

PNMR Services Company 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 1-866-670-0603 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 1-866-670-0603 to request a copy.

Important Questions	Answers	Why This Matters:			
What is the overall deductible?	In-network: \$500 Individual / \$1,000 Individual + One / \$1,500 Family Out-of-network: \$1,000 Individual / \$2,000 Individual + One / \$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 is covered before you meet your Deductible.	This <u>plan</u> covers some items & services even if you haven't met the <u>deductible</u> amount. But a <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 deductibles for specific services?		You don't have to meet <u>deductibles</u> for specific services.			
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In-network: \$6,000 Individual / \$9,250 Individual + One / \$12,500 Family Out-of-network: \$12,000 Individual / \$18,500 Individual + One / \$25,000 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 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 <u>network provider</u> ?	Yes. See www.phs.org or call 1-866-670-0603 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, you <u>network provider</u> might use an 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	
	Primary care visit to treat an injury or illness	\$20 <u>copayment</u> /visit not subject to <u>deductible</u>	35% <u>coinsurance</u> after <u>deductible</u> is met	Copayment for office visit only. Deductible and coinsurance apply for all other services. Virtual Visits for In Network are No Charge.	
If you visit a health care provider's office or clinic	<u>Specialist</u> visit	\$40 <u>copayment</u> /visit not subject to <u>deductible</u>	35% <u>coinsurance</u> after <u>deductible</u> is met	Copayment for office visit only. Deductible and coinsurance apply for all other services. Virtual Visits for In Network are No Charge.	
	Preventive care/screening/immunization	No charge	35% <u>coinsurance</u> after <u>deductible</u> 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	<u>Diagnostic test</u> (x-ray, blood work)	15% <u>coinsurance</u> after <u>deductible</u> is met	35% <u>coinsurance</u> after <u>deductible</u> is met	Prior authorization may be required or benefits may be	
ii you nave a test	Imaging (CT/PET scans, MRIs)	15% <u>coinsurance</u> after <u>deductible</u> is met	35% <u>coinsurance</u> after <u>deductible</u> is met	denied.	
	Generic drugs (Tier 1)	Retail: \$8 <u>copayment/</u> Mail: \$16 <u>copayment</u>	Not covered	Administered by Express Scripts- contact for more information.	
If you need drugs to treat your illness or condition	Preferred brand drugs (Tier 2)	Retail: 30% <u>coinsurance</u> (\$30 min -\$70 max)/ Mail: 30% <u>coinsurance</u> (\$60 min - \$140 max)	Not covered		
More information about prescription drug coverage	Non-preferred drugs (Tier 3)	Retail: 40% coinsurance (\$60 min-\$120 max)/ Mail: 40% coinsurance (\$120 min-\$240 max)	Not covered		
is available at www.express- scripts.com	Self-Administered Specialty (Tier 4)	Generic/Preferred Brand: 15% coinsurance (\$250 max)/ Non-Preferred Brand: 15% coinsurance (\$500 max)	Not covered		
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	15% <u>coinsurance</u> after <u>deductible</u> is met	35% <u>coinsurance</u> after <u>deductible</u> is met	Prior Authorization may be required or benefits may be denied.	

surgery	Physician/surgeon fees	15% <u>coinsurance</u> after <u>deductible</u> is met	35% <u>coinsurance</u> after <u>deductible</u> is met	Prior Authorization may be required or benefits may be denied.
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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
	Emergency room care	\$150 copayment/visit not subject to deductible; 15% coinsurance for non-emergency situations after deductible is met	\$150 copayment/visit not subject to deductible; 35% coinsurance for non-emergency situations after deductible is met	Copayment for office visit only. Deductible and coinsurance apply for all other services. Copayment waived if admitted.
If you need immediate medical attention	Emergency medical transportation	15% <u>coinsurance</u> ground/air after <u>deductible</u> is met	15% coinsurance ground/air after deductible is met, 15% coinsurance non- emergency air after deductible is met	None
	<u>Urgent care</u>	\$35 <u>copayment</u> /visit not subject to <u>deductible</u>	35% <u>coinsurance</u> after <u>deductible</u> is met	Copayment for office visit only. Deductible and coinsurance apply for all other services. Virtual Visits for In Network are No Charge.
If you have a hospital	Facility fee (e.g., hospital room)	15% <u>coinsurance</u> after <u>deductible</u> is met	35% <u>coinsurance</u> after <u>deductible</u> is met	Prior Authorization may be required or benefits may be denied.
stay	Physician/surgeon fees	15% <u>coinsurance</u> after <u>deductible</u> is met	35% <u>coinsurance</u> after <u>deductible</u> 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	\$20 <u>copayment</u> not subject to <u>deductible</u>	35% <u>coinsurance</u> after <u>deductible</u> is met	Copayment for office visit only. Deductible and coinsurance apply for all other services. Virtual Visits for In Network are No Charge.
	Inpatient services	15% <u>coinsurance</u> after <u>deductible</u> is met	35% <u>coinsurance</u> after <u>deductible</u> is met	Prior authorization may be required.
	Office visits	\$20 <u>copayment</u> non- specialist/ \$40 <u>copayment</u> specialist for the first visit only	35% <u>coinsurance</u> after <u>deductible</u> is met	Cost sharing does not apply for preventative services. Prior Authorization is not required for gynecological or obstetrical ultrasounds.
If you are pregnant	Childbirth/delivery professional services	15% <u>coinsurance</u> after <u>deductible</u> is met	35% <u>coinsurance</u> after <u>deductible</u> 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	15% <u>coinsurance</u> after <u>deductible</u> is met	35% <u>coinsurance</u> after <u>deductible</u> is met	Prior authorization may be required or benefits may be denied. Prior Authorization is not required for gynecological or obstetrical ultrasounds.

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)	Informátion	
	Home health care	15% <u>coinsurance</u> after <u>deductible</u> is met	35% <u>coinsurance</u> after <u>deductible</u> is met	Maximum of 100 visits /plan year. Prior authorization may be required or benefits may be denied.	
	Rehabilitation services	15% <u>coinsurance</u> after <u>deductible</u> is met	35% <u>coinsurance</u> after <u>deductible</u> is met	Prior authorization may be required or benefits may be denied.	
	Habilitation services	15% <u>coinsurance</u> after <u>deductible</u> is met	35% <u>coinsurance</u> after <u>deductible</u> is met		
If you need help recovering or have other special health	Skilled nursing care	15% <u>coinsurance</u> after <u>deductible</u> is met	35% <u>coinsurance</u> after <u>deductible</u> is met	Coverage is limited up to 30 days per year. Prior authorization may be required or benefits may be denied.	
needs	Durable medical equipment	15% <u>coinsurance</u> after <u>deductible</u> is met	35% <u>coinsurance</u> after <u>deductible</u> is met	Prior authorization may be required or benefits may be denied. Mastectomy bras and support hose (pair) limited to 2 per calendar year. 1 Wig is covered every 3 years.	
	Hospice services	15% <u>coinsurance</u> after <u>deductible</u> is met	35% <u>coinsurance</u> after <u>deductible</u> is met	Maximum of 3 benefit periods per lifetime. Respite care limited to 5 days per 60 days of hospice and 3 stay maximum. Prior authorization may be required or benefits may be denied.	
	Children's eye exam	Not covered	Not covered	None	
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	None	
domai or oyo ouro	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 Outle the U.S. 	utside • Routine Foot Care		
Hearing Aids	 Private-Duty Nursing 			
Other Covered Services (Limitations may	y apply to these services. This isn't a complete list. Please see	your <u>plan</u> document.)		

Acupuncture (\$1,500 maximum per calendar year)
 Bariatric Surgery (as specifically provided by the plan)
 Chiropractic Care (\$1,500 maximum per calendar year)
 Weight Loss Programs (as specifically provided by the plan)
 Infertility Treatment (\$5,000 lifetime maximum for medical and surgical services)

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 <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. 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 1-800-356-2219.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-356-2219.

如果需要中文的帮助,请拨打这个号码 1-800-356-2219.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-356-2219.

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 ca hospital delivery)	re and a	Managing Joe's type 2 D (a year of routine in-network car controlled condition)	re of a well-	Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$500	■ The plan's overall deductible	\$500	■ The plan's overall deductible	\$500
Specialist	\$40	Specialist	\$40	Specialist	\$40
Hospital (Facility)	15%	Hospital (Facility)	15%	Hospital (Facility)	15%
Other	15%	Other	15%	Other	15%
This EXAMPLE event includes services 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 (indisease education) Diagnostic tests (blood work) Prescription drugs Durable medical equipment (glucose in	ncluding	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	\$12,731	Total Example Cost	\$7,389	Total Example Cost	\$2,041
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	\$500	Deductibles	\$500	Deductibles	\$500
Copayments	\$40	Copayments	\$240	Copayments	\$570
Coinsurance	\$1,860	Coinsurance	\$279	Coinsurance	\$161
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$96	Limits or exclusions	\$4,313	Limits or exclusions	\$0
The total Peg would pay is	\$2,496	The total Joe would pay is	\$5,332	The total Mia would pay is	\$1,231

The <u>plan</u> would be responsible for the other costs of these EXAMPLE covered services.