

# Albuquerque Public Schools

## Plan Highlights – 2026

Administered by:



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

EPO Plan Benefits There is no lifetime maximum benefit. However, certain services have maximum annual limits. See below.	Member's Share of Covered Charges
	Nationwide EPO Provider <sup>1,7</sup>
<b>Annual Deductible<sup>1</sup></b> Deductible does not apply to services with copays or "No Charge."	\$1,000/Individual \$2,000/Two-Person \$2,500/Family
<b>Annual Out-of-Pocket Limit</b> Includes deductible, coinsurance, and copayments; NOT prescription drugs, penalty amounts, or noncovered charges. <sup>2</sup>	\$5,000/Individual \$10,000/Two-Person \$12,500/Family
<b>Coinsurance</b>	20%
<b>Primary Care Provider (PCP)</b> Office Visit/Exam and initial office visit to diagnose pregnancy; Telehealth/Telemedicine	\$30 copay/visit
Virtual Visit – (MDLIVE providers)	No Charge
COVID-19 Testing and Treatment	Based on Place of Treatment and Type of Service
Maternity (initial office visit, pre-natal, post-natal, and OB delivery charges) See next page for hospital benefits.	\$60 copay/visit
Mental Health and Chemical Dependency (MH/CD) (outpatient/office); Telehealth/Telemedicine	No Charge
Virtual Visit (MH/CD) – (MDLIVE providers)	No Charge
Specialist Office Visit and initial office visit to diagnose pregnancy; Telehealth/Telemedicine	\$60 copay/visit
Office Surgery (including casts, splints, and dressings)	Office Visit (OV) Copay
Allergy office visits, Testing, Treatment	\$60 copay/visit
Allergy Extract prep, Allergy Serum, and Allergy Injections	\$10 copay/visit
Therapeutic Injection (billed without an office visit)	No Charge
<b>Preventive Services</b> 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, Immunizations; Smoking/Tobacco Cessation Counseling	No Charge (deductible waived)
<b>Acupuncture, Chiropractic, Massage Therapy, and Rolwing</b> (max. 25 visits/year; all services combined)	\$30 copay/visit
<b>Ambulance Services</b> Ground and Emergency Air Transport <sup>4</sup> (must be medically necessary)	20% <sup>4</sup>
<b>Autism Spectrum Disorders</b> Applied Behavioral Analysis <sup>4</sup> Occupational, Physical, and Speech Therapy	No Charge
<b>Biofeedback</b> (for specified services only)	\$60 copay/visit
<b>Cardiac and Pulmonary Rehabilitation</b>	\$0 copay/visit
<b>Dental/Facial Accident, Oral Surgery, and TMJ/CMJ Services<sup>4</sup></b>	20%
<b>Diabetic Supplies</b>	No Charge
<b>Emergency Room Treatment</b>	\$450 copay <sup>3</sup> (In-Network or Out-of-Network)
<b>Hearing Aids, Ear Molds, Fitting and Dispensing</b> (for dependents under age 21 only)	No Charge up to \$2,200 / 36 months
<b>Office Visit</b>	\$60 copay/visit
<b>Home Health Care/Home I.V. Services</b>	\$60 copay/visit
<b>Hospice Services</b> (Bereavement/3 sessions. Respite care (5 consecutive days for each 60 days of hospice; no more than two respite stays allowed).) <sup>4,5</sup>	20%

\* A Primary Care Provider (PCP) is a physician or other professional provider in the EPO Provider Network 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 EPO Provider network.

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<b>EPO Plan Benefits</b> There is no lifetime maximum benefit. However, certain services have maximum annual limits. See below.	<b>Member's Share of Covered Charges</b>
	<b>Nationwide EPO Provider<sup>1,7</sup></b>
<b>Infertility</b> (testing services to identify medical diagnosis)	Based on place of service
<b>Lab, X-Ray, and Other Basic Diagnostic Tests</b>	\$30 copay/day
<b>MRI, CT Scans, PET Scans</b>	
Free-standing Imaging Center	\$120 copay/day <sup>4</sup>
Hospital	20% <sup>4</sup>
<b>Inpatient Hospital/Facility Services</b>	
Room and Board, and Covered Ancillaries for: Medical/Surgical, Inpatient Rehabilitation, and Maternity-Related and Delivery	20% <sup>5</sup>
Mental Health/Chemical Dependency (including Partial Hospitalization); Residential Treatment Center (RTC) – Mental Health/Chemical Dependency (MH / CD)	No Charge <sup>5</sup>
<b>Maternity Services</b>	
Routine Nursery / Pediatrician Care for Covered Newborns - Facility	No Charge (all charges covered under Mother's claims) <sup>5</sup>
Extended Newborn Stay	20% <sup>5</sup>
<b>Outpatient Facility/Surgeon/Physician</b> (including Surgical procedures related to pregnancy and family planning)	20%
<b>Prescription Drugs, Enteral Nutritional Products, Special Medical Foods, Smoking/Tobacco Cessation</b>	For details, see the Express Scripts Summary of Benefits or call Express Scripts at 1-866-563-9297
<b>Short-Term Rehabilitation</b> Occupational, Physical, and Speech Therapy; Outpatient/Office Rehabilitation (max. 60 visits per condition/year)	\$30 copay/visit up to \$480 annual maximum
<b>Skilled Nursing Facility</b> (max. 60 days per year)	20%
<b>Sleep Studies</b> (Inpatient and Sleep Lab) <sup>4,5</sup>	20%
<b>Supplies, Durable Medical Equipment, Prosthetics, Orthotics<sup>4</sup></b> (preauthorization may be required)	20% <sup>6</sup> (deductible waived)
<b>Therapy: Chemotherapy, Dialysis, and Radiation</b>	20%
<b>Transplant Services</b> (Must be received at a facility that contracts with BCBSNM or with the national BCBS transplant network <sup>4,5</sup> .)	
Cornea, Kidney, Bone Marrow	Based on place of treatment and type of service <sup>4,5</sup>
Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney	20% <sup>4,5</sup>
<b>Urgent Care Facility</b>	\$75 copay/visit <sup>3</sup> (In-Network or Out-of-Network)

**Footnotes:**

<sup>1</sup> The deductible must be met before benefit payments are made for services with coinsurance.

<sup>2</sup> After a member reaches the applicable out-of-pocket limit, the APS plan pays 100 percent of most of that member's covered EPO Provider charges.

<sup>3</sup> Initial treatment of a medical emergency or urgent care visit is paid at the EPO Provider level. Follow-up treatment and treatment that is not for an emergency or urgent care that is provided by a Non-EPO provider, will not be covered.

<sup>4</sup> 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.

<sup>5</sup> Preauthorization is required for inpatient admissions. See a Member's Benefit Booklet for details.

<sup>6</sup> Rental benefits for medical equipment and other items will not exceed the purchase price of a new unit.

<sup>7</sup> EPO: Exclusive Provider Organization provides in-network ONLY coverage with Nationwide coverage. Also see footnote #3 above regarding emergency and urgent care services.

**IMPORTANT:** Deductible amounts and coinsurance percentages are applied to BCBSNM's covered charges, which may be less than the provider's billed charges. EPO providers will not charge you the difference between the covered charge and the billed charge for covered services.

**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.**