Santa Fe County HMO

Coverage for: Individual or Family | Plan Type: HMO



The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 1-855-593-7737 or visit www.phs.org. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-855-593-7737 to request a copy.

| Important Questions | Answers | Why This Matters: | | | |
|--|---|---|--|--|--|
| What is the overall \$325 Single / \$650 Two-person / \$975 Family | | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . | | | |
| Are there services covered before you meet your deductible? | Yes. Preventive care is covered before you meet your deductible. | This <u>plan</u> covers some items & services even if you haven't met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive care</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits. | | | |
| Are there other <u>deductibles</u> for specific services? | Yes. \$50 Single \$100 Two-Person/Family | You must pay all the Pharmacy costs up to the <u>deductible</u> amount before this <u>plan</u> begins to pay for covered services you use. | | | |
| What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ? | \$3,500 Single/ \$7,000 Two-person/ \$10,500 Family. | The <u>out of pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out of pocket limit</u> until the overall family <u>out of pocket limit</u> has been met. | | | |
| What is not included in the out-of-pocket limit? | Premiums, balance billing charges, health care this plan doesn't cover, and penalty amounts. | Even though you pay these expenses, they don't count toward the out of pocket limit. | | | |
| Will you pay less if you use a <u>network provider</u> ? | Yes. See https://www2.phs.org/providers ?insurance_plans=aso-hmo- aso-ppo-aso-hdhp or call 1- 888-275-7737 for a list of participating providers. | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out of network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). | | | |
| Do you need a <u>referral</u> to see a <u>specialist</u> ? | No. | You can see the specialist you choose without a referral. | | | |



All $\underline{\text{copayment}}$ and $\underline{\text{coinsurance}}$ costs shown in this chart are after your $\underline{\text{deductible}}$ has been met, if a $\underline{\text{deductible}}$ applies.

| Common | | What You | ı Will Pay | Limitations, Exceptions, & Other Important | |
|--|--|---|---|---|--|
| Medical Event | Services You May Need | In-network Provider (You will pay the least) | Out-of-network Provider (You will pay the most) | Information | |
| | Primary care visit to treat an injury or illness | \$25 <u>copayment</u> /visit Video Visit- No Charge. | Not covered | None | |
| If you visit a health | Specialist visit | \$40 copayment/visit | Not covered | None | |
| care <u>provider's</u> office or clinic | 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. | |
| | <u>Diagnostic test</u> (x-ray, blood work) | 20% <u>coinsurance</u> after <u>deductible</u> is met | Not covered | | |
| If you have a test | Imaging (CT/PET scans, MRIs) | 20% coinsurance up to a max of \$200 per test/per day after deductible is met | Not covered | Prior authorization may be required or benefits may be denied. | |
| If you need drugs to treat your illness or | Generic drugs (Tier 1) | \$5 <u>copayment</u> (retail) / \$15 <u>copayment</u> (mail order) | Not Covered | | |
| condition More information about prescription drug | Preferred brand drugs (Tier 2) | 30% coinsurance (\$30 minimum up to \$90) (retail) / \$95 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 | |
| coverage is available at https://client.formul | Non-preferred drugs (Tier 3) | 40% coinsurance (\$55 minimum up to \$125) (retail) / \$125 copayment(mail order) | Not Covered | prescription)Tier 4 Mail order is not covered. Prior authorization for some drugs may be required. | |
| arynavigator.com/ Search.aspx?siteC ode=0322075909 | Self-Administered Specialty (Tier 4) | \$60 Generic \$85 Preferred Brand \$125 Non-Preferred | Not covered | | |
| If you have outpatient | Facility fee (e.g., ambulatory surgery center) | 20% <u>coinsurance</u> after <u>deductible</u> is met | Not covered | Prior Authorization may be required or benefits may be denied. | |
| surgery | Physician/surgeon fees | 20% <u>coinsurance</u> after <u>deductible</u> is met | Not covered | Facility claim only | |

| Common | Services You May Need | What You | u Will Pay | Limitations, Exceptions, & Other Important | |
|--|---|--|--|---|--|
| Medical Event | | In-network Provider (You will pay the least) | Out-of-network Provider (You will pay the most) | Information | |
| | Emergency room care | \$175 copayment/visit | \$175 <u>copayment</u> /visit | Waived if admitted into a hospital, then hospital copayment applies. | |
| If you need immediate medical attention | Emergency medical transportation | \$30 <u>copayment</u> /trip ground; \$100 <u>copayment</u> /trip air | \$30 <u>copayment</u> /trip ground; \$100 <u>copayment</u> /trip air | None | |
| | <u>Urgent care</u> | \$50 copayment/visit | \$50 <u>copayment</u> /visit | None | |
| If you have a hospital | Facility fee (e.g., hospital room) | \$500 <u>copayment</u> /admission after <u>deductible</u> is met | Not covered | Prior Authorization may be required or benefits may be denied. | |
| stay | Physician/surgeon fees | No charge | Not covered | Prior Authorization may be required or benefits may be denied. | |
| If you need mental health, behavioral health, or substance | Outpatient services | \$25 copayment/visit | Not covered | None | |
| health, or substance abuse services | Inpatient services | \$500 <u>copayment</u> /admission after <u>deductible</u> is met | Not covered | Prior authorization may be required. | |
| | Office visits | \$25 <u>copayment</u> initial visit only | Not covered. | Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Cost sharing does not apply for preventative services. Prior Authorization is not required for gynecological or obstetrical ultrasounds. | |
| If you are pregnant | Childbirth/delivery professional services | No charge | Not covered | Prior Authorization is not required for gynecological or obstetrical ultrasounds. | |
| | Childbirth/delivery facility services | \$500 <u>copayment/pregnancy</u> after <u>deductible</u> is met | Not covered | Prior authorization may be required or benefits may be denied. Prior Authorization is not required for gynecological or obstetrical ultrasounds. | |

| Common | | What You | ı Will Pay | Limitations, Exceptions, & Other Important | |
|--|----------------------------|--|---|---|--|
| Medical Event | Services You May Need | In-network Provider (You will pay the least) | Out-of-network Provider (You will pay the most) | Information | |
| | Home health care | \$40 <u>copayment</u> /physician services | Not covered | No charge for nursing services. Prior authorization may be required or benefits may be denied. | |
| If you need help recovering or have | Rehabilitation services | Inpatient: \$500 copayment/admission after deductible is met; Outpatient: \$40 copayment/visit | Not covered | Prior authorization may be required or benefits may be denied. | |
| other special health | Habilitation services | \$40 copayment/visit | Not covered | None | |
| needs | Skilled nursing care | \$500 <u>copayment</u> /admission after <u>deductible</u> is met | Not covered | Admission copayment waived if readmitted within 15 days. Prior authorization may be required or benefits may be denied. | |
| | Durable medical equipment | 20% <u>coinsurance</u> after <u>deductible</u> is met | Not covered | Prior authorization may be required or benefits may be denied. | |
| | Hospice services | No charge | Not covered | Prior authorization may be required or benefits may be denied. | |
| | Children's eye exam | Not covered | Not covered | None | |
| If your child needs dental or eye care | Children's glasses | 20% <u>coinsurance</u> after <u>deductible</u> is met | Not covered | Prior authorization may be required. | |
| | Children's dental check-up | Not covered | Not covered | None | |

Excluded Services & Other Covered Services:

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|---|--|---|---|---|--|--|--|
| S | 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 | • | Glasses (Child) | • | Private-Duty Nursing | | |
| • | Dental Care (Adult) | • | Infertility Treatment (Only limited services covered) | • | Routine Eye Care (Adult) | | |
| • | Dental check-up (Child) | • | Long-Term Care | • | Routine Foot Care | | |
| • | Eye exam (Child) | • | Non-Emergency Care When Traveling Outside the U.S. | • | Weight Loss Programs (Morbid obesity treatment only) | | |
| O | Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | | | | | |
| • | Acupuncture | • | Chiropractic Care | • | Hearing Aids | | |
| • | Bariatric Surgery | | | | | | |

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 claim. Your plan documents also provide complete information on how 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 1-888-275-7737.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-275-7737.

如果需要中文的帮助,请拨打这个号码 1-888-275-7737.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-275-7737.

Learn more about Presbyterian's Notice of Nondiscrimination, go to www.phs.org/nondiscrimination.aspx.

To see examples of how this <u>plan</u> 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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

| Peg is Having a Baby (9 months of in-network pre-natal c hospital delivery) | | Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition) | | Mia's Simple Fracture (in-network emergency room visit and follow up care) | |
|---|-------|--|--|---|--|
| The plan's overall deductible \$325 Specialist \$40 Hospital (Facility) \$500 Other Charge | | The plan's overall deductibleSpecialistHospital (Facility)Other | \$325 \$40 \$500 No Charge | The plan's overall deductibleSpecialistHospital (Facility)Other | \$325 \$40 \$500 No Charge |
| This EXAMPLE event includes services Specialist office visits (prenatal care) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood Specialist visit (anesthesia) | 3 | 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) | | 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 \$12,731 | | Total Example Cost | \$7,389 | Total Example Cost | \$1,925 |
| In this example, Peg would pay: | | In this example, Joe would pay: | | In this example, Mia would pay: | |
| Cost Sharing | | Cost Sharing | | Cost Sharing | |
| Deductibles | \$325 | Deductibles | \$325 | Deductibles | \$53 |
| Copayments | \$20 | Copayments | \$155 | Copayments | \$0 |
| Coinsurance \$209 | | Coinsurance | \$1,101 | Coinsurance | \$13 |
| What isn't covered | | What isn't covered | | What isn't covered | |
| Limits or exclusions | \$60 | Limits or exclusions | \$55 | Limits or exclusions | \$0 |
| The total Peg would pay is | \$614 | The total Joe would pay is | \$1,636 | The total Mia would pay is | \$67 |

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