PRESBYTERIAN 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 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 1-855-593-7737 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 1-855-593-7737 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$325** Single / **$650** Two-person / **$975** 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 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?	Yes. **$50** Single **$100** Two-Person/Family	You must pay all the Pharmacy costs up to the deductible amount before this plan begins to pay for covered services you use.
What is the out-of-pocket limit for this plan?	**$3,500** Single/**$7,000** Two-person/**$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 **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 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.

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 Video Visit- No Charge.	Not covered	----------None----------
	Specialist visit	$40 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)	20% coinsurance after deductible is met	Not covered	Prior authorization may be required or benefits may be denied.
	Imaging (CT/PET scans, MRIs)	20% coinsurance up to a max of $200 per test/per day after deductible is met	Not covered	
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)	$5 copayment (retail) / $15 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)	30% coinsurance ($30 minimum up to $90) (retail) / $95 copayment (mail order)	Not Covered	
	Non-preferred drugs (Tier 3)	40% coinsurance ($55 minimum up to $125) (retail) / $125 copayment(mail order)	Not Covered	
	Self-Administered Specialty (Tier 4)	$60 Generic $85 Preferred Brand $125 Non-Preferred	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible is met	Not covered	Prior Authorization may be required or benefits may be denied.
	Physician/surgeon fees	20% coinsurance after deductible is met	Not covered	Facility claim only

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	$175 copayment/visit	$175 copayment /visit	Waived if admitted into a hospital, then hospital copayment applies.
	Emergency medical transportation	$30 copayment/trip ground; $100 copayment/trip air	$30 copayment/trip ground; $100 copayment/trip air	----------None----------
	Urgent care	$50 copayment/visit	$50 copayment/visit	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copayment/admission after deductible is met	Not covered	Prior Authorization may be required or benefits may be denied.
	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 abuse services	Outpatient services	$25 copayment/visit	Not covered	----------None----------
	Inpatient services	$500 copayment/admission after deductible is met	Not covered	Prior authorization may be required.
If you are pregnant	Office visits	$25 copayment initial visit only	Not covered.	Depending on the type of services, a copayment, coinsurance, or deductible may apply. Cost sharing does not apply for preventative services. Prior Authorization is not required for gynecological or obstetrical ultrasounds.
	Childbirth/delivery professional services	No charge	Not covered	Prior Authorization is not required for gynecological or obstetrical ultrasounds.
	Childbirth/delivery facility services	$500 copayment/pregnancy after deductible 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 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/physician services	Not covered	No charge for nursing services. Prior authorization may be required or benefits may be denied.
	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.
	Habilitation services	$40 copayment/visit	Not covered	----------None----------
	Skilled nursing care	$500 copayment/admission after deductible 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% coinsurance after deductible 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.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	----------None----------
	Children's glasses	20% coinsurance after deductible is met	Not covered	Prior authorization may be required.
	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 (Adult)
- Dental check-up (Child)
- Eye exam (Child)
- Glasses (Child)
- Infertility Treatment (Only limited services covered)
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Private-Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs (Morbid obesity treatment only)

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

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- 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 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 **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	$325
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	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$325
Copayments	$20
Coinsurance	$209
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$614

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

The plan's overall deductible	$325
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	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$325
Copayments	$155
Coinsurance	$1,101
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$1,636

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	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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$53
Copayments	$0
Coinsurance	$13
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$67

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