

Administered by



# State of New Mexico

## Plan Highlights – 2026 SILVER PPO HSA Plan

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

| Benefit Highlights   |  | Preferred (PPO)  | Nonpreferred (OON)   |
|--|--|--|--|
| <b>Highlights of Cost-Sharing Features</b>   |  |  |  |
| <b>Annual Deductible<sup>1</sup></b><br>(All services are subject to deductible unless noted otherwise.)   |  | \$3,000 / Individual<br>\$6,000 / Two-Person<br>\$6,000 / Family*  | \$4,500 / Individual<br>\$9,000 / Two-Person<br>\$9,000 / Family*    |
| <b>Annual Out-of-Pocket Limit<sup>2</sup></b><br>(Includes medical deductible, coinsurance, copayments, plus drug plan deductible, drug coinsurance, and drug copays. <b>Does not</b> include penalty amounts, or noncovered charges.) |  | \$8,500 / Individual<br>\$10,150 / Two-Person<br>\$10,150 / Family*  | \$12,000 / Individual<br>\$24,000 / Two-Person<br>\$24,000 / Family* |
| Lifetime Maximum   |  | Unlimited (Certain services are subject to calendar year and/or lifetime maximums or are limited per condition.) |  |
| Type of Service  | Description of Service and Limitations | Your Share After Annual Deductible <sup>1,2</sup>  |  |
|  |  | Preferred (PPO)  | Nonpreferred (OON)   |
| <b>Physician Services, Office</b>  |  |  |  |
| PPO Primary Provider (PPP) Office Visit/Exam Copayment (non-preventive)  |  | 30% coinsurance<br>(after Deductible)  | 50% coinsurance<br>(after deductible)                                |
| Telehealth Services  |  |  |  |
| Office Surgery (including casts, splints, etc.)  |  |  |  |
| Lab Tests, X-rays, EKGs, Diagnostic Services   |  |  |  |
| Other non-Routine Office Services: Includes services of non-PPP preferred providers (PPO Specialists) and Nonpreferred Providers   |  | 30% coinsurance<br>(after Deductible)  | 50% coinsurance<br>(after deductible)                                |
| Office Surgery   |  |  |  |
| Allergy Tests, Serum   |  |  |  |
| Allergy Injections   |  |  |  |
| Therapeutic Injections (by Physician)  |  |  |  |
| Therapeutic Injections (by Nurse)  |  |  |  |
| <b>Preventive Services:</b> Including immunizations, lab, X-ray, colonoscopies, pap tests, mammograms, immunizations, and other wellness services; smoking/tobacco cessation counseling, etc.  |  | No charge<br>(deductible waived)   | No charge<br>(deductible waived)                                     |
| <b>Diagnostic Testing, Outpatient</b>  |  |  |  |
| PET Scans, CT Scans, MRIs, (unless covered as part of a fixed-dollar copayment during ER visit, admission, etc.)   |  | 30% coinsurance<br>(after Deductible)  | 50% coinsurance<br>(after deductible)                                |
| Other lab, X-ray, EKGs, diagnostic services  |  |  |  |
| <b>Inpatient Hospital Services, Acute Care</b>   |  |  |  |
| Hospitalization (includes semi-private room, board, drugs, medications, and ancillaries; inpatient physician visits, surgeon, assistant, and anesthesiologist)   |  | 30% coinsurance<br>(after Deductible)  | 50% coinsurance<br>(after deductible)                                |
| <b>Inpatient Hospital Services, Acute Care</b>   |  |  |  |
| Hospitalization (includes semi-private room, board, drugs, medications, and ancillaries; inpatient physician visits, surgeon, assistant, and anesthesiologist)   |  | 30% coinsurance<br>(after Deductible)  | 50% coinsurance<br>(after deductible)                                |

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

| Benefit Highlights   | Preferred (PPO)                                      | Nonpreferred (OON)                                   |
|--|--|--|
| <b>Outpatient Hospital Services</b>  |  |  |
| Surgery – operating and recovery room<br>Observation (nonemergency)  | 30% coinsurance<br>(after Deductible)                | 50% coinsurance<br>(after deductible)                |
| Other treatment room services not otherwise specified in this Summary  |  |  |
| Related physician services (e.g., anesthetist, surgeon)  |  |  |
| <b>Emergency Services and Urgent Care</b>  |  |  |
| Emergency room or emergency observation room visit   | 30% coinsurance<br>(after Deductible)                | 30% coinsurance<br>(after Deductible)                |
| Urgent care center   |  |  |
| Ambulance (nonemergency air transfer)  |  |  |
| Ambulance (emergency ground and air transport)   |  |  |
| <b>Transplants</b>   |  |  |
| 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.)   | 30% coinsurance<br>(after Deductible)                | 50% coinsurance<br>(after deductible)                |
| Transplant Travel  | 30% after deductible,<br>\$10,000 max per transplant | 50% after deductible,<br>\$10,000 max per transplant |
| <b>Maternity Services</b>  |  |  |
| Initial visit to confirm pregnancy   | 30% coinsurance<br>(after Deductible)                | 50% coinsurance<br>(after deductible)                |
| Physician / midwife services (delivery, prenatal/ postnatal care)  |  |  |
| Hospital admission   |  |  |
| Routine nursery care for covered newborn<br>(Child covered from birth but must apply for coverage within 31 days.)   |  |  |
| <b>Mental Health and Substance Abuse Rehabilitation Services</b>   |  |  |
| Outpatient / Office services   | 30% coinsurance<br>(after Deductible)                | 50% coinsurance<br>(after deductible)                |
| Telehealth Services  |  |  |
| Inpatient services   |  |  |
| Partial hospitalization  |  |  |
| Intensive Outpatient Program   |  |  |
| Residential Treatment Center<br>(max. <b>60 days</b> / calendar year)  |  |  |
| <b>Other Office and Home Services</b>  |  |  |
| Acupuncture and Chiropractic Services<br>(Limited to <b>25 visits / combined</b> / calendar year.)   | 30% coinsurance<br>(after Deductible)                | 50% coinsurance<br>(after deductible)                |
| Cardiac and Pulmonary rehabilitation   |  |  |
| Chemotherapy, radiation therapy; dialysis  |  |  |
| 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 <b>30-day supply</b> during a 30-day period) |  |  |

| <b>Benefit Highlights</b>  | <b>Preferred (PPO)</b>   | <b>Nonpreferred (OON)</b>             |
|--|--|---------------------------------------|
| Hearing exam / test – Adults and Children  | 30% coinsurance<br>(after Deductible)  | 50% coinsurance<br>(after deductible) |
| Hearing aids – Adults Only (age 22 and older)  |  |                                       |
| Hearing aids – Children Only (age 21 and younger)  |  |                                       |
| Home health care and home I.V. services<br>(up to <b>100 visits</b> per calendar year)                                       | 30% coinsurance<br>(after Deductible)  | 50% coinsurance<br>(after deductible) |
| Hospice  | 30% coinsurance<br>(after Deductible)  | 50% coinsurance<br>(after deductible) |
| Naprapathy and Massage Therapy<br>(limited to <b>25 visits / combined</b> / calendar year)                                   | 30% coinsurance<br>(after Deductible)  | 50% coinsurance<br>(after deductible) |
| Rehabilitation Facility and Skilled Nursing Facility   |  |                                       |
| Short-term rehabilitation: outpatient/office Physical, Occupational, and Speech therapies                                    |  |                                       |
| Applied Behavioral Analysis for Autism<br>Occupational, Physical and Speech Therapy for Autism                               | 30% coinsurance<br>(after Deductible)  | 50% coinsurance<br>(after deductible) |
| TMJ / CMJ, oral surgery, and dental accident services  | Applicable copayments, deductible, and / or coinsurance based on place and type of treatment |                                       |
| <b>Prescription Drugs, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods, Smoking/Tobacco Cessation</b> | See your PBM benefit summary for details.  |                                       |

**\*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.

Blue Cross and Blue Shield of New Mexico (BCBSNM) provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims, except as may be specified in the Professional Services Agreement

#### FOOTNOTES:

<sup>1</sup> 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.) Preferred Provider amounts do not cross apply to the Nonpreferred Provider deductible nor vice versa.

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

<sup>2</sup> After you reach the applicable out-of-pocket limit, BCBSNM pays 100 percent of most of your covered Preferred or Nonpreferred Provider charges, whichever is applicable, for the rest of the calendar year. Preferred Provider amounts do not cross-apply to the Nonpreferred Provider limit nor vice versa. Amounts in excess of covered charges, penalty amounts, and noncovered charges do not count toward the out-of-pocket limit or deductible.

<sup>3</sup> Initial treatment of a medical emergency at a Preferred or Nonpreferred emergency room or trauma center is paid at the Preferred 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 Preferred Provider benefit level. Follow-up treatment and treatment that is not for an emergency is paid at the Nonpreferred Provider level. The emergency room or observation room copayment is waived if an inpatient admission results; then inpatient hospital benefits apply.

<sup>4</sup> 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.

<sup>5</sup> 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 in your benefit booklet for additional details.

<sup>6</sup> Transplants must be received at a facility that contracts with BCBSNM or with the national BCBS transplant network.

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