PRESBYTERIAN City of Rio Rancho Copay Plan

Coverage for: Individual or Family | Plan Type: POS

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 1-877-752-4164 or visit www.phs.org for Medical and 1-800-232-6549 or visit www.express-scripts.com for pharmacy. 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 1-877-752-4164 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network $0 Out-of-network $300 Individual $600 Double $900 Family	See the Common Medical Events chart below for your costs for services this plan covers.
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 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?	In-network $1,000 Individual $2,000 Double $3,000 Family. Out-of-network $3,500 Individual $7,000 Double $10,500 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, 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 network provider?	Yes. See www.phs.org or call 1-877-752-4164 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	$20 copayment/visit - adult /$10 copayment/visit -child	30% coinsurance after deductible is met. Video visits-deductible may apply and coinsurance	$0 copayment for virtual visits apply only to Online Visits and TalkSpace Behavioral Health.
	Specialist visit	$40 copayment/visit	30% coinsurance after deductible is met	----------None----------
	Preventive care/screening/immunization	No charge	30% coinsurance after deductible is met	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	30% coinsurance after deductible is met	Prior authorization may be required.
	Imaging (CT/PET scans, MRIs)	$100 copayment/test per day	30% coinsurance after deductible is met	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scrpits.com	Generic drugs (Tier 1)	$5 copayment (30-day retail)/ $10 copayment (90-day mail order)	$5 copayment (30-day retail)/ Not Covered (90-day mail order)	Tier 1, Tier 2 and Tier 3: Covers up to a 30-day supply (retail); 90-day supply (mail order prescription). Not all drugs are covered or have quantity limits. For more info go to www.express-scripts.com or call 1-866-217- 3774. Please see the "Important Questions" section (page 1) of this document regarding the plan's out-of-pocket limit.
	Preferred brand drugs (Tier 2)	$35 copayment (30-day retail) /$87.50 copayment (90-day mail order)	$35 copayment (30-day retail)/ Not Covered (90-day mail order)	
	Non-preferred drugs (Tier 3)	$55 copayment (30-day retail) /$137.50 copayment (90-day mail order)	$55 copayment (30-day retail)/ Not Covered (90-day mail order)	
	Self-Administered Specialty (Tier 4)	Same cost as other generic, preferred brand, and non-preferred brand drugs Visit www.express-scripts.com	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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copayment	30% coinsurance after deductible is met	Prior authorization may be required.
	Physician/surgeon fees	No charge	30% coinsurance after deductible is met	Prior authorization may be required.
If you need immediate medical attention	Emergency room care	$100 copayment/visit	$100 copayment initial visit	Out-of-network follow-up Deductible does apply and 30% coinsurance.
	Emergency medical transportation	$50 copayment/occurrence ground; $100 copayment/occurrence air	$50 copayment/occurrence ground; $100 copayment/occurrence air	The member will be responsible for any balance due above Reasonable and Customary Charges for out-of-network air ambulance service.
	Urgent care	$40 copayment/visit	$40 copayment/visit	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copayment/admission	30% coinsurance after deductible is met	Prior authorization may be required.
	Physician/surgeon fees	No charge	30% coinsurance after deductible is met	Prior authorization may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copayment/visit - adult /$10 copayment/visit -child	30% coinsurance after deductible is met	----------None----------
	Inpatient services	$500 copayment/admission	30% coinsurance after deductible is met	Prior authorization may be required.
If you are pregnant	Office visits	$20 copayment/visit up to a maximum of $200/pregnancy	30% coinsurance after deductible is met	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	All delivery services are included	30% coinsurance after deductible is met	All services included.
	Childbirth/delivery facility services	$500 copayment/admission	30% coinsurance after deductible is met	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	$40 copayment	30% coinsurance after deductible is met; 20% penalty applies if prior authorization not obtained.	Prior authorization may be required.
	Rehabilitation services	Inpatient: $500 copayment/admission; Outpatient: $40 copayment/visit	30% coinsurance after deductible is met; 20% penalty applies if prior authorization not obtained.	Coverage is limited to 80 visits/calendar year combined in- and out-of-network. Prior authorization may be required.
	Habilitation services	Inpatient: $500 copayment/admission; Outpatient: $40 copayment/visit	30% coinsurance after deductible is met; 20% penalty applies if prior authorization not obtained.	----------None----------
	Skilled nursing care	$500 copayment/admission	30% coinsurance after deductible is met; 20% penalty applies if prior authorization not obtained.	Coverage is limited to 60 days/calendar year combined in- and out-of-network. Prior authorization may be required.
	Durable medical equipment	30% coinsurance	50% coinsurance after deductible is met; 20% penalty applies if prior authorization not obtained.	Prior authorization may be required.
	Hospice services	No Charge	30% coinsurance after deductible is met	Waived if transferred directly from an inpatient hospital, rehabilitation, or skilled nursing facility. Prior authorization may be required
If your child needs dental check-up 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 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.
	Children's dental check-up	Included in office visit copayment	Not covered	----------None----------

Excluded Services and 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	• Non-Emergency Care When Traveling Outside the U.S.	• Routine Foot Care * Only covered when medically necessary for diabetes. See SPD for details.
• Dental Care (Adult)	• Private-Duty Nursing	• Weight Loss Programs
• Long-Term Care	• Routine Eye Care (Adult)	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Chiropractic Care	• Infertility Treatment
• Bariatric Surgery	• Hearing Aids for school aged children	

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. 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 1-877-752-4164.
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-752-4164.
如果需要中文的帮助，请拨打这个号码 1-877-752-4164.
Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-752-4164.
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	$0
Specialist	$40
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	$0
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$760

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

The plan's overall deductible	$0
Specialist	$40
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	$900
Coinsurance	$90
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$1,010

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

The plan's overall deductible	$0
Specialist	$40
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	$0
Copayments	$500
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$570

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