurance)*	**$3,000/Individual** **$6,000/Family**	**$3,000/Individual** **$6,000/Family**	**$3,100/Individual** **$6,200/Family**
Prescription Specialty Drugs ***(No charge for drugs used to treat behavioral health conditions)***	Specialty drugs must be filled via the CVS Specialty pharmacy that offers the **PrudentRx Copay Assistance Program at 1-800-578-4403**. • Specialty drugs require preauthorization by calling **CVS Caremark Specialty Pharmacy at 1-866-387-2573**. For most specialty drugs, the contracted specialty drug mail-order pharmacy is required after two fills at retail. In certain cases, specialty drugs are covered only at the contracted mail order pharmacy. • Specialty drugs that are essential health benefits and obtained from in-network retail and mail order locations accumulate to the Outpatient Drug Out-of-Pocket Limit. Members may qualify for Specialty drug copayment assistance available via enrollment in the PrudentRx program for certain Specialty drugs. **To enroll, contact PrudentRx at 1-800-578-4403**. Non-essential health benefit specialty pharmacy drugs under the PrudentRx program do not accumulate to the Outpatient Drug Out-of-Pocket Limit.		