PRESBYTERIAN County of Bernalillo 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?	**$250** Individual / **$750** 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 Behavioral Health services and any benefit where there is no charge, Covid-19 screening, testing, treatment, vaccines/boosters and 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?	**$3,000** Individual / **$6,000** 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.	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.

HWH20008_PHR10414

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	Adult/Child: $30/$15 copayment/visit Video visit - No charge	Not covered	----------None----------
	Specialist visit	Adult/Child: $60/$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)	No charge	Not covered	Prior authorization may be required or benefits may be denied.
	Imaging (CT/PET scans, MRIs)	Adult/Child: PET/MRI: $150/$100 copayment/test; CT: $125/ $75 copayment/test	Not covered	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at phs.org/formsanddocuments	Preferred Generic Drugs (Tier 1)	$10 copayment (retail) / $20 copayment (mail order)	Not covered	Tier 1, Tier 2 and Tier 3 Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription)Tier 4 Mail order is not covered. Prior authorization for some drugs may be required.
	Preferred brand drugs (Tier 2)	$40 copayment (retail) / $80 copayment (mail order)	Not covered	
	Non-preferred drugs (Tier 3)	$75 copayment (retail) / $200 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)	$500/visit-Adult and $200/visit-Child	Not covered	Prior Authorization may be required or benefits may be denied.
	Physician/surgeon fees	Included in facility fee	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	$250 copayment/visit	$250 copayment/visit	Waived if admitted into a hospital, then hospital copayment applies.
	Emergency medical transportation	$50 copayment ground; $100 copayment air; No charge inter-facility	$50 copayment ground; $100 copayment air; No charge inter-facility	----------None----------
	Urgent care	Adult/Child: $50/$10 copayment/visit	Adult/Child: $50/$10 copayment /visit	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	Adult/Child: $500/$350 copayment/admission	Not covered	Prior Authorization may be required or benefits may be denied.
	Physician/surgeon fees	Included in facility fee	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	No charge	Not covered	There is no cost-sharing for behavioral health services or drugs.
	Inpatient services	No charge	Not covered	Prior authorization may be required or benefits may be denied. There is no cost-sharing for behavioral health services or drugs.
If you are pregnant	Office visits	$30 copayment initial visit only; No charge all other visits	Not covered	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	No charge	Not covered	----------None----------
	Childbirth/delivery facility services	$500 copayment/admission	Not covered	Prior authorization may be required.

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 help recovering or have other special health needs	Home health care	No charge	Not covered	Prior authorization may be required or benefits may be denied.
	Rehabilitation services	Adult/Child: $50/$40 copayment/visit	Not covered	Coverage is limited up to 24 visits not combined. Prior authorization may be required or benefits may be denied.
	Habilitation services	Child: $40 copayment /visit	Not covered	----------None----------
	Skilled nursing care	Adult/Child: $500/$350 copayment/admission	Not covered	Coverage is limited up to 60 days per contract year. Prior authorization may be required or benefits may be denied.
	Durable medical equipment	20% coinsurance deductible applies	Not covered	Prior authorization may be required or benefits may be denied.
	Hospice services	Adult/Child: $500/$350 copayment/admission	Not covered	Prior authorization may be required or benefits may be denied. Waived if transferred directly from an inpatient facility.
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	• Long-Term Care	• Routine Eye Care (Adult)
• Dental Care (Adult)	• Non-Emergency Care When Traveling Outside the U.S.	• Routine Foot Care * Only covered when medically necessary for diabetes. See SPD for details.
• Dental check-up (Child)	• Private-Duty Nursing	• 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 calendar year unless for rehabilitative or habilitative svc)	• Chiropractic Care (20 visits per calendar year unless for rehabilitative or habilitative svc)	• Infertility Treatment
• Bariatric Surgery	• Hearing Aids	

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

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.
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	$250
Specialist	$60
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	**$12,738**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$90
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$150

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

The plan's overall deductible	$250
Specialist	$60
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$1,055

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

The plan's overall deductible	$250
Specialist	$60
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	**$1,934**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$29
Copayments	$500
Coinsurance	$7
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$537

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