Albuquerque Public Schools

Administered by:

Blue Cross and Blue Shield of New Mexico

Plan Highlights 2019

Lists copayments, deductible, member coinsurance percentage amounts, out-of-pocket limits, and provides a brief description of Albuquerque Public Schools Medical Plan benefits.

Three Tier Option Plan Benefits There is no lifetime maximum benefit. However, certain services have maximum annual limits. See below.	**Member's Share of Covered Charges**		
	Blue Preferred Plus (NBP) Provider[1]	**Blue Nationwide PPO Provider[1]**	**Out of Network NonPPO Provider[1]**
Annual Deductible[1] – Deductible does not apply to services with copays or "No Charge."	$500/Individual $1,000/Two-Person $1,500/Family	$2,000/Individual $4,000/Two-Person $6,000/Family	$4,000/Individual $8,000/Two-Person $12,000/Family
Annual Out-of-Pocket Limit (Includes deductible, coinsurance, and copayments; NOT prescription drugs, penalty amounts, or noncovered charges.[2])	$3,000/Individual $6,000/Two-Person $9,000/Family	4,500/Individual $7,875/Two-Person $11,250/Family	$8,500/Individual $14,875/Two-Person $21,250 Family
Coinsurance	20%	40%	50%
Primary Care Physician (PCP)* Office Visit/Exam and initial office visit to diagnose pregnancy	$15 copay/visit	$50 copay/visit	50%
Virtual Visit - Powered by MD LIVE	No Charge		Not Covered
Maternity (initial office visit, pre-natal, post-natal, and OB delivery charges) See next page for hospital benefits.	$40 copay	$75 copay	50%
Mental Health and Chemical Dependency (MH/CD) (outpatient/office)	$15 copay/visit	$50 copay/visit	50%
Virtual Visit (MH/CD) - Powered by MD LIVE	No Charge		Not Covered
Specialist Office Visit and initial office visit to diagnose pregnancy	$40 copay/visit	$75 copay/visit	50%
Office Surgery (including casts, splints, and dressings)	Office Visit (OV) Copay		50%
Allergy office visits, testing, treatment	Office Visit (OV) Copay		50%
Allergy Extract prep, Allergy Serum, and Allergy Injections	No Charge		50%
Therapeutic Injection (billed without an office visit)	No Charge		50%
Preventive Services Routine Adult Physicals and Gynecological Exams, Well-Child Care; Routine Vision or Hearing Screenings, Related Testing (includes routine Pap tests, cholesterol tests, urinalysis, etc.), Colonoscopies, and Immunizations	No Charge (deductible waived)		50%
Acupuncture, Chiropractic, Massage Therapy, and Rolfing (max. **25** visits/year; all services combined)	$40 copay/visit	$75 copay/visit	50%
Ambulance Services: Ground and Emergency Air Transport[4] (must be medically necessary)	20%[4] (subject to Blue Preferred Plus (NBP) Provider deductible)		
Autism Spectrum Disorders Applied Behavioral Analysis[4], and Occupational, Physical, and Speech Therapy	20%	40%	50%
Biofeedback (for specified services only)	$40 copay/visit	$75 copay/visit	50%
Cardiac and Pulmonary Rehabilitation	$0 copay/visit	$75 copay/visit	50%
Dental/Facial Accident, Oral Surgery, and TMJ/CMJ Services[4]	$150 copay and NBP deductible and 20% coinsurance[4]		
Diabetic Supplies	No Charge		50%
Emergency Room Treatment	$150 copay and NBP deductible and 20% coinsurance[3]		
Hearing Aids, Ear Molds, Fitting and Dispensing (for dependents under age 21 only, up to **$2,200** every 36 months) **Office Visit**	No Charge up to $2,200 / 36 months $40 copay/visit	No Charge up to $2,200 / 36 months $75 copay/visit	50%
Home Health Care/Home I.V. Services (NonPreferred Provider Level maximum: **120** visits/year)	$40 copay/visit	$75 copay/visit	50%
Hospice Services (Bereavement/3 sessions. Respite care (**5 continuous days** for each **60 days** of hospice; no more than two respite stays allowed.)	20%	40%	50%
Infertility (testing services to identify medical diagnosis)	Based on place of service		50%
Lab, X-Ray, and Other Basic Diagnostic Tests	No Charge (deductible waived)		50%

* A Primary Care Provider (PCP) is a physician or other professional provider in one of the following categories of practice: Family or General Practice, Internal Medicine, Pediatrics, Obstetrics and Gynecology, and Gynecology Only. A "PPP" is a Primary Preferred Provider in the NBP and PPO Provider networks.

Blue Cross and Blue Shield of New Mexico (BCBSNM) is a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

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	Blue Preferred Plus (NBP) Provider[1]	**Blue Nationwide PPO Provider[1]**	**Out of Network NonPPO Provider[1]**
MRI, CT Scans, PET Scans	$100 copay per day then deductible and 20% coinsurance[4]	$100 copay per day then deductible and 40% Coinsurance[4]	$100 copay per test then deductible and 50% coinsurance[4]
Inpatient Hospital/Facility Services			
Room and Board, and Covered Ancillaries for: Medical/Surgical, Mental Health/Chemical Dependency (including Partial Hospitalization), and Maternity Related and Delivery	20%[5]	40%[5]	50%[5]
Residential Treatment Center (RTC) – Mental Health/Chemical Dependency (MH/CD) (max. **60** days/year for each MH/CD)	20%[5]	40%[5]	50%[5]
Maternity Services			
Routine Nursery/Pediatrician Care for Covered Newborns - Facility	No Charge (all charges covered under Mother's claims)		50%
Extended Newborn Stay	20%	40%	50%
Outpatient Facility/Surgeon/Physician (including Surgical procedures related to pregnancy and family planning)	20%	40%	50%
Prescription Drugs, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods, Smoking/Tobacco Cessation	For details, see the Express Scripts Summary of Benefits or call Express Scripts at 1-866-563-9297.		
Short-Term Rehabilitation: Occupational, Physical, and Speech Therapy; Outpatient/Office Rehabilitation (max. **60** visits per condition/year/combined)	$40 copay/visit up to $400 annual maximum	$40 copay/visit up to $600 annual maximum	50%
Skilled Nursing Facility & Inpatient Rehabilitation (max. **60** days/year combined)	20%	40%	50%
Sleep Studies (Inpatient & Sleep Lab)	20%	40%	50%
Supplies, Durable Medical Equipment, Prosthetics, Orthotics[4] (preauthorization may be required)	20%[6] (deductible waived)	20%[6] (deductible waived)	50%[6]
Therapy: Chemotherapy, Dialysis, and Radiation	20%	40%	50%
Transplant Services (Must be received at a facility that contracts with BCBSNM or with the national BCBS transplant network[4,5].)			
Cornea, Kidney, Bone Marrow	20%[4,5]	40%[4,5]	Not Covered
Heart, Heart-Lung, Liver, Lung, & Pancreas-Kidney			
Urgent Care Facility	$50 copay/visit	$75 copay/visit	

FOOTNOTES:

[1] The deductible must be met before benefit payments are made for services with coinsurance. Deductible amounts do cross-apply between the NBP and PPO Provider levels; the Non PPO Provider does not.

[2] After a member reaches the applicable out-of-pocket limit, BCBSNM pays 100 percent of most of that member's covered NBP, PPO or Non PPO Provider charges, whichever is applicable. Out-of-pocket amounts do cross-apply between the NBP and PPO Provider levels; the Non PPO Provider does not.

[3] Initial treatment of a medical emergency is paid at the NBP Provider level. Follow-up treatment and treatment that is not for an emergency is paid based on the place of service (NBP, PPO or Non PPO Provider)

[4] Certain services are not covered if preauthorization is not obtained from BCBSNM. See a Member's Benefit Booklet for a list of services requiring preauthorization.

[5] Preauthorization is required for inpatient admissions. You pay a $300 penalty for covered medical/surgical and mental health/chemical dependency facility services if preauthorization is not obtained. See a Member's Benefit Booklet for details.

[6] Rental benefits for medical equipment and other items will not exceed the purchase price of a new unit.

IMPORTANT: Deductible amounts and coinsurance percentages are applied to BCBSNM's covered charges, which may be less than the provider's billed charges. Blue Preferred Plus NBP and PPO providers will not charge you the difference between the covered charge and the billed charge for covered services; Non PPO providers may.

Note: The APS medical plan is a self-funded plan. BCBSNM provides administrative claims payment only and does not assume any financial risk or obligation with respect to claims, except as may be specified in the Administrative Services Agreement.

This is a summary only – please refer to the Summary of Benefits and Coverage (SBC) document and Benefit Booklet for more details.