PRESBYTERIAN APS EPO Plan

Coverage for: Individual or Family | **Plan Type:** HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-855-261-7737 or visit www.phs.org. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-855-261-7737 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$500**/Individual **$1,000**/Two Party **$1,250** Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive care without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Yes. **$4,000** Individual/ **$8,000** Two Party/ **$12,000** Family	The out of pocket limit is the most you could pay in a year for covered services. Prescription drugs have a separate out-of-pocket limit.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, prescription drugs and health care this plan doesn't cover. In addition, certain specialty pharmacy drugs are considered non-essential health benefits under the Affordable Care Act (ACA), and fall outside the out-of-pocket limits.	Even though you pay these expenses, they don't count toward the out of pocket limit.
Will you pay less if you use a network provider?	Yes. See **www.phs.org or call 1-800-356-2219** for a list of participating providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out of network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out of network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider	Out-of-network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment/visit Video visit - No charge	Not covered	----------None----------
	Specialist visit	$50 copayment/visit	Not covered	----------None----------
	Preventive care/screening/immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$20 copayment	Not covered	Diagnostic Test: None Only Free-Standing facility will have a $120 copayment. All other CAT, MRI, and PET scans at a hospital require a 20% coinsurance. Deductible does apply. Prior authorization may be required.
	Imaging (CT/PET scans, MRIs)	PET/MR/CT: $120 copayment/day or 20% coinsurance	Not covered	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available from Express Scripts: 1-866-563-9297	Generic drugs	Retail: 20% coinsurance, minimum $10 and maximum $25 (up to 34 day supply); Home delivery and Walgreens: $25 (up to 90 day supply)	Not covered	Prescription drug benefits are administered for Albuquerque Public Schools by Express Scripts. Insulin and Diabetic Supplies: $0 copayment. Insulin or a Medically Necessary alternative will no exceed $0 for a 30-day supply. Maintenance (long term) medications: A maximum of two 30-day fills of maintenance medications are allowed at a retail pharmacy. Then, maintenance medications require a 90-day fill either via Express Scripts home delivery or at a Walgreens pharmacy. Specialty medications: 30-day fills of specialty medications must be filled using Accredo, the Express Scripts home delivery specialty pharmacy. Please see the "Important Questions" section (page 1) of this document regarding the plan's out-of-pocket limit.
	Preferred brand drugs	Retail: 30% coinsurance, minimum $35 and maximum $65 (up to 34 day supply); Home delivery and Walgreens: $70 (up to 90 day supply)	Not covered	
	Non-preferred brand drugs	Retail: 40% coinsurance, minimum $70 and maximum $140 (up to 34 day supply); Home delivery and Walgreens: $150 (up to 90 day supply)	Not covered	
	Specialty drugs Specialty medications must be filled through Accredo, the Express Scripts home delivery specialty pharmacy	30 day supply of specialty medications $70 for generic specialty medications; $100 for preferred brand specialty medications; $150 for non-preferred brand specialty medications; Copays for certain specialty medications may be set to the maximum of the current plan design ($150) or the amount available manufacturer-funded copay assistance.	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider	Out-of-network Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible is paid	Not covered	Prior authorization may be required.
	Physician/surgeon fees	20% coinsurance after deductible is paid	Not covered	Prior authorization may be required.
If you need immediate medical attention	Emergency room care	$350 copayment/visit	$350 copayment/visit	Waived if admitted into a hospital, then hospital 20% coinsurance applies after deductible.
	Emergency medical transportation	20% coinsurance ground; air	20% coinsurance ground; air	Inter-facility transport no charge
	Urgent care	$50 copayment/visit	$50 copayment/visit	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance/admission after deductible is paid	Not covered	Prior authorization may be required.
	Physician/surgeon fees	20% coinsurance after deductible is paid	Not covered	Prior authorization may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copayment/visit up to a $260 annual maximum	Not covered	----------None----------
	Inpatient services	No charge	Not covered	Prior authorization may be required.
If you are pregnant	Office visits	$50 copayment initial visit only then plan pays 100%	Not covered	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	20% coinsurance after deductible is paid	Not covered	----------None----------
	Childbirth/delivery facility services	20% coinsurance after deductible is paid	Not covered	Prior authorization may be required.
If you need help recovering or have other special health needs	Home health care	$50 copayment/visit	Not covered	Prior authorization may be required.
	Rehabilitation services	$20 copayment/visit $320 annual maximum	Not covered	Maximum of 60 days per condition per calendar year combined. Prior authorization may be required.
	Habilitation services	$20 copayment/visit $320 annual maximum	Not covered	Maximum of 60 days per condition per calendar year combined. Prior authorization may be required.
	Skilled nursing care	20% coinsurance/admission after deductible is paid	Not covered	Maximum of 60 days per calendar year. Prior authorization may be required.
	Durable medical equipment	20% coinsurance deductible does NOT apply	Not covered	Prior authorization may be required.
	Hospice services	20% coinsurance/admission after deductible is paid	Not covered	Prior authorization may be required. Waived if transferred directly from an inpatient facility.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider	Out-of-network Provider	
If your child needs dental or eye care	Children's eye exam	Included in office visit copayment	Not covered	Coverage is limited to refraction eye exam associated with post cataract surgery or Keratoconus correction
	Children's glasses	50% coinsurance deductible applies	Not covered	Coverage is limited to eyeglasses/contact lenses within 12 months following cataract surgery, correction of Keratoconus or when related to Genetic Inborn Errors of Metabolism. Prior authorization may be required.
	Children's dental check-up	Not covered	Not covered	----------None----------

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic Surgery
- Dental Care (Adult)
- Dental check-up (Child)
- Hearing aids (Adult)
- Home Births
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Private-Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care * Only covered when medically necessary for diabetes. See SPD for details.
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids for school aged children
- Infertility Treatment

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical appeal. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, you may contact the Office of the Superintendent of Insurance Managed Health Care Bureau at 1-855-427-5674 or by email at mhcb.grievance@state.nm.us.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standard, you may be eligible for a premium tax credits to help you pay for a plan through the Marketplace.

Language Access Services:
Para obtener asistencia en Español, llame al 1-800-356-2219.
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-356-2219.
如果需要中文的帮助，请拨打这个号码　1-800-356-2219.
Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-356-2219.

To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$500**
Specialist copayment	**$50**
Hospital (Facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$50
Coinsurance	$2400
What isn't covered	
Limits or exclusions	$30
The total Peg would pay is	$2980

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$500**
Specialist copayment	**$50**
Hospital (Facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$190
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$550

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$500**
Specialist copayment	**$50**
Hospital (Facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$530
Coinsurance	$140
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1170

The **plan** would be responsible for the other costs of these EXAMPLE covered services.