New Mexico Public Schools Insurance Authority

NMPSIA Wellness

2022

Medical Plan
Side-by-Side Comparison Chart

High Option
Low Option
Exclusive Provider Organization (EPO)

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")	**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 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** (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 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)***
Acupuncture, Chiropractic (Spinal Manipulation), and Massage Therapy (If medically necessary) (combined max. benefit of 30 visits/calendar year) **Naprapathy and Rolfing** (combined max. benefit of 30 visits/calendar year) (Not covered out-of-network)	**$50 copay** ***(deductible waived)***	**40%** **Naprapathy and Rolfing Not Covered**	**25%** **$50 copay Naprapathy & Rolfing** ***(deductible waived*** **(Limit $500 per year)**	**50%** **Naprapathy and Rolfing Not Covered**	**$35 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)***
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)***

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See below:	**In-Network Provider**	**Out-Of-Network Provider**	**In-Network Provider**	**Out-Of-Network Provider**	**Preferred Provider (Narrow Network)**
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 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)***
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)***
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%**

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See below:	**In-Network Provider**	**Out-Of-Network Provider**	**In-Network Provider**	**Out-Of-Network Provider**	**Preferred Provider (Narrow Network)**
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, 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, if 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**
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**

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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 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**
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%**
Insulin Pump Supplies (Insertion sets, 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)***
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 x-ray/labs/ physician fees)	**$50 copay *(deductible waived)***	**40%**	**$60 copay *(deductible waived)***	**50%**	**$45 copay *(deductible waived)***

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Prescription Drugs, Insulin, Diabetic Supplies, Nutritional Products, Smoking/Tobacco Cessation Products: Administered by CVS Caremark. Visit Caremark.com or call CVS Customer Care: 1-877-787-0652					
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	Speciality drugs must be filled via the **CVS Speciality** pharmacy that offers the **PrudentRx Copay Assistance Program at 1-800-578-4403**. • Specialty drugs require preauthorization by calling CVS Carenark at **1-877-787-0652**. 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.				