PRESBYTERIAN

**Presbyterian Native American Limited Clear Cost Gold with Limited Service Area On Exchange**

**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 **1-855-923-7528** 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 **1-800-923-7528** to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | IHCP: **$0/$0** In Network: **$3,000**/Individual / **$6,000**/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 other deductibles for specific services?** | Yes. Preventive care, Behavioral Health services Covid- 19 testing, treatment, or vaccines. | 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. |
| **Is there an out–of–pocket limit on my expenses?** | No. | You don't have to meet deductibles for specific services. |
| **What is not included in the out–of–pocket limit?** | IHCP: **$0/$0** In-network: **$5,300**/Individual / **$10,600**/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. |
| **Is there an overall annual limit on what the plan pays?** | 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. |
| **Does this plan use a network of providers?** | Yes. See Individual Select HMO Network at https://www2.phs.org/providers/?insurance_plans=individual-select-hmo or call 1-800-923-6980 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 |
|---|---|---|---|---|---|
| | | IHCP Provider(You will pay the least) | Non-IHCP Provider In-Network Provider | 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 | No charge deductible does not apply | $20 copayment/visit deductible does not apply | Not Covered | There is zero cost sharing for any telehealth service. Cost share does not include Medical drugs which will have a separate charge. No charge for anything related to Covid-19 testing, vaccines or medical treatment. Prior Authorization is not required for gynecological or obstetrical ultrasounds |
| | Specialist visit | No charge deductible does not apply | $60 copayment/visit deductible does not apply | Not Covered | |
| | Preventive care /Screening/Immunization | No charge deductible does not apply | No charge deductible does not apply | Not Covered | You may have to pay for services that aren't preventative. Then check what your plan will pay for. There is zero cost sharing for any telehealth services. Prior Authorization is not required for gynecological or obstetrical ultrasounds |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge deductible does not apply | $60 copayment/visit deductible does not apply | Not Covered | Prior Authorization may be required or benefits may be denied. |
| | Imaging (CT/PET scans, MRIs) | No charge deductible does not apply | $60 copayment/visit deductible does not apply | Not Covered | |

| Common Medical Event | Services You May Need | What you will pay | | | Limitations, Exceptions & other Important information |
|---|---|---|---|---|---|
| | | IHCP Provider(You will pay the least) | Non-IHCP Provider In-Network Provider | Out-of-Network Provider (You will pay the most) | |
| **If you need drugs to treat your illness More information about prescription drug coverage is available at:** Formulary Search (formularynavigator.com) | Generic Drugs (Tier 1) | No charge deductible does not apply | $20 copayment (retail) per 30-day supply/ $60 copayment (mail order) deductible does not apply | Not Covered | 90-day maximum supply (retail).<br><br>Preferred insulin or medically necessary alternative will not exceed $25 copayment per 30-day supply.<br><br>Out-of-Network prescription drugs are covered in urgent situations. The In-Network cost share applies.<br><br>Prior authorization may be required or benefits may be denied.<br><br>This plan accepts cost-sharing accumulation for any third-party payment (such as a drug manufacturer's coupon) and the rebate amount is applied towards your cost-sharing.<br><br>Refer to the Formulary for a complete listing and coverage details.<br><br>Self-Administered Specialty Drugs (Tier 4 & 5) limited to 30-day supply and Mail ordered Not covered. |
| | Preferred Brand Drugs (Tier 2) | No charge deductible does not apply | $30 copayment (retail) per 30-day supply/ $90 copayment (mail order) deductible does not apply | Not Covered | |
| | Non-Preferred Drugs (Tier 3) | No charge deductible does not apply | $100 copayment with deductible (retail) per 30-day supply; $300 copayment with deductible (mail order) | Not Covered | |
| | Preferred Specialty Drugs (Tier 4) | No charge deductible does not apply | $75 copayment deductible does not apply Limited to 30-day supply max/Not Covered mail order | Not Covered | |
| | Non-Preferred Specialty Drugs (Tier 5) | No charge deductible does not apply | $190 copayment deductible does not apply Limited to 30-day supply max/Not Covered mail order | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No charge deductible does not apply | $125 copayment deductible does not apply | Not Covered | Prior Authorization may be required or benefits may be denied. |
| **If you have outpatient surgery** | Physician/surgeon fees | No charge deductible does not apply | $125 copayment deductible does not apply | Not Covered | |

| Common Medical Event | Services You May Need | What you will pay | | | Limitations, Exceptions & other Important information |
|---|---|---|---|---|---|
| | | IHCP Provider(You will pay the least) | Non-IHCP Provider In-Network Provider | Out-of-Network Provider (You will pay the most) | |
| **If you need immediate medical attention** | Emergency room services | No charge deductible does not apply | $150 copayment with deductible | $150 copayment with deductible | No charge for anything related to Covid-19 testing, vaccines or medical treatment. There is zero cost sharing for any telehealth service. Cost share does not include Medical drugs which will have a separate charge. Prior Authorization is not required for gynecological or obstetrical ultrasounds. Balance billing is not allowed for out-of-network care. |
| | Emergency medical transportation | No charge deductible does not apply | $125 copayment /ground & air deductible does not apply | $125 copayment /ground & air deductible does not apply | |
| | Urgent care | No charge deductible does not apply | $60 copayment deductible does not apply; | $60 copayment deductible does not apply; | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No charge deductible does not apply | $150 copayment with deductible | Not Covered | Prior Authorization may be required or benefits may be denied. |
| | Physician/surgeon fee | No charge deductible does not apply | $150 copayment with deductible | Not Covered | |
| **If you have mental health, behavioral health, or substance use disorder services** | Mental/Behavioral health outpatient services | No charge deductible does not apply | No charge deductible does not apply | Not Covered | There is no cost-sharing for behavioral health services or drugs. Acute Medical Detoxification benefits are covered & will cover no less than 30 outpt visits for alcohol dependency treatment. |
| | Mental/Behavioral health inpatient services | No charge deductible does not apply | No charge deductible does not apply | Not Covered | There is no cost-sharing for behavioral health services or drugs. Acute Medical Detoxification benefits are covered & will cover no less than 30 days in an alcohol dependency treatment center. |

| Common Medical Event | Services You May Need | What you will pay | | | Limitations, Exceptions & other Important information |
|---|---|---|---|---|---|
| | | IHCP Provider(You will pay the least) | Non-IHCP Provider In-Network Provider | Out-of-Network Provider (You will pay the most) | |
| **If you are pregnant** | Office visits | No charge deductible does not apply | No charge deductible does not apply | Not Covered | Cost sharing does not apply for preventative services. Prior Authorization is not required for gynecological or obstetrical ultrasounds. Prior authorization may be required or benefits may be denied. |
| | Childbirth/delivery professional services | No charge deductible does not apply | $150 copayment with deductible | Not Covered | |
| | Childbirth/delivery facility services | No charge deductible does not apply | $150 copayment with deductible | Not Covered | |
| **If you need help recovering or have other special health needs** | Home health care | No charge deductible does not apply | $20 copayment/visit deductible does not apply | Not Covered | Coverage is limited to 100 days/plan year. Prior authorization may be required or benefits may be denied. |
| | Rehabilitation services | No charge deductible does not apply | $20 copayment/visit deductible does not apply | Not Covered | Prior Authorization may be required or benefits may be denied. |
| | Habilitation services | No charge deductible does not apply | $20 copayment/visit deductible does not apply | Not Covered | |
| | Skilled nursing care | No charge deductible does not apply | $60 copayment deductible does not apply | Not Covered | Coverage is limited to 60 days/plan year. Prior authorization may be required or benefits may be denied. |
| | Durable medical equipment | No charge deductible does not apply | $60 copayment deductible does not apply | Not Covered | Prior Authorization may be required or benefits may be denied. |
| | Hospice service | No charge deductible does not apply | $60 copayment deductible does not apply | Not Covered | |

| Common Medical Event | Services You May Need | What you will pay | | | Limitations, Exceptions & other Important information |
|---|---|---|---|---|---|
| | | IHCP Provider(You will pay the least) | Non-IHCP Provider In-Network Provider | Out-of-Network Provider (You will pay the most) | |
| **If your child needs Dental or Eyecare** | Eye exam | No charge deductible does not apply | No charge deductible does not apply | Not Covered | One Eye Refraction associated with post cataract surgery or Keratoconus correction/year is covered; additional charges may apply |
| | Glasses | No charge deductible does not apply | No charge deductible does not apply | Not Covered | Eyeglasses & contact lenses within 12mo following cataract surgery or the correction of keratoconus or related Genetic Inborn errors of metabolism is limited to once/yr; additional charges may apply |
| | Dental check-up | Not Covered | Not Covered | Not Covered | Not Covered |

**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<br>• Dental Care (Adult) | • Long-Term Care<br>• Non-Emergency Care When Traveling Outside the U.S. | • Private-Duty Nursing<br>• Routine Foot Care * Only covered when medically necessary for diabetes. See GSA for details. |
| **Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)** | | |
| • Abortion Services (excepted and non-excepted)<br>• Acupuncture (20 visits per Calendar Year unless for Rehabilitation or Habilitative Services)<br>• Bariatric Surgery (for patients with a Body Mass Index (BMI) of 35kg/m2 or greater who are at high risk for increased morbidity due to specific obesity related comorbid medical conditions) | • Chiropractic Care (20 visits per Calendar Year unless for Rehabilitation or Habilitative Services)<br>• Hearing Aids (one per year every three years)<br>• Infertility Treatment (Diagnosis and medically indicated treatments for physical conditions causing infertility)<br>• | • Weight Loss Programs (Includes coverage for drugs and programs if medically necessary for morbid obesity and obesity) |

**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 visit **www.osi.state.nm.us**.

**Does this Coverage 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 Coverage Meet the Minimum Value Standard? No;** 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 1-855-592-7737.
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-592-7737.
如果需要中文的帮助，请拨打这个号码1-855-592-7737.
Dinek'ehgoshika at'ohwol ninisingo, kwiijigo holne' 1-855-592-7737.
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 | $3,000 |
| Specialist *[cost sharing]* | $60 |
| Hospital (facility) *[cost sharing]* | $150 |
| Other *[cost sharing]* | $125 |

**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 | $3000 |
| Copayments | $800 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,860** |

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

| | |
|---|---|
| The plan's overall deductible | $3,000 |
| Specialist *[cost sharing]* | $60 |
| Hospital (facility) *[cost sharing]* | $150 |
| Other *[cost sharing]* | $125 |

**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 | $1700 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,720** |

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

| | |
|---|---|
| The plan's overall deductible | $3,000 |
| Specialist *[cost sharing]* | $60 |
| Hospital (facility) *[cost sharing]* | $150 |
| Other *[cost sharing]* | $125 |

**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 | $400 |
| Copayments | $800 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,200** |

The plan would be responsible for the other costs of these EXAMPLE covered services. Note: These numbers assume the patient received care from an IHCP provider or with IHCP referral at a non-IHCP. If you receive care from a non-IHCP provider without a referral from an IHCP your costs may be higher