RFP NO. 16-011MG-AM

Albuquerque Public Schools
Procurement Department

Addendum #1 for RFP 16-011MG-AM
On-Site Health Center Services

September 15, 2015, 11:00 AM

September 2, 2015

Please note the following changes/corrections:

- Responses to written questions are listed on the following pages.

Thank you for your interest in Albuquerque Public Schools

ACKNOWLEDGE ADDENDUM WITH RFP:

Addenda not signed and returned may consider the RFP non-responsive and may be rejected.

_____
Company/Firm Name

_____
Signature

_____
Date

Marilee P. Gallacher
District Buyer

REQUEST FOR PROPOSAL
RFP 16-011MG-AM
ON-SITE HEALTH CENTER SERVICES

Response to Submitted Questions

Questions have been grouped by topic.
Answers are prefaced with A:, are italicized and in blue font.

FACILITY

1. What is the breakdown for the dependents, spouses and children?
   A: Following is the enrollment in medical plans by relationship and gender.

Relationship	Total Participants	Female	Male
Employee	7,856	5,819	2,037
Spouse/DP	3,448	985	2,463
Children	5,563	2,730	2,833
TOTALS	**16,867**	**9,534**	**7,333**

2. Does APS have a Union?
   A: There are six separate bargaining units (unions) within APS. They represent teachers, educational assistants, secretarial/clerical workers, maintenance and operations workers, food service personnel and school police.

3. Number of Employees: (hourly) _____ (salary) _____
   A: APS does not offer benefits to employees classified as hourly. Therefore, employee counts are broken down by exempt and non-exempt.

4. Average Hourly Salary: _____
   A: See answer to question #3

5. Average Age: _____ Gender %: (M) _____ (F) _____
   A: Average age of all participants on the medical plan is 37.5 years.

6. Is it the intent that year 1 operations will only include primary care/non-occupational and wellness services for the approximately 7,800 employees and their dependents? Please clarify as occupational health and worker's compensation services are listed in the scope of services.
   A: The intent for "year one" is to provide health center services identified in 4.2.2 of the RFP.

7. In the second and subsequent years of operation, will occupational services be available to all 14,000 APS employees?
   A: Yes.

8. It is understood that APS would like the vendor to manage various aspects of the physical space such as (repair and maintenance of facilities, utilities, internet access, telecom and data infrastructure, furniture, janitorial services, security, etc). Please note that until space is identified and surveyed,

estimating costs for these items will not be possible. How would APS like this addressed in the cost proposal?

A: Attachment 2 indicates the approximate size and components of the health center. The attachment is provided to assist in estimating the costs for the items mentioned above. Please indicate any services listed above that are not included in your proposal.

9. Please provide medical plan benefit summaries and current employee enrollment in each option.

A: APS offers one medical plan, administered by two medical plan administrators (each contracts with a different provider network in Albuquerque). ***The medical plan benefit summary begins on page 13 of this Addendum; an eight (8) page document.*** *Also see answer to question #1.*

10. Does APS prefer a solution that involves only one health and wellness center? Will it consider alternate solutions?

A: At this time, APS is requesting proposals for **one** *health/wellness center. APS may consider alternative solutions with the awarded offeror. Responses to the RFP should consider only one health center.*

11. Is the goal to have laboratory, radiology, and pharmacy all onsite or just available?

A: The RFP reflects limited on-site laboratory, radiology and pharmacy services.

12. Does APS expect biometrics to be performed at the clinic (by clinic staff during clinic hours) or by separate onsite biometric events administered by the clinic vendor?

A: APS is a very large district and there are many options to complete the task of biometric screenings. APS requests that each offeror address creative solutions on how to conduct and complete biometric screenings for such a large district. (Refer to 4.5.9.T on page 28 of the RFP.)

13. What is the average hourly wage for APS employees?

A: See answer to question #3.

14. Will the clinic be a brand new build on APS property or renovation of an existing APS building (page 19, 4.1.2)? Can APS provide any additional detail on prospective locations?

A: The health center will be a brand new facility, and is scheduled to be built on APS property in the general vicinity of APS' Lincoln Complex, located in the southeast part of Albuquerque, near I-25 and Coal Avenue.

15. What is the average age of the APS employees?

A: See answer to question #5.

16. Could you provide a member breakdown by employee, spouse, and child?

A: See answer to question #1.

17. (4.1.2) Is the approximate 5,600 to 9,200 sq. ft. for the on-site clinic available at one location or two different locations? Could you provide address(es)?

A: The initial APS on-site health center is scheduled to be built in one location. See answer to question #14.

18. Will there be any monthly lease charges for this space?

A: No, there will not be any scheduled monthly lease charges.

19. (4.3.1) Do you want the initial build-out based on year one eligible members or second and subsequent years eligible member?
    A: The initial build-out is to be based on "year-one" eligible members.

FINANCES – FUNDING

20. Please note that all services provided to operate the health center (and possible costs associated) are not listed in Attachment A. Will vendors have the opportunity to clarify all that is included but not listed to allow APS normalize costs when comparing each vendor's costs listed?
    A: Yes, vendors will have the opportunity to clarify all that is included, but not listed, to allow APS to normalize costs when comparing each vendor's costs listed. However, please include all anticipated costs on the cost response form in Appendix A. Start-up and implementation fees should be included in Table 2, administration costs in Table 3, and clinical costs in Table 4. If there are additional costs that do not fit into one of these categories, please outline those costs on a separate page or spreadsheet and include that in Volume 2. Please be certain to include the total amount of these costs in the appropriate table (or closest appropriate table) on the cost response form.

21. On page 22 (4.3.1 (c)), it indicates that the respondent should propose a monthly charge for provision of services, and directly bill APS's self-funded medical plan at an advantageous rate for medical treatment, laboratory and radiology services, and prescription drugs that are dispensed. Can APS clarify if the intent of the billing process?
    a. Is the intent to submit claims for reimbursement directly to the third party administrators listed at the bottom of page 22, in addition to the monthly fee? Would the monthly fee then be reduced to (net) of those collections?
       A: See answer to 21.c. below.

    b. Is the intent to submit <u>only the monthly fee</u> to the APS self-funded medical plan through an agreed upon method, with no claims submission of any kind? In this case, what data would need to be provided to the third party administrators (if any), and on what cadence?
       A: See answer to 21.c. below.

    c. Is the answer to either of the above different for occupational health and/or workers' compensation services?
       A: The intent is for the selected vendor to submit medical and pharmacy claims to APS' third party administrators, at a pass-through rate. Payment to the health center vendor will be based on a monthly fee paid by APS to the vendor.

22. In Appendix A, Tables 1 and 3 allow the Offeror to enter any additional costs for years 2, 3 and 4, however Table 4 appears to only allow the Offeror to report year 1 staffing and start-up costs; There could be some incremental staffing and other costs incurred to ramp up for the addition eligibility and volume in year 2 – is there an area where these costs should be entered?
    A: APS is aware that there are various additional costs during the second year to increase the health center's capability. However, all Offerors are asked to base their pricing at no additional cost for clinical and additional equipment and administration, to include staffing for years 2, 3 and 4.

23. Are there specific dollars ranges appropriated for this project? If yes, can they be impacted by ROI guarantees?
    A: There are no specific dollar amounts appropriated at this time. However, they will be impacted by ROI guarantees.

HEALTH CENTER – ACCESS AND ELIGIBILITY

24. Referring to page 22 (4.3.1) and the multi-year trajectory for eligibility, does APS have any assumptions on growth in the employed population over the next 4 years?
    A: At this time there are no assumptions on growth. However, the medical plans offered by APS have decreased in the enrollment over the past five years.

25. Referring to page 22 (4.3.1), does APS have an information or assumptions around the number of employees/dependents that are likely to utilize the clinic?
    A: Based on forecasting, best practices, and past experience, APS is relying on the selected vendor to assist with calculating utilization.

26. On page 22 (4.3.1 (a)) it states that in the second year of the contract, the clinic would be available to all employees and their dependents, including those not eligible in year one. We can estimate that this is approximately 6,200 additional employees that will become eligible, but would like to know approximately how many additional dependents would also gain access?
    A: APS estimates that employees have an average of 2.09 to 2.18 dependents, which is based on the average contract size for the employees currently enrolled on our medical plan.

27. What was intent for excluding well child checks and immunizations from the scope of services (page 23, 4.3.2 (c)?
    A: See answer to question #28.

28. Is the desire that children of all ages (including newborns) be able to receive services in the clinic (page 23, 4.3.2 (c))?
    A: The proposed staffing of the health center does not include a pediatrician. APS believes that the "best practice" to support pediatric well child checks be done by pediatricians. However, the health center will accept and treat children for urgent care services.

29. Could you provide either (a) plan performance reports for the most recent two years, or (b) a breakdown of your medical claims data (i.e. outpatient, inpatient, worker's compensation, etc.) so we are able to determine the most accurate cost savings for Albuquerque?
    A: The available claims data is posted on the APS Procurement Department's website. The RFP indicates how to obtain access to the data. Additionally, APS averages 620 new worker's compensation claims per year. Also see answers to question #74.

30. We understand there are 17,500 eligible members who may access the clinic in the first year of operations, but what is the total number of members (APS employees and their dependents) the clinic will be available to after the first year?
    A: APS has approximately 14,000 employees. However, cost should be based on the approximately 17,500 employees who have medical plan coverage.

31. Could you provide a census report, or insight regarding the geographical distribution of your members?
    A: The vast majority of APS employees live in Albuquerque (Bernalillo County). Many of our employees also reside in the surrounding four-county area (Sandoval, Valencia, Torrance and Santa Fe).

HEALTH SERVICES

32. For question 4.2.2 please expand on what you mean "Behavioral Health to include Employee Assistance Program".
    A: APS currently offers an "in-house" Employee Assistance Program (EAP). APS requests that Offerors for the health center elaborate on the ability to include behavioral health services. APS is also interested in the option to provide an Employee Assistance Program for behavioral health only. If a potential offeror is unable to offer an EAP, or if the EAP would only be during health center hours, please indicate that information in your response to the RFP.

33. For question 4.2.2.3 what is APS' vision for the Pharmacy? The Contractor will also provide other services at the On-Site Pharmacy, including, but not limited to, pharmacy interventions, tablet splitting, and patient counseling. Do you want a full retail pharmacy or pharmacy management program with targeted dispensing?
    A: APS does not intend to provide a full retail pharmacy. It is intended that the health center will dispense a select group of pre-packaged generic medications. APS requests that potential vendors propose their best-practice to provide a limited formulary of the most common prescriptions for dispensing at the health center.

34. Will APS be planning to offer any type of financial incentives for participation in the HRA/Biometric process and/or program?
    A: APS' employee wellness program executes many wellness initiatives. However, one of the primary initiatives is the "know your numbers" wellness incentive program. This program was implemented in 2010. Annual participation in the wellness incentive program has been determined "best in class" with an 80% - 90% participation rate for employees and spouses/domestic partners who are enrolled on the medical plan.

    Employees who participate in the wellness incentive program receive a $25 per month reduction on their medical plan contributions. If both the employee and his/her spouse/domestic partner participate, the employee receives a $50 per month reduction on medical plan contributions. The "know your numbers" wellness incentive program includes:
    - *An annual biometric screening*
    - *Annual acknowledgement of tobacco-free status (or completion of a 12-week on-line tobacco cessation course)*

    For 2015 and 2016, employees have the option to complete a Personal Health Profile (Health Risk Assessment), however it is not a requirement to qualify for the financial incentive.

    APS is not planning to offer any additional financial incentives to employees for participation in the "know your numbers" wellness incentive program. However, discussion of best-practices with the vendor selected for the on-site health center is welcomed.

35. What are the top 3 key challenges and/or concerns APS has with the health of the population?
    A: The top three challenges and/or concerns are:
    - *Improvement of the overall health of APS, specifically obesity and diabetes.*
    - *Affordable, accessible and safe healthcare, while decreasing claims costs.*
    - *Adequate communication of health and wellness services; health literacy.*

36. Would APS like the selected vendor to provide an EAP program for behavioral health only, one with behavioral health and various other EAP services (please list) or prefer that the vendor partner with an existing EAP program that APS might use?
    A: See answer to question #32.

37. Please provide NDC numbers, drug names, strength and quantity for the medications listed on the Rx data spreadsheet provided in the RFP to allow for a pharmacy services analysis.
    A: ***The file with this information is posted to the Albuquerque Public Schools Procurement Department website, under this RFP as Addendum 2: Express Scripts Data File .*** *The password for this file is the same as for the other secured files.*

38. Please provide the spend and volume of radiology services.
    A: Blue Cross Blue Shield of New Mexico:
    Radiology spend over the past 12 months: $765,089
    Radiology visits over the past 12 months: 341 per 1,000

    Presbyterian Health Plan:
    Radiology spend over the past 12 months: $1,141,208
    Utilization was requested but was not received by the due date of this addendum.

39. Please provide the visit count and spend for physical therapy and occupational therapy.
    A: Blue Cross Blue Shield of New Mexico:
    Therapy spend over the past 12 months: $153,716
    Therapy visits over the past 12 months: 202 per 1,000

    Presbyterian Health Plan:
    Therapy spend over the past 12 months: $385,435
    Utilization was requested but was not received by the due date of this addendum.

40. Does Albuquerque have any current wellness programs in place? If yes, what is the rate of participation? Do they offer incentives?
    A: See answer to question #34.

41. If they don't have anything in place, are they planning to offer incentives with the launch of their new program?
    A: See answer to question #34.

42. Can APS expand on what on-site pharmacy services they are looking for the chosen clinic vendor to provide? Are they looking for a full on-site pharmacy or rather an expanded formulary of prepackaged medications?
    A: See answer to question #33.

43. On page 21, (4.2.2 (g)) it is indicated that behavioral health to include Employee Assistance Program (EAP) should be one of the services – can you clarify: *See answer to question #32.*
    a. Is the currently offered EAP program internal only?
       A: Yes, the current EAP program is internal only.

    b. How many counselors are part of the current EAP program, and are they full time or part time?
       A: There are two full-time counselors. Collectively they have about 1,350 visits per school year (they do not work during Summer Break).

    c. Is the number of EAP sessions limited in the current program?
       A: Yes, the number of EAP sessions is limited in the current EAP program.

    d. What are the hours that EAP services are available?
       A: The current hours are 8:00 AM to 6:00 PM, Monday – Thursday, and 8:00 AM to 4:00 PM on Friday.

    e. Is APS able to share any utilization data from the current EAP program?
       A: No

    f. Does the current EAP program offer emergency support? If yes, is this offered after hours?
       A: No, the current EAP program does not offer emergency support.

    g. Who handles Critical Incident Stress Debriefing for APS currently?
       A: Not available

    h. How does APS currently handle DOT-mandated SAP services?
       A: For further information in response to question #42, see answer to question #31.

44. Are immunizations offered at the schools as part of the school clinics?
    *A: Immunizations are **not** offered to employees at the school-based clinics; some immunizations are available to students at the clinics.*

45. (4.2.2) What staffing requirements are you considering for the behavioral health component?
    A: APS is considering two (2) or three (3) behavioral health providers. Offerors are asked to provide their best-practice for the types of providers.

46. (4.2.2) Does APS currently provide an EAP benefit or would this be a new benefit offered through the on-site clinic under the behavioral health offering?
    A: See answer to question #32.

HOURS OF OPERATION

47. What is your expectation for after-hours care?
    A: The health center is to provide normal hours of operation that will meet the needs of the District. The hours of operation will be identified once the award is confirmed, and agreed upon between the vendor and APS. The health center will not be available for service before or after confirmed center hours of operation.

LICENSING AND CERTIFICATIONS

48. Please confirm that a statement of concurrence, licenses, and certifications to deliver services in New Mexico is not required to submit the RFP.
    A: If a vendor does not currently have the necessary licenses and certifications to deliver medical services in New Mexico, they may still submit a proposal. However, a statement indicating that they are not currently licensed in New Mexico, and that all necessary licenses and certifications will be obtained (if they are the selected vendor) is required in the response to the RFP. (Refer to 4.5.1 on page 26 of the RFP.)

OCCUPATIONAL HEALTH AND WORKER'S COMPENSATION

49. Total number of injuries current YTD
    A: 290

50. Total number of injuries previous year
    A: 616

51. Total number of OSHA Recordable injuries current YTD
    A: 254

52. Total number of OSHA Recordable injuries previous year
    A: 550

53. Total number of Work Comp claims filed previous year
    A: 616

54. Total number of Lost Work Days current YTD
    A: Not available

55. Total number of Lost Work Days previous year
    A: Not available

56. Average number of days lost per Lost Time Accident current YTD
    A: Not available

57. Average number of days lost per Lost Time Accident previous year
    A: Not available

58. Total Incurred Workers' Comp Costs current YTD (Medical, TTD; paid and reserved)
    A: $3,225,530

59. Total Incurred Workers' Comp Costs for previous year (Medical, TTD; paid and reserved)
    A: $3,915,741

60. Total Amount Paid in Workers Comp in current YTD
    A; $3,616,597

61. Total Amount Paid in Workers Comp in previous year
    A: $4,899,425

62. Do you have a Return to Work Program? If so, please describe.
    A: Yes, APS has a return to work program, run in-house by the Risk Management and Human Resources Departments.

63. Annual number of Drug screens.
    A: 75

64. Annual number of Breath Alcohol tests
    A: 75

65. Annual number of Audiometry screens
    A: 10

66. Annual number of Vision screens
    A: Not available

67. First Occupational Health Visits
    A: Not available

68. Follow-Up Occ. Health Visits
    A: Not available

69. Does APS want a cost proposal for Work Comp/Occ Health Services at this time? If so, please supply the following data:
    a. Total Work Comp Spend
       A: $4,899,242 in calendar year 2014

    b. Total Number of Reportable Injuries
       A: 550 in calendar year 2014

    c. Total Number of Work Comp Claims
       A: 616 in calendar year 2014

    d. Types, Volume and Cost of all Occupational Tests to be performed in the health center
       A: 75 drug tests in calendar year 2014

    e. Number of Employees eligible for Work Comp and Occ Services
       A: APS has approximately 14,000 employees

70. Who would give us the "max allowable"?
    A: The maximum allowable payment on the worker's compensation bills is set by the NMWCA, and can be obtained from that agency.

71. Who would we be billing?
    A: The APS Risk Management Department.

72. Would we be billing via claim or with an invoice?
A: Billing would be with an invoice.

73. What is APS's expectation for what HS would do with the $ received? Used to offset the cost of the clinic program?
A: Risk Management has no expectations on this matter.

74. Please provide the following:
    a. Number of DOT drivers
    A: 225, including bus drivers

    b. Number of annual workers compensation claims.
    A: 616 claims for calendar year 2014

    c. Number of annual workers compensation visits.
    A: PT visits: approximately 250 visits per month, 3,000 per year. Office visits: approximately 80 – 100 per month, 960 – 1,200 per year.

    d. Number of pre-employment physicals and drug screens per year.
    A: 75 physicals and 75 drug screens per calendar year 2014

    e. Types of regulatory exams required and quantity
    A: 75 DOT exams per year per calendar year 2014

75. Related to the occupational health services in this RFP:
    a. Is APS self-insured for Workers' Compensation?
    A: Yes, APS is self-insured for Worker's Compensation.

    b. Who is the TPA for Workers' Compensation?
    A: APS Worker's Compensation is self-administered.

    c. Can APS share the last three years of Workers' Compensation claims and cost – ideally a summary report of loses by contract year, separated between time lost and medical-only claims, with average incurred/paid by claim type?
    A: APS has an average of 620 new worker's compensation claims per year; worker's compensation total per year is $4.8 million.

    d. Can/Will APS mandate that work-related injuries report to the On-Site clinic? If not, where will injured workers be treated if outside the proposed On-Site clinic?
    A: APS will direct all non-emergency worker's compensation claims to the clinic.

    e. Does APS have employees staffed around the clock (what are the hours of operation)?
    A: APS does have 24/7 operations.

    f. Is APS conducting pre-employment physicals now, and if so, what kind of testing is being done? Is there a standard for each job description, and are those job descriptions available for review?
    A: APS does DOT physicals and APS has job descriptions for each position.

g. Can APS provide copies of the documentation used for pre-employment physicals and other fit-for-duty exams?
A: No

h. What are the expectations of treatment for work-related injuries? Beyond minor injuries, are more serious injuries to be referred to occupational clinics in the area? Does APS have a contract with a network for these services? If so, can you identify the provider group(s)?
A: APS' expectation is the clinic would handle minor worker's compensation cases and refer out as needed.

i. Does APS currently use a telephonic triage provider?
A: APS does not have a telephone triage provider.

j. Will the selected vendor be responsible for OSHA record keeping?
A: Yes, as required by law.

k. Who will be responsible for monitoring case management services?
A: APS Risk Management will be responsible for monitored case management services.

l. Who manages the drug testing program currently? Are all injured workers subject to a drug and or alcohol screening currently? How many screenings were done in the last 12 months?
A: APS uses a local company in Albuquerque to manage our drug testing program. All injured workers are not subject to a drug test, only drivers of motor vehicles after an accident.

76. Attachments 1 & 2 list Physical Therapy as a requested service with allocated space, however we find no mention of Physical Therapy in the Specifications in Section IV – please clarify the intent for Physical Therapy services?
A: Risk Management will request physical therapy service for injured APS workers when prescribed.

WORK PERFORMANCE

77. Does APS have a broker for records, and if so, who?
A: APS does not contract with a broker, however APS does contract with a Benefits and Actuarial Consultant, USI Midwest. The Risk Management Department also has a contract with an insurance broker, Poms and Associates.

78. Can APS estimate the number of plan participants enrolled in HSA plans, if any?
A: APS does not offer a high deductible health plan that would allow employees to be eligible to contribute to a Health Savings Account (HSA).

79. On page 24 (4.3.8 (d)), would the data reporting requirement be directly with the APS self-funded medical plan, or through the third party administrators (or both)? If directly to the APS self-funded medical plan, is there a 3rd party data warehouse or similar vendor that the APS Employee Benefits Department and Risk Management department work with for the storage of data (Example: Truven Health)?
A: Reporting requirements will be determined with the selected vendor. APS does not currently utilize a data warehouse, however, it is something that may be developed in the future.

80. Are there any planned mandatory monthly meetings the winning contractor would be required to attended: Employee Benefits Department, Risk Management or other entities?
    A: During the planning and implementation phase, APS anticipates meeting as often as necessary with the selected vendor and advisory committees. After the health center is open, many of the meetings will be every other month or quarterly, and can be conducted via conference call, Skype, or other form of efficient communication. Risk Management holds quarterly meetings.

81. What management responsibilities for this account does APS want available locally?
    A: Management responsibilities will be determined with the selected vendor. APS anticipates that many of the management and account responsibilities will be handled via email and phone and will not require a local Account Manager.

2015 APS Open Access Medical Plan

Administrative Services for the APS self-funded medical plan are provided by Presbyterian Health Plan and BlueCross BlueShield of New Mexico. Employees select either Presbyterian Health Plan or BlueCross BlueShield at the time of enrollment.		In-network	Out-of-network[7]
Physician Services	Non-Specialist • Primary Care Physician selection not required Specialist • Referral not required Surgery in Office • Injectable drugs administered in physician's office • Self-injectable drugs (specialty pharmaceuticals) can be ordered through the prescription drug plan	$25 office visit copay $40 office visit copay Included in office visit copay Copay based on place of service Refer to the prescription drug plan	Subject to Deductible and Coinsurance
	Preventive Care Services[1] • Routine physical • Annual women's exam • Annual men's exam including PSA • Related laboratory tests and X-rays (Includes routine pap tests, cholesterol tests, urinalysis, mammogram, colonoscopy, etc.) • Well child care including vision and hearing screenings (through age 17) • Immunizations • Health education and counseling (including smoking/tobacco cessation education) • Family planning Women's Health Care Contraceptive methods[1] (preferred agents) • Intrauterine devices (IUD) • Hormone contraceptive injections • Inserted contraceptive devices • Implanted contraceptive devices • Generic birth control Breastfeeding support[6] • Supplies and counseling for one year after delivery	Plan pays 100% Plan pays 100% (Prescription medications are covered under the prescription drug plan)	Subject to Deductible and Coinsurance Subject to Deductible and Coinsurance

		In-network	Out-of-network[7]
Deductible	Annual Member Deductible (calendar year) • Single • Two-party • Family • The deductible does not apply to Preventive Care Services or Prescription Drugs. • Copayments do not apply towards deductible. • Except for Preventive Care and those services where a copayment applies, the deductible must be met before benefit payment is made by the plan (coinsurance applies). • After each family member meets his or her individual plan deductible, the plan will pay a percentage of his or her claims and the member will pay applicable coinsurance until the out-of-pocket maximum is met. • After the family plan deductible has been met, the plan will pay a percentage of each individual's claims and the member(s) will pay applicable coinsurance until the out-of-pocket maximum is met. • Deductible amounts do not cross-accumulate between in-network and out-of-network	 $250 $500 $750	 $500 $1,000 $1,500
Coinsurance	Coinsurance	You pay 20% and the Plan pays 80% after the Annual Deductible is met	You pay 30% and the Plan pays 70% after the Annual Deductible is met
Out-of-Pocket Maximum	Annual Out-of-Pocket Maximum • Single • Two-party • Family • The medical plan copayments, deductible and coinsurance apply to the annual out-of-pocket maximum. • Prescription drug copayments or coinsurance do not apply to the medical plan out-of-pocket maximum. The prescription drug plan includes a separate out-of-pocket maximum. • After each family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of that individual's covered expenses. • After the family out-of-pocket maximum has been met, the plan will pay 100% of each family members' covered expenses. • Amounts do not cross-accumulate between in-network and out-of-network.	 $2,250 $4,500 $6,750	 $4,500 $9,000 $13,500

		In-network	Out-of-network[7]
Out-Patient Diagnostic Testing	Advanced Radiology[2] (i.e., PET, MRI, CT Scans) • Medically necessary outpatient imaging tests Other Laboratory Other X-rays	$100 copay, then deductible and coinsurance Plan pays 100% Plan pays 100%	$100 copay, then deductible and coinsurance Subject to Deductible and Coinsurance
Hospital Services	Hospitalization[2] • Includes room and board, inpatient physician care – physician visits, surgeon, anesthesiologist, laboratory tests and X-rays Inpatient Rehabilitation Services[2] Observation Stay[2]	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Sleep Studies	Inpatient[2] Sleep Labs (two nights)[2]	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Surgical Services	Inpatient Surgery[2] Outpatient Surgery[2]	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
	Office Surgery	Included in office visit copay	Subject to Deductible and Coinsurance
Urgent Care Services	Urgent Care Facility Non-urgent follow-up care	$50 copay Subject to place of service copay or coinsurance	$50 copay Subject to Deductible and Coinsurance
Emergency Services	Emergency room[4] / Emergency observation treatment[4] • Hospital and Physician charges Non-emergent follow-up care	$150 copay, then deductible and coinsurance Subject to place of service copay or deductible and coinsurance	$150 copay, then deductible and coinsurance Subject to Deductible and Coinsurance
Ambulance	Ambulance – Emergency Air Transport	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance

		In-network	Out-of-network[7]
Maternity Services	Physician/Midwife Services • Delivery, prenatal and postnatal care	$40 copay – initial visit only, then the plan pays 100%	Subject to Deductible and Coinsurance
	Genetic Testing and Counseling	Copay based on place of service	Subject to Deductible and Coinsurance
	Hospital Admission	Subject to Deductible (on the mother) and Coinsurance	Subject to Deductible (on the mother) and Coinsurance[2]
	Routine nursery care for newborn • If mother is covered under the plan • Baby is covered from birth but must be enrolled in the medical plan as quickly as possible but no later than 60 days from date of birth	Plan pays 100%	Subject to Deductible and Coinsurance
	Extended stay charges for covered newborn • If baby is admitted to the hospital post-delivery	Subject to Deductible (on the baby) and Coinsurance	Subject to Deductible (on the baby) and Coinsurance[2]
Behavioral/ Mental Health	Outpatient services	$25 office visit copay	Subject to Deductible and Coinsurance
	Inpatient Services[2]	Subject to Deductible and Coinsurance	
	Partial Hospitalization[2] • Two partial hospitalizations equal one inpatient day		
	Residential Treatment Center[3] • Combined in-network and out-of-network maximum of 60 days per calendar year; must be Medically Necessary		
Substance Abuse	Outpatient services	$25 office visit copay	Subject to Deductible and Coinsurance
	Inpatient Services[2]	Subject to Deductible and Coinsurance	
	Partial Hospitalization[2] • Two partial hospitalizations equal one inpatient day		
	Residential Treatment Center[3] • Combined in-network and out-of-network maximum of 60 days per calendar year; must be Medically Necessary		

		In-network	Out-of-network[7]
Other Services	Allergy Testing and Treatment Allergy Injections only Allergy Extract preparation	$40 office visit copay Plan pays 100% Plan pays 100%	Subject to Deductible and Coinsurance
	Alternative Therapy[3] • Acupuncture, Chiropractic, Massage Therapy and Rolfing • Combined in-network and out-of-network maximum of 25 visits per calendar year	$40 copay per visit	Subject to Deductible and Coinsurance
	Autism Spectrum Disorders[2,] • Diagnosis and treatment of autism spectrum disorder for members 19 years of age or younger (or under 22 years of age if still enrolled in high school) • Well-baby and well-child screening for diagnosing the presence of autism spectrum disorder • The habilitative and rehabilitative treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy and applied behavioral analysis. Providers must be credentialed to provide such therapy. • Treatment must be prescribed by the member's treating physician in accordance with a treatment plan, and must be preauthorized by Presbyterian Health Plan or BlueCross BlueShield of New Mexico	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
	Biofeedback • For specified medical conditions only	$40 copay per visit	Subject to Deductible and Coinsurance[2]
	Cardiac Rehabilitation[2] Pulmonary Rehabilitation[2]	$40 copay per session $40 copay per session	Subject to Deductible and Coinsurance
	Chemotherapy and/or Radiation Therapy	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
	Dialysis	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance

		In-network	Out-of-network[7]

Other Services (continued)	Diabetes Coverage
	• Office visit and diabetes educations
	• Diabetic medications
	• Diabetic supplies, equipment, appliances and services [2]
	  • Prescribed by the attending physician
	  • Purchased through a Durable Medical Equipment (DME) provider
		Subject to place of service copay
		Refer to the prescription drug plan
		Plan pays 100%
			Subject to Deductible and Coinsurance

	Durable Medical Equipment (DME), orthopedic appliances, prosthetics and functional orthotics[2] • Medically Necessary services, supplies and devices • Supplies limited to a 30-day supply during a 30-day period • Rental benefits may not exceed the purchase price of a new unit • Support hose limited to 6 pair (or 12 hose) per calendar year • Mastectomy bras limited to 3 per calendar yr.	20% coinsurance, deductible does not apply	Subject to Deductible and Coinsurance
	Hearing Aids • Coverage is limited to members 19 years of age or younger (or under 21 years of age if still enrolled in high school)	The plan pays 100% of the covered charges (including fitting and dispensing services) up to a maximum of $2,200 every 36 months per hearing impaired ear	
	Home Health Care[2] / Home Intravenous Service[2] • Prescribed home physician services, nursing care and rehabilitative therapy	$40 copay per visit	Subject to Deductible and Coinsurance[3] (Out-of-network limited to 120 visits per calendar year)
	Hospice Bereavement counseling[3] • Limited to 3 sessions during the hospice benefit period Respite care[3'] • Limited to 5 continuous days for each 60 days of Hospice care. No more than two respite stays allowed.	Subject to Deductible and Coinsurance Subject to Deductible and Coinsurance Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance

		In-network	Out-of-network[7]
	Infertility related services • Test performed in a Laboratory • Test performed in a Non-Specialist Physician's office • Test performed in a Specialist Physician's office • Refer to the Summary Plan Description for covered services	Copays based on place of service	Subject to Deductible and Coinsurance
	Physical, Occupational and Speech Therapy[3] • Combined in-network and out-of-network maximum of 60 visits per condition per calendar year	$40 copay per visit	Subject to Deductible and Coinsurance
	Skilled Nursing Facility[3] • Combined in-network and out-of-network maximum of 60 days per condition per calendar year	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
	Tobacco cessation[3] • Screening for tobacco use • At least two tobacco cessation attempts per year which include: • Four tobacco cessation counseling sessions of at least 10 minutes each (telephone counseling, group counseling or individual counseling) • No prior authorization required • Tobacco cessation medications prescribed by a health care provider are covered under the prescription drug plan	Plan pays 100%	Not covered out of network
	Dental Services • For limited medical conditions only	Copay or Deductible and Coinsurance based on place of service	Subject to Deductible and Coinsurance
Pre-Existing Conditions	Pre-Existing Condition Limitation	Not applicable	
Lifetime Maximum	Not applicable	Certain services are subject to calendar year maximum visits or days or are limited per condition	
Transplants[5]	Coverage for human organ transplants[5] • Case Management required • Refer to Summary Plan Description for complete details on transplant coverage • Maximums apply to covered travel and lodging services	Subject to Deductible and Coinsurance	No benefit (transplant services are covered in-network only)
Prescription Drugs	Administered by Express Scripts. Call Express Scripts at 1-866-563-9297		

1. The Patient Protection and Affordable Care Act (also known as Health Care Reform) requires health plans to cover specific Preventive Care Services, including Women's Preventive Care Services, at no cost to the member when the services are provided by an In-Network Participating Provider. Although these services are covered at no charge, the provider may charge a copayment for other services provided during the office visit. Additionally, some covered Family Planning services, including male vasectomies, continue to require member cost-sharing. If you have questions regarding the Preventive Care Services that are covered under this plan, including Family Planning Services, or your cost for these services, please refer to your Evidence of Coverage/ Summary Plan Description, or contact BlueCross BlueShield of New Mexico or Presbyterian Health Plan at the phone number listed on your ID card. These services must be Medically Necessary as defined by the Summary Plan Description.

2. Pre-Admission Review and/or Prior Authorization is required; $300 penalty, reduction or denial may apply to facility services if the required Pre-Admission Review and/or Prior Authorization is not obtained.

3. This benefit includes an annual visit limitation. See your Summary Plan Description for more information.

4. The Emergency Services copayment/deductible/coinsurance is waived if an inpatient hospital admission results; then the hospital admission deductible and coinsurance applies.

5. Transplants are covered In-Network only. Case Management Services for transplant patients ***must*** be obtained from BlueCross BlueShield of New Mexico or Presbyterian Health Plan at the phone number listed on your ID card.

6. Patients are responsible for copayments or deductible and coinsurance related to place of service, ancillary services, and additional procedures performed at the same time. Prior Authorization rules still apply.

7. If you choose to receive routine care from Out-of-Network providers, payments by the plan for Covered Services will be limited to Reasonable and Customary Charges. For care other than Emergency Care, you will be responsible for any balance due to the provider above Reasonable and Customary Charges.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

Special Rights Following Mastectomy: A group health plan generally must, under federal law, make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of mastectomy

Our Plan complies with these requirements. Benefits for these items generally are comparable to those provided under our Plan for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by consultation between the attending physician and the patient. Our Plan neither imposes penalties (for example, reducing or limiting reimbursements) nor provides incentives to induce attending providers to provide care inconsistent with these requirements.