Administered by

State of New Mexico

Plan Highlights – 2026 Gold HMO Plan

The following are the highlights of the State of New Mexico HMO Plan administered by Blue Cross and Blue Shield of New Mexico (BCBSNM). Any services received must be medically necessary to be covered.

Benefit Highlights		HMO Provider[1,2]
Highlights of Cost-Sharing Features	**Annual Deductible[1]** (All services are subject to deductible unless noted otherwise.)*	$500 / Individual $1,000 / Two Party $1,500 / Family*
	Annual Out-of-Pocket Limit[2] (Includes medical deductible, coinsurance, copayments, plus drug plan deductible, drug coinsurance, and drug copays. **Does not** include penalty amounts, or non-covered charges.)*	$4,000 / Individual $8,000 / Two Party $12,000 / Family*
	Lifetime Maximum	Unlimited
Type of Service	**Description of Service and Limitations**	**Your Share After Annual Deductible[1,2]** **HMO Provider**
Physician Services, Office	• Primary Care Physician/Provider (PCP) Office Visit / Exam Copayment (non-preventive) • Office Surgery (including casts, splints, etc.) • Telehealth Services	$30 $0 $0
	• Other non-Routine Office Services: Includes services of non-PCP providers (Specialists) • Office Surgery • Allergy Tests, Serum • Allergy Injections	$60 $0 $60 $0
	Preventive Services: including immunizations, lab, X-ray, colonoscopies, pap tests, mammograms, immunizations, and other wellness services; smoking/ tobacco cessation counseling, etc.	$0
Diagnostic Testing, Outpatient	PET Scans, CT scans, MRIs, (unless covered as part of a fixed-dollar copayment during ER visit, admission, etc.) Lab X-Ray	30% after deductible (up to a max. member share of $250 per test)[4] $30 $100
Inpatient Hospital Services, Acute Care	Hospitalization (includes semi-private room, board, drugs, medications, and ancillaries, inpatient physician visits, surgeon, assistant, and anesthesiologist)	30% after deductible
	Related physician services (e.g., anesthetist, surgeon)	30% after deductible[4]
Outpatient Hospital Services	Surgery	$75 copay
Emergency Services and Urgent Care	Emergency room or emergency observation room visit	$250 (waived if admitted)
	Urgent care center	$50
	Ambulance (ground and air transport)	30% after deductible
Transplants	Cornea, Kidney and Bone Marrow	Copay or deductible/coinsurance based on place and type of service[4,5,6]
	Bone marrow, heart, heart-lung, liver, lung, pancreas- kidney, and other medically necessary transplants (Case Management required; maximums apply to covered travel and lodging fees.)	Copay or deductible/coinsurance based on place and type of service[4,5,6]
	Maternity- Physician/midwife services (delivery, prenatal / postnatal care)	Copays apply for office visits (Initial visit only) other 30% after deductible
	Hospital admission	30% after deductible
	Routine nursery care for covered newborn (Child covered from birth but must apply for coverage within 31 days.)	$0

Type of Service	Description of Service and Limitations	Your Share After Annual Deductible[1,2]
		HMO Provider
Mental Health and Substance Abuse Rehabilitation Services	Outpatient/Office services	$0
	Telehealth services	
	Inpatient services	
	Partial hospitalization	
	Intensive outpatient program	
	Residential treatment center (max. **60 days** / calendar year)	
Other Services	Acupuncture (limited to **25 visits combined** plan year)	$60 copay
	Chiropractic Services (Limited to **25 visits combined** plan year.)	$30 copay
	Cardiac and Pulmonary Rehabilitation	Specialist Copays apply for office visits, other 30% after deductible
	Chemotherapy, Radiation therapy; Dialysis	Specialist copay applies for office visits, other outpatient place of service 30% after deductible
	Durable medical equipment, diabetic equipment, and supplies; orthopedic appliances, prosthetics and orthotics (Rental benefits may not exceed the purchase price of a new unit. Supplies limited to a **30-day supply** during a 30-day period) Diabetic supplies, equipment, appliances and services	30% coinsurance after deductible $0
	Hearing aids	No copay, up to $2,500 per ear every 36 months
	Home health care and home I.V. services	$60
	Hospice	0% after deductible
	Naprapathic services and Massage Therapy (limited to **25 visits / combined** / calendar year) No copay applies for behavioral health	$60 per visit (deductible waived) $0
	Rehabilitation facility and Skilled Nursing facility	30% after deductible
	Physical, Occupational, and Speech therapies	$30
	Autism Spectrum Disorders • Diagnosis and treatment of autism spectrum disorder • Well-baby and well-child screening for diagnosing the presence of autism spectrum disorder	$0
	TMJ/CMJ, oral surgery, and dental accident services	Applicable copayments, deductible, and/or coinsurance based on place and type of treatment
	See your PBM benefit summary for details.	

FOOTNOTES:

[1] All benefits are based on the covered charges as determined by BCBSNM. The deductible must be met before benefit payments are made for most covered services in a calendar year. ("Deductible waived" is indicated above for those services that are excluded from the deductible requirement.)

Note: A "PCP" is any HMO provider in one of the following categories of practice: Family Practice, Internal Medicine, General Practice, Gynecology, Pediatrics, or Obstetrics/Gynecology.

[2] After you reach the applicable out-of-pocket limit, BCBSNM pays 100 percent of most of your covered preferred Provider charges, whichever is applicable, for the rest of the calendar year. Amounts in excess of covered charges, penalty amounts, and non-covered charges do not count toward the out-of-pocket limit or deductible.

[3] Initial treatment of a medical emergency at an HMO or nonpreferred emergency room or trauma center is paid at the HMO Provider benefit level. If you must be admitted as an inpatient as a result of an emergency, the entire, related hospitalization is paid at the HMO Provider benefit level. Follow-up treatment and treatment that is not for an emergency is not covered. The emergency room or observation room copayment is waived if an inpatient admission results; then inpatient hospital benefits apply.

[4] Certain services are not covered if preauthorization is not obtained from BCBSNM. Nonemergency air ambulance transfer services are covered only when it is medically necessary to transfer the patient from one facility to another. A list of services requiring preauthorization is in Section 4 of your benefit booklet.

[5] Preauthorization (or admission review approval) is required for inpatient admissions. Some services, such as transplants, require additional approval. If you do not receive preauthorization for these individually identified procedures or services, benefits for any related admissions will be denied. See Section 4 of your benefit booklet for additional details.

[6] Transplants must be received at a facility that contracts with BCBSNM or with the national BCBS transplant network.

***Note about Family deductibles and out-of-pocket limits:** If you have a Family contract, an entire family meets an applicable deductible or out-of- pocket limit for a calendar year when the total deductible amount or out-of-pocket limit for all family members reaches three times the Individual deductible or out-of-pocket limit amount (the deductible and out-of-pocket limit amounts for three or more family members are combined to satisfy the Family deductible and the Family out-of-pocket limit). However, once a member meets an Individual deductible, that member's applicable deductible is satisfied for the calendar year, and no more charges incurred by that member can be used to satisfy the Family deductible.

Note: For outpatient surgeries, you will pay a coinsurance percentage for the facility and the related physician charges.

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