PRESBYTERIAN **TriCore Preferred Care PPO**

Coverage for: Individual or Family | **Plan Type:** PPO

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 1-866-979-6778 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 1-866-979-6778 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: **$1,250** Individual / **$2,500** Family Out-of-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 services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your Deductible.	This plan covers some items & services even if you haven't met the deductible amount. But a 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: **$3,000** Individual / **$6,000** Family Out-of-network: **$6,000** Individual / **$12,000** 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 https://www2.phs.org/providers?directory_type=php&insurance_plans=aso-hmo-aso-ppo-aso-hdhp **or call 1-866-979-6778** 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, you network provider might use an 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
		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	$25 copayment/visit not subject to deductible	40% coinsurance after deductible is met	Copayment for office visit only. Deductible and coinsurance apply for all other services. Video Visits for In Network are No Charge through phs.org/video visits. Telehealth for In Network is based on a member's specific benefit. Out of Network 40% coinsurance after deductible is met
	Specialist visit	$35 copayment/visit not subject to deductible	40% coinsurance after deductible is met	Copayment for office visit only. Deductible and coinsurance apply for all other services.
	Preventive care/screening/immunization	No charge	40% 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	40% coinsurance after deductible is met	Prior authorization may be required or benefits may be denied.
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible is met	40%coinsurance after deductible is met	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://client.formularynavigator.com/Search.aspx?siteCode=0322075909	Generic drugs (Tier 1)	Retail: $7 copayment/ Mail: $14 copayment	Retail: $7 copayment/ Mail: Not covered	Covers up to a 30-day supply (retail)/90-day supply (mail order).You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. If you use a non-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference between drugs in addition to any applicable copay and/or coinsurance may be applied. Specialty Drugs limited to a 30-day supply
	Preferred brand drugs (Tier 2)	Retail: $50 copayment/ Mail: $100 copayment	Retail: $50 copayment/ Mail: Not covered	
	Non-preferred drugs (Tier 3)	Retail: $75 copayment/ Mail: $150 copayment	Retail: $75 copayment/ Mail: Not covered	
	Self-Administered Specialty (Tier 4)	Retail: 20% coinsurance up to a maximum of $400 per prescription Mail: Not Available	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)	20% coinsurance after deductible is met	40% coinsurance after deductible is met	Prior Authorization may be required or benefits may be denied.
	Physician/surgeon fees	20% coinsurance after deductible is met	40% coinsurance after deductible is met	Prior Authorization may be required or benefits may be denied.
If you need immediate medical attention	Emergency room care	$250 copayment/visit not subject to deductible	$250 copayment/visit not subject to deductible	----------None----------
	Emergency medical transportation	20% coinsurance ground/air not subject to deductible	20% coinsurance ground/air after deductible is met	----------None----------
	Urgent care	$40 copayment/visit not subject to deductible	$40 copayment/visit not subject to deductible	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible is met	40% coinsurance after deductible is met	Prior Authorization may be required or benefits may be denied.
	Physician/surgeon fees	20% coinsurance after deductible is met	40% coinsurance after deductible is met	Prior Authorization may be required or benefits may be denied.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copayment not subject to deductible	40% coinsurance after deductible is met	Copayment for office visit only. Deductible and coinsurance apply for all other services.
	Inpatient services	20% coinsurance after deductible is met	40% coinsurance after deductible is met	Prior Authorization may be required or benefits may be denied.
If you are pregnant	Office visits	No charge	40% coinsurance after deductible is met	Cost sharing does not apply for preventative services. Prior Authorization is not required for gynecological or obstetrical ultrasounds.
	Childbirth/delivery professional services	20% coinsurance after deductible is met	40% coinsurance after deductible is met	Prior authorization may be required or benefits may be denied. Prior Authorization is not required for gynecological or obstetrical ultrasounds.
	Childbirth/delivery facility services	20% coinsurance after deductible is met	40% coinsurance after deductible is met	Prior authorization may be required or benefits may be denied. Prior Authorization is not required for gynecological or obstetrical ultrasounds.

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	20% coinsurance after deductible is met	40% coinsurance after deductible is met	Prior authorization may be required or benefits may be denied.
	Rehabilitation services	20% coinsurance after deductible is met	40% coinsurance after deductible is met	Prior authorization may be required or benefits may be denied.
	Habilitation services	20% coinsurance after deductible is met	40% coinsurance after deductible is met	----------None----------
	Skilled nursing care	20% coinsurance after deductible is met	40% coinsurance after deductible is met	Coverage is limited up to 60 days per calendar year. Prior authorization may be required or benefits may be denied.
	Durable medical equipment	20% coinsurance after deductible is met	40% coinsurance after deductible is met	Prior authorization may be required or benefits may be denied.
	Hospice services	20% coinsurance after deductible is met	40% coinsurance after deductible is met	Prior authorization may be required or benefits may be denied.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	----------None----------
	Children's glasses	Not covered	Not covered	----------None----------
	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
- Glasses
- Infertility
- Long-Term Care
- Non-Emergency care when travelling outside the US
- Private duty nursing
- Routine eye care
- Routine foot care – (Except as covered for Diabetes)
- Weight loss Program

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (20 maximum visits per calendar year)
- Bariatric Surgery
- Chiropractic Care (20 maximum visits per calendar year)
- Hearing aids – Every 36 months per hearing impaired ear for school-aged children under 18 years old (or under 21 years of age if still attending high school)

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 1-866-979-6778.
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-979-6778.
如果需要中文的帮助，请拨打这个号码 1-866-979-6778.
Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-979-6778.
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	**$1,250**
Specialist	**$35**
Hospital (Facility)	**20%**
Other	**20%**

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	$1,250
Copayments	$10
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,520

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

The plan's overall deductible	**$1,250**
Specialist	**$35**
Hospital (Facility)	**20%**
Other	**20%**

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	$1,250
Copayments	$400
Coinsurance	$500
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$2,170

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

The plan's overall deductible	**$1,250**
Specialist	**$35**
Hospital (Facility)	**20%**
Other	**20%**

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	$700
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,300

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