Administered by

BlueCross BlueShield of New Mexico

HEALTH CARE AUTHORITY

State of New Mexico

Plan Highlights – 2026 GOLD PPO 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		Tier 1 Provider [1,2] Preferred (PPO)	Tier 2 Provider [1,2] Nonpreferred (OON)	Tier 3 Provider [1,2] Nonpreferred (OON)
Highlights of Cost-Sharing Features				
Annual Deductible[1] (All services are subject to deductible unless noted otherwise.) *		$500 / Individual $1,000 / Two-Person $1,500 / Family*	$700 / Individual $1,400 / Two-Person $2,100 / Family*	$3,000 / Individual $6,000 / Two-Person $9,000 / 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 noncovered charges.) *		$4,000 / Individual $8,000 / Two-Person $12,000 / Family*	$6,000 / Individual $12,000 / Two-Person $18,000 / Family*	$9,000 / Individual $18,000 / Two-Person $27,000 / 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**[1,2] **Tier 1 Provider** **Preferred (PPO)**	**Tier 2 Provider** **Nonpreferred (OON)**	**Tier 3 Provider** **Nonpreferred (OON)**
Physician Services, Office				
PPO Primary Provider (PPP) Office Visit/Exam Copayment (non-preventive)		$30 (deductible waived)	$40 (deductible waived)	50% after deductible
Telehealth Services		No copay (deductible waived)	No copay (deductible waived)	50% after deductible
Office Surgery (including casts, splints, etc.)		$0 per visit (deductible waived)[4]	$0 per visit (deductible waived)[4]	50% after deductible
Lab Tests, X-Rays, EKGs, Other Diagnostics		30% after deductible	35% after deductible	50% after deductible
Other non-Routine Office Services: Includes services of non-PPP preferred providers (PPO Specialists) and Nonpreferred Providers		$60 per visit (deductible waived)[4]	$80 per visit (deductible waived)[4]	50% after deductible
Office Surgery		$60 per visit (deductible waived)[4]	$80 per visit (deductible waived)[4]	50% after deductible
Therapeutic Injections (by Physician) Therapeutic Injections (by Nurse)		No Charge (deductible waived)	No Charge (deductible waived)	50% after deductible
Allergy Testing / Treatment, Serum		$60 (deductible waived)	$80 (deductible waived)	50% after deductible
Allergy Injections		No copay (deductible waived)	No copay (deductible waived)	50% after deductible
Preventive Services: Including immunizations, lab, X-ray, colonoscopies, pap tests, mammograms, immunizations, and other wellness services; smoking/tobacco cessation counseling, etc.		No charge (deductible waived)	No charge (deductible waived)	50% after deductible
Diagnostic Testing, Outpatient				
PET Scans, CT Scans, MRIs, (unless covered as part of a fixed-dollar copayment during ER visit, admission, etc.) Other lab, X-ray, EKGs, diagnostic services		30% coinsurance after deductible (up to a max. member share of $300 per test)[4]	35% coinsurance after deductible (up to a max. member share of $300 per test)[4]	50% after deductible

Benefit Highlights	Tier 1 Provider [1,2] Preferred (PPO)	Tier 2 Provider [1,2] Nonpreferred (OON)	Tier 3 Provider [1,2] Nonpreferred (OON)
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 subject to deductible then no copay/coinsurance applies)[4,5]	35% after deductible (Related physician subject to deductible then no copay/coinsurance applies)[4,5]	50% after deductible
Outpatient Hospital Services			
Surgery – operating and recovery room Observation (nonemergency)	30% after deductible	35% after deductible	50% after deductible
Other treatment room services not otherwise specified in this Summary	30% after deductible	35% after deductible	50% after deductible
Related physician services (e.g., anesthetist, surgeon)	30% after deductible	35% after deductible	50% after deductible
Emergency Services and Urgent Care			
Emergency room or emergency observation room visit	$350 (waived if admitted)		
Urgent Care Center	$80	$100	50% after deductible
Ambulance (ground and air transfer) (emergency / nonemergency)	30% after deductible (Tier I deductible applies)		
Transplants			
Bone marrow, heart, heart-lung, liver, lung, pancreas-kidney, and other medically necessary transplants. Case management required. ($10,000 maximum for travel and lodging per diem)	Copay or deductible / coinsurance based on place and type of service[4,5,6]	Copay or deductible / coinsurance based on place and type of service[4,5,6]	Not covered
Transplant Travel	$10,000 max per transplant	$10,000 max per transplant	50% after deductible $10,000 max per transplant
Maternity Services			
Initial visit to confirm pregnancy	$20 for initial visit if to a PPP (deductible waived)	$25 for initial visit if to a PPP (deductible waived)	50% after deductible
Physician / midwife services (delivery, prenatal / postnatal care)	Applicable copays based on place and type of service[4,5]	Applicable copays based on place and type of service[4,5]	50% after deductible
Hospital admission	30% after deductible	35% after deductible	50% after deductible
Routine nursery care for covered newborn (Child covered from birth but must apply for coverage within 31 days.)	No copay (Related physician subject to deductible then no copay/coinsurance.)[4,5]	No copay (Related physician subject to deductible then no copay/coinsurance.)[4,5]	50% after deductible
Mental Health and Substance Abuse Rehabilitation Services			
Outpatient / Office services	$0 Copay (deductible waived)[4]	$0 Copay (deductible waived)[4]	50% after deductible
Telehealth Services	No charge (deductible waived)	No charge (deductible waived)	50% after deductible
Inpatient services	No charge (deductible waived)[4,5]	No charge (deductible waived)[4,5]	50% after deductible
Partial hospitalization	No charge (deductible waived)[5]	No charge (deductible waived)[5]	50% after deductible
Intensive Outpatient Program	No charge (deductible waived)[5]	No charge (deductible waived)[5]	50% after deductible
Residential Treatment Center (max. **60 days** / per plan year)	No charge (deductible waived)[4,5]	No charge (deductible waived)[4,5]	50% after deductible
Naprapathy and Massage Therapy for Behavior Health (limited to **25 visits / combined** / per plan year)	No charge (deductible waived)	No Charge (deductible waived)	50% after deductible
Other Office and Home Services			
Acupuncture (limited to **25 visits / combined** / per plan year)	$60 per visit (deductible waived)	$80 per visit (deductible waived)	50% after deductible
Chiropractic Services (limited to **25 visits / combined** / per plan year)	$30 per visit (deductible waived)	$40 per visit (deductible waived)	50% after deductible

Benefit Highlights	Tier 1 Provider [1,2]	Tier 2 Provider [1,2]	Tier 3 Provider [1,2]
	Preferred (PPO)	Nonpreferred (OON)	Nonpreferred (OON)
Cardiac and Pulmonary rehabilitation	Specialist Copays apply for office visits, other 30% after deductible	Specialist Copays apply for office visits, other 35% after deductible	50% coinsurance after deductible
Chemotherapy, radiation therapy, dialysis	Specialist copay applies for office visits, other outpatient place of service 30% after deductible	Specialist copay applies for office visits, other outpatient place of service 35% after deductible	50% coinsurance 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)	30% coinsurance after deductible	35% coinsurance after deductible	50% coinsurance after deductible
Hearing exam / test – Adults a Children	$60 per visit	$70 per visit	50% coinsurance after deductible
Hearing aids – Adults Only (age 22 and Older)	No copay, up to $2,500 per ear every 36 months	No copay, up to $2,500 per ear every 36 months	50% after deductible, up to $2,500 per ear every 36 months
Hearing aids – Children Only (age 21 and younger)	No charge (deductible waived)	No charge (deductible waived)	50% coinsurance after deductible
Home health care and home I.V. services (up to **100 visits** per calendar year)	$60 per visit (deductible waived)[4]	$80 per visit (deductible waived)[4]	50% coinsurance after deductible
Hospice	0% after deductible	0% after deductible	50% coinsurance after deductible
Naprapathy and Massage Therapy (limited to **25 visits / combined** / per plan year)	$60 per visit (deductible waived)	$80 per visit (deductible waived)	50% coinsurance after deductible
Rehabilitation Facility and Skilled Nursing Facility	30% after deductible	35% after deductible	50% coinsurance after deductible
Short-term rehabilitation: outpatient / office Physical, Occupational, and Speech therapies	$30 per visit (deductible waived)	$40 per visit (deductible waived)	50% coinsurance after deductible
Applied Behavioral Analysis for Autism Occupational, Physical and Speech Therapy for Autism	$0 Copay Based on place of treatment and type of service	$0 Copay Based on place of treatment and type of service	50% coinsurance after deductible
TMJ / CMJ, oral surgery, and dental accident services	Applicable copayments, deductible, and / or coinsurance based on place and type of treatment		
Prescription Drugs, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods, Smoking/Tobacco Cessation	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:

[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.) 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.

[2] 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.

[3] 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.

[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 in 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.

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