County of Bernalillo PPO

Coverage for: Individual or Family | Plan Type: PPO



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 1-800-923-6980 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 1-800-923-6980 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: \$1,000 Individual / \$2,000 Family. Out-of-Network: \$1,500 Individual / \$3,000 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 Behavioral Health services and any benefit where there is no charge, Covid-19 testing, treatment and vaccines, and any service that have a copayment are covered before you meet your deductible.	This <u>plan</u> covers some items and services even if you haven't yet 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?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	In-Network: \$5,000 Individual / \$10,000 Family. Out-of- Network: \$10,000 Individual / \$20,000 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 <u>out-of-pocket limit</u> ?	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://www.phs.org/ or call 1-800-923-6980 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>). Be aware, your <u>provider network might</u> use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the specialist you choose without a referral.

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All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met if a <u>deductible</u> applies.

Common		What You \	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	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$30 <u>copayment</u> /visit <u>deductible</u> does not apply	50% coinsurance Telehealth /Video visits 50% coinsurance	Video Visits with contracted providers through our national vendor are \$0 copay and paid at 100% in network. Telehealth appointments with a contracted network provider, including Presbyterian Medical Group providers, or out of network provider require members to pay a normal copay or cost share in network or out of network.	
	<u>Specialist</u> visit	\$60 <u>copayment</u> /visit <u>deductible</u> does not apply	50% coinsurance	None	
	Preventive care/screening/immunization	No charge <u>deductible</u> does not apply	50% coinsurance	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. There is zero cost-sharing for any telehealth service. <u>Copayment</u> does not include Medical Drugs which will have a separate charge. No cost sharing for COVID-19 testing, treatment and vaccines. Prior authorization is not required for gynecological or obstetrical ultrasounds.	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge <u>deductible</u> does not apply	50% coinsurance	Prior authorization may be required or benefits may be	
	Imaging (CT/PET scans, MRIs)	PET/MRI: \$200 copayment/test; CT: \$125 copayment/test deductible does not apply	50% coinsurance	denied.	
If you need drugs to treat your illness or condition prescription drug coverage is available	at your illness or ndition scription drug erage is available	Prescription drug benefits are administered by ClearScript	Prescription drug benefits are administered by ClearScript	Prescription drug benefits are administered for County of Bernalillo by ClearScript. For more information please call 1-800-593-8505.	
from ClearScript	Preferred brand drugs (Tier 2)	Prescription drug benefits are administered by ClearScript	Prescription drug benefits are administered by ClearScript		

		Non-preferred drugs (Tier 3)	Prescription drug benefits are administered by ClearScript	Prescription drug benefits are administered by ClearScript	
		Self-Administered Specialty (Tier 4)	Prescription drug benefits are administered by ClearScript	Prescription drug benefits are administered by ClearScript	
	If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u> after <u>deductible</u> is met	50% <u>coinsurance</u> after <u>deductible</u> is met	Prior authorization may be required or benefits may be denied.
	The state of the s	Physician/surgeon fees	20% <u>coinsurance</u> after <u>deductible</u> is met	50% <u>coinsurance</u> after <u>deductible</u> is met	Prior authorization may be required or benefits may be denied.

Common	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information	
Medical Event		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	momaton	
If you need immediate	Emergency room care	\$300 <u>copayment</u> /visit <u>deductible</u> does not apply	\$300 <u>copayment</u> /visit	Waived if admitted into a hospital, then hospital copayment applies.	
medical attention	Emergency medical transportation	\$50 <u>copayment</u> ground; \$100 <u>copayment</u> air; No charge inter-facility <u>deductible</u> does not apply	\$50 copayment ground; \$100 copayment air; No charge inter-facility deductible does not apply	None	
	Urgent care	\$75 <u>copayment</u> /visit <u>deductible</u> does not apply	\$75 <u>copayment</u> /visit <u>deductible</u> does not apply	None	
If you have a hospital	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Prior Authorization may be required or benefits may be denied.	
stay	Physician/surgeon fees	20% coinsurance	50% coinsurance	Prior Authorization may be required or benefits may be denied.	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge <u>deductible</u> does not apply	50% coinsurance	There is no cost-sharing for behavioral health services or drugs.	
abuse services	Inpatient services	No charge <u>deductible</u> does not apply	50% coinsurance	Prior authorization may be required or benefits may be denied. There is no cost-sharing for behavioral health services or drugs.	
If you are pregnant	Office visits	\$30 <u>copayment</u> /visit <u>deductible</u> does not apply	50% coinsurance	Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> does apply.	
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	<u>Deductible</u> does apply.	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Prior authorization may be required. <u>Deductible</u> does apply.	

Common Medical Event	Services You May Need	What You In-network Provider (You will pay the least)	Will Pay Out-of-network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help	Home health care	20% coinsurance	50% coinsurance	Prior authorization may be required or benefits may be denied.
recovering or have other special health needs	Rehabilitation services	\$75 <u>copayment</u> //visit <u>deductible</u> does not apply	50% coinsurance	Coverage is limited up to 24 visits not combined/ contract year. Prior authorization may be required or benefits may be denied.
	Habilitation services	\$30 <u>copayment</u> //visit <u>deductible</u> does not apply	50% coinsurance	None
	Skilled nursing care	20% coinsurance	50% <u>coinsurance</u>	Coverage is limited up to 30 days/plan year. Prior authorization may be required or benefits may be denied.
	Durable medical equipment	50% coinsurance	50% coinsurance	Prior authorization may be required or benefits may be denied.
	Hospice services	20% coinsurance	50% coinsurance	Prior authorization may be required or benefits may be denied.
If your child needs	Children's eye exam	Included in office visit copayment deductible does not apply	Not covered	Coverage is limited to refraction eye exam associated with post cataract surgery or Keratoconus correction
dental or eye care	Children's glasses	50% <u>coinsurance</u>	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 or benefits may be denied.
	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

Long-Term Care

Routine Eye Care (Adult)

Dental Care (Adult)

- Non-Emergency Care When Traveling Outside the U.S.
- Routine Foot Care * Only covered when medically necessary for diabetes. See SPD for details.

Dental check-up (Child)

Private-Duty Nursing

Weight Loss Programs

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

- Acupuncture (20 visits per calendar year unless for rehabilitative or habilitative svc)
- Chiropractic Care (20 visits per calendar year unless for rehabilitative or habilitative svc)
- Infertility Treatment

Bariatric Surgery

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 http://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

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-855-592-7737.

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'ehgo shika 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 <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 can hospital delivery)	e and a	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 \$1000 Specialist \$60 Hospital (Facility) 20% Other 20% 		The plan's overall deductibleSpecialistHospital (Facility)Other	\$1000 \$60 20% 20%	The plan's overall deductibleSpecialistHospital (Facility)Other	
This EXAMPLE event includes services lill Specialist office visits (prenatal care) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood w Specialist visit (anesthesia)		This EXAMPLE event includes service Primary care physician office visits (includes as education) Diagnostic tests (blood work) Prescription drugs Durable medical equipment (glucose recommend)	cluding	This EXAMPLE event includes services Emergency room care (including media supplies) Diagnostic test (x-ray) Durable medical equipment (crutches) Rehabilitation services (physical theray)	ical
Total Example Cost	\$12,738	Total Example Oost	Ψ1,1Ψ	Total Example Cost	\$2,009
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	\$750	Deductibles	\$0	Deductibles	\$29
Copayments	\$100	Copayments	\$1,060	Copayments	\$630
Coinsurance	\$1,792	Coinsurance	\$0	Coinsurance	\$7
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	\$2,702	The total Joe would pay is	\$1,115	The total Mia would pay is	\$667

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