



**New Mexico
Public Schools
Insurance
Authority**



NMPSIA
Wellness

2023

**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

These are only summaries that list the member cost-sharing amounts and provides a brief description of NMPSIA Health Plan medical benefits.
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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
	In-Network Provider	Out-Of-Network Provider	In-Network Provider	Out-Of-Network Provider	Preferred Provider (Narrow Network)
See below:					
Calendar Year Deductible					
Individual	\$750	\$1,500	\$2,000	\$4,000	\$500
Family	\$1,500	\$3,000	\$4,000	\$8,000	\$1,000
Annual Out-Of-Pocket Limit (Includes copayments, coinsurance, and deductibles)					
Individual	\$4,100	\$9,500	\$4,100	\$9,500	\$3,250
Family	\$8,200	\$19,000	\$8,200	\$19,000	\$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.)	Office Visit Copay (deductible waived)		Office Visit Copay (deductible waived)		Office Visit Copay (deductible waived)
Primary Preferred Provider Office/Home Visit	\$25	40%	\$30	50%	\$25
Specialist/Office/Home Visit	\$50	40%	\$60	50%	\$35
Telehealth (Virtual video visit access. *Cost varies dependent on specific plan details - see your health plan for more information.)	\$0*	Not Covered	\$0*	Not Covered	\$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)	\$50 copay (deductible waived)	40%	25%	50%	\$35 copay (deductible waived)
Naprapathy and Roling (combined max. benefit of 30 visits/calendar year) (Not covered out-of-network)		Naprapathy and Roling Not Covered	\$50 copay Naprapathy & Roling (deductible waived) (Limit \$500 per year)	Naprapathy and Roling Not Covered	
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:					
Cardiac and Pulmonary Rehabilitation (Office/Outpatient)	\$50 copay <i>(deductible waived)</i>	40%	25%	50%	\$35 copay <i>(deductible waived)</i>
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 <i>(deductible waived)</i>		\$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 <i>(deductible waived)</i>	40%	25%	50%	No Charge <i>(deductible waived)</i>
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 <i>(deductible waived)</i>	40%	\$35 copay or actual allowable amount, whichever is less per day <i>(deductible waived)</i>	50%	\$25 copay or actual allowable amount, whichever is less per day <i>(deductible waived)</i>
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 <i>(deductible waived)</i>	40%	\$70 copay or actual allowable amount, whichever is less per day <i>(deductible waived)</i>	50%	\$50 copay or actual allowable amount, whichever is less per day <i>(deductible waived)</i>
High Tech Imaging: MRI, MRA, CT Scan, PET Scan	\$600 copay or 20%, whichever is less per day <i>(deductible waived)</i>	40%	\$700 copay or 25%, whichever is less per day <i>(deductible waived)</i>	50%	\$500 copay or 20%, whichever is less per day <i>(deductible waived)</i>
Professional Interpretation & Reading (Lab, X-Ray, & High Tech)	No Charge	40%	No Charge	50%	No Charge
Prothrombin Time Test	\$10 copay <i>(deductible waived)</i>	40%	\$10 copay <i>(deductible waived)</i>	50%	\$10 copay <i>(deductible waived)</i>
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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	In-Network Provider	Out-Of-Network Provider	In-Network Provider	Out-Of-Network Provider	Preferred Provider (Narrow Network)
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 (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	<p>Specialty drugs must be filled via the CVS Specialty pharmacy that offers the PrudentRx Copay Assistance Program at 1-800-578-4403.</p> <ul style="list-style-type: none"> • Specialty drugs require preauthorization by calling CVS Caremark 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. <p>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 <i>do not</i> accumulate to the Outpatient Drug Out-of-Pocket Limit.</p>		