PRESBYTERIAN City of Albuquerque My Care Active

**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? | **$175** Individual / **$350** Family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| Are there services covered before you meet your deductible? | Yes. Preventive care, COVID-19 screening, testing, treatment & vaccines/boosters & any service that have a copayment are 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? | **$6,350** Individual / **$12,700** Family | The out of pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out of pocket limit until the overall family out of pocket limit has been met. |
| What is not included in the out-of-pocket limit? | Premiums, balance billing charges, and health care this plan doesn't cover. Certain specialty pharmacy drugs are considered non-essential health benefits and fall outside the out-of-pocket limits. | Even though you pay these expenses, they don't count toward the out of pocket limit. The cost of these drugs (though reimbursed by the manufacturer at no cost to you) will not be applied towards satisfying your out-of-pocket maximums. |
| Will you pay less if you use a network provider? | Yes. See **www.phs.org or call 1-855-261-7737** 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). |
| Do you need a referral to see a specialist? | No. | You can see the specialist you choose without a referral. |

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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 (You will pay the least) | Out-of-network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | $35 copayment/visit only deductible does not apply - all other services deductible applies | Not covered | There is zero cost sharing for any telehealth service. Copayment does not include Medical Drugs which will have a separate charge. No charge for anything related to COVID-19 screening, testing, vaccines/boosters, or medical treatment. Prior authorization is not required for gynecological or obstetrical ultrasounds. |
| | Specialist visit | $50 copayment/visit only deductible does not apply - all other services deductible applies | Not covered | There is zero cost sharing for any telehealth service. Copayment does not include Medical Drugs which will have a separate charge. No charge for anything related to COVID-19 screening, testing, vaccines/boosters, or medical treatment. Prior authorization is not required for gynecological or obstetrical ultrasounds. |
| | Preventive care/screening/immunization | No charge deductible does not apply | 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. No charge for anything related to COVID-19 screening, testing, vaccines/boosters, or medical treatment. |
| If you have a test | Diagnostic test (x-ray, blood work) | No charge deductible does not apply | Not covered | Prior authorization may be required or benefits may be denied. |
| | Imaging (CT/PET scans, MRIs) | PET/MRI: $125 copayment/test; CT: $75 copayment/test deductible applies | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-network Provider (You will pay the least) | Out-of-network Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition** More information about prescription drug coverage is available at phs.org/formsanddocuments | Generic drugs (Tier 1) | $10 copayment (retail) $20 copayment (mail order) | Not covered | **Administered by Express Scripts - contact at 1-877-860-9256.** |
| | Preferred brand drugs (Tier 2) | $35 copayment (retail) $87.50 copayment (mail order) | Not covered | |
| | Non-preferred drugs (Tier 3) | $55 copayment (retail) $165 copayment (mail order) | Not covered | |
| | Self-Administered Specialty (Tier 4) | 20% up to a maximum of $400 per prescription (retail)/ Not available (mail order) | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance up to $500 copayment/visit after deductible is met | Not covered | Prior Authorization may be required or benefits may be denied. |
| | Physician/surgeon fees | Included in facility fee deductible does not apply | Not covered | Prior Authorization may be required or benefits may be denied. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-network Provider (You will pay the least) | Out-of-network Provider (You will pay the most) | |
| If you need immediate medical attention | Emergency room care | $200 copayment/visit deductible applies | $200 copayment/visit deductible applies | Waived if admitted into a hospital, then hospital copay applies. No charge for anything related to COVID-19 screening, testing, medical treatment, vaccines/boosters. Balance billing is not allowed for out-of-network care. |
| | Emergency medical transportation | $50 copayment /occurrence ground; $100 copayment /occurrence air deductible applies ; No charge inter-facility deductible does not apply | $50 copayment /occurrence ground; $100 copayment /occurrence air deductible applies ; No charge inter-facility deductible does not apply | No charge for anything related to COVID-19 screening, testing, medical treatment, vaccines/boosters. Balance billing is not allowed for out-of-network care. |
| | Urgent care | $35 copayment/visit deductible applies | $35 copayment/visit deductible applies | Lab and X-ray deductible does not apply. No charge for anything related to COVID-19 screening, testing, medical treatment, vaccines/boosters. Balance billing is not allowed for out-of-network care. There is zero cost sharing for any telehealth service. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | $500 copayment /admission deductible does not apply | Not covered | Prior Authorization may be required or benefits may be denied. |
| | Physician/surgeon fees | Included in facility fee deductible does not apply | Not covered | Prior Authorization may be required or benefits may be denied. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | $35 copayment/visit deductible does not apply | Not covered | ----------None---------- |
| | Inpatient services | $500 copayment /admission deductible applies | Not covered | Prior authorization may be required or benefits may be denied. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-network Provider (You will pay the least) | Out-of-network Provider (You will pay the most) | |
| If you are pregnant | Office visits | $35 copayment/visit up to $200/pregnancy deductible does not apply | Not covered | Depending on the type of services, a copayment, coinsurance, or deductible may apply. Cost sharing does not apply for preventative services. Prior authorization is not required for gynecological or obstetrical ultrasounds. |
| | Childbirth/delivery professional services | No charge deductible does not apply | Not Covered | Prior authorization is not required for gynecological or obstetrical ultrasounds. |
| | Childbirth/delivery facility services | $500 copayment /admission deductible applies | Not covered | Prior authorization may be required or benefits may be denied. Prior authorization is not required for gynecological or obstetrical ultrasounds. |
| If you need help recovering or have other special health needs | Home health care | No charge deductible does not apply | Not covered | Prior authorization may be required or benefits may be denied. |
| | Rehabilitation services | Inpatient: $500 copayment/admission deductible applies; Outpatient: $35 copayment/visit deductible does not apply | Not covered | Coverage is limited up to 24 visits/plan year; combined. Prior authorization may be required for inpatient or benefits may be denied. |
| | Habilitation services | Inpatient: $500 copayment/admission deductible applies; Outpatient: $35 copayment/visit deductible does not apply | Not covered | ----------None---------- |
| | Skilled nursing care | $500 copayment /admission deductible applies | Not covered | Coverage is limited up to 60 days per plan year. Prior authorization will be required or benefits may be denied. |
| | Durable medical equipment | 50% coinsurance deductible applies | Not covered | Prior authorization may be required or benefits may be denied. |
| | Hospice services | $500 copayment /admission deductible applies | Not covered | Waived if transferred directly from an inpatient hospital, rehabilitation, or skilled nursing facility. Prior authorization may be required or benefits may be denied. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-network Provider (You will pay the least) | Out-of-network Provider (You will pay the most) | |
| If your child needs dental or eye care | Children's eye exam | Included in office visit copayment deductible does not apply | Not covered | Coverage is limited to refraction eye exam associated with post cataract surgery or Keratoconus correction. |
| | Children's glasses | 50% coinsurance after deductible is met | 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 or benefits may be denied. |
| | 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)
- 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 (20 visits per Contract Year unless for Rehabilitative or Habilitative Svc)
- Bariatric Surgery
- Chiropractic Care (20 visits per Contract Year unless for Rehabilitative or Habilitative Svc)
- Hearing Aids
- 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 on how to submit a claim, appeal, or a grievance for any reason to your plan.

**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 1-855-261-7737.
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-261-7737.
如果需要中文的帮助，请拨打这个号码　1-855-261-7737.
Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-261-7737.
Learn more about Presbyterian's Notice of Nondiscrimination, go to www.phs.org/nondiscrimination.aspx.

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 | $175 |
| Specialist | $50 |
| Hospital (Facility) | $500 |
| Other | No Charge |

**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 | $175 |
| Copayments | $700 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | $875 |

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

| | |
|---|---|
| The plan's overall deductible | $175 |
| Specialist | $50 |
| Hospital (Facility) | $500 |
| Other | No Charge |

**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 | $3,600 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $800 |
| **The total Joe would pay is** | $4,400 |

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

| | |
|---|---|
| The plan's overall deductible | $175 |
| Specialist | $50 |
| Hospital (Facility) | $500 |
| Other | No Charge |

**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 | $175 |
| Copayments | $600 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | $875 |

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