

 **PRESBYTERIAN** **APS EPO Plan**

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 1-855-261-7737 or visit [www.phs.org](http://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 1-855-261-7737 to request a copy.

Important Questions	Answers	Why This Matters:
<a href="#">What is the overall deductible?</a>	\$500/Individual \$1,000/Two Party \$1,250 Family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this plan begins to pay.
<a href="#">Are there services covered before you meet your deductible?</a>	Yes. <a href="#">Preventive care</a> is covered before you meet your <a href="#">deductible</a> .	This plan covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this plan covers certain <a href="#">preventive care</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered preventive services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits">www.healthcare.gov/coverage/preventive-care-benefits</a> .
<a href="#">Are there other <a href="#">deductibles</a> for specific services?</a>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<a href="#">What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</a>	Yes. <a href="#">\$4,000</a> Individual/ <a href="#">\$8,000</a> Two Party/ <a href="#">\$12,000</a> Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. Prescription drugs have a separate out-of-pocket limit.
<a href="#">What is not included in the <a href="#">out-of-pocket limit</a>?</a>	Premiums, <a href="#">balance billing</a> charges, prescription drugs and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<a href="#">Will you pay less if you use a <a href="#">network provider</a>?</a>	Yes. See <a href="http://www.phs.org">www.phs.org</a> or call 1-800-356-2219 for a list of participating providers.	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out of network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. The Aetna Network is Available Outside of New Mexico for dependents ages 17 – 26.
<a href="#">Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</a>	No.	You can see the <a href="#">specialist</a> you choose without a referral.

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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	Out-of-network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copayment</u> /visit Video visit - No charge	Not covered	-----None-----
	Specialist visit	\$50 <u>copayment</u> /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 <u>copayment</u>	Not covered	Diagnostic Test: None Only Free-Standing facility will have a \$120 <u>copayment</u> . All other CAT, MRI, and PET scans at a hospital require a 20% coinsurance. <u>Deductible</u> does apply. Prior authorization may be required.
	Imaging (CT/PET scans, MRIs)	PET/MR/CT: \$120 <u>copayment</u> /day or 20% <u>coinsurance</u>	Not covered	
If you need drugs to treat your illness or condition  More information about <u>prescription drug coverage</u> is available from Express Scripts: 1-866-563-9297	Generic drugs	20% <u>coinsurance</u> , maximum \$10 <u>copayment</u> /prescription (retail up to 1 month supply) \$20 <u>copayment</u> /prescription Home delivery and Walgreens (up to 3 month supply)	Not covered	Prescription drug benefits are administered for Albuquerque Public Schools by Express Scripts.  Insulin and Diabetic Supplies: \$0 copayment. Insulin or a Medically Necessary alternative will not exceed \$0 for a 1 month supply.
	Preferred brand drugs	30% <u>coinsurance</u> , minimum \$50 <u>copayment</u> and maximum \$100 <u>copayment</u> /prescription (retail up to 1 month supply) \$150 <u>copayment</u> /prescription home delivery and Walgreens (up to 3 month supply)	Not covered	Certain prescription drugs for the treatment of mental illness, behavioral health, or substance abuse disorders will be covered at No Charge to you, when obtained from a participating pharmacy. Contact Express Scripts for more information.
	Non-preferred brand drugs	40% <u>coinsurance</u> , minimum \$100 <u>copayment</u> and maximum \$175 <u>copayment</u> /prescription (retail up to 1 month supply) \$300 <u>copayment</u> /prescription Home delivery and Walgreens (up to 3 month supply)	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider	Out-of-network Provider	
	<u>Specialty drugs</u>	<p><b>Specialty medications must be filled through Accredo, the Express Scripts home delivery specialty pharmacy</b></p> <p>1 month supply of specialty medications</p> <ul style="list-style-type: none"> <li>• \$100 <a href="#">copayment</a> for generic specialty medications</li> <li>• \$125 <a href="#">copayment</a> for preferred brand specialty medications</li> <li>• \$200 <a href="#">copayment</a> for Non-preferred brand specialty medications</li> </ul> <p>If it is determined that it is appropriate for you to receive greater than a 1 month supply of your specialty medication, your <a href="#">copayment</a> will be based on the quantity of medication ordered.</p> <p><a href="#">Copayments</a> for certain specialty medications may be set to 30% <a href="#">coinsurance</a> or the amount of any available manufacturer-funded <a href="#">copayment</a> assistance.</p>	Not covered	<p>Maintenance (long-term) medications: A maximum of two 1 month fills of maintenance medications are allowed at a retail pharmacy. Then, maintenance medications require a 3 month fill either via Express Scripts home delivery or at a Walgreens pharmacy.</p> <p>Specialty medications: 1 month or 3 month (when clinically appropriate) fills of specialty medications must be filled using Accredo, the Express Scripts home delivery specialty pharmacy.</p>
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a> is paid	Not covered	Prior authorization may be required.
	Physician/surgeon fees	20% <a href="#">coinsurance</a> after <a href="#">deductible</a> is paid	Not covered	Prior authorization may be required.
If you need immediate medical attention	<u>Emergency room care</u>	\$350 <a href="#">copayment</a> /visit	\$350 <a href="#">copayment</a> /visit	All services inclusive of <a href="#">copayment</a> . Waived if admitted into a hospital, then hospital 20% <a href="#">coinsurance</a> applies after <a href="#">deductible</a> .
	<u>Emergency medical transportation</u>	20% <a href="#">coinsurance</a> ground; air	20% <a href="#">coinsurance</a> ground; air	Inter-facility transport no charge.
	<u>Urgent care</u>	\$50 <a href="#">copayment</a> /visit	\$50 <a href="#">copayment</a> /visit	All services inclusive of <a href="#">copayment</a> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider	Out-of-network Provider	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u> /admission after <u>deductible</u> is paid	Not covered	Prior authorization may be required.
	Physician/surgeon fees	20% <u>coinsurance</u> after <u>deductible</u> is paid	Not covered	Prior authorization may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Not covered	-----None-----
	Inpatient services	No charge	Not covered	Prior authorization may be required.
If you are pregnant	Office visits	\$50 <u>copayment</u> initial visit only then plan pays 100%	Not covered	Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply.
	Childbirth/delivery professional services	20% <u>coinsurance</u> after <u>deductible</u> is paid	Not covered	-----None-----
	Childbirth/delivery facility services	20% <u>coinsurance</u> after <u>deductible</u> is paid	Not covered	Prior authorization may be required.
If you need help recovering or have other special health needs	<u>Home health care</u>	\$50 <u>copayment</u> /visit	Not covered	Prior authorization may be required.
	<u>Rehabilitation services</u>	\$20 <u>copayment</u> /visit \$320 annual maximum	Not covered	
	<u>Habilitation services</u>	\$20 <u>copayment</u> /visit \$320 annual maximum	Not covered	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u> /admission after <u>deductible</u> is paid	Not covered	Maximum of 60 days per calendar year. Prior authorization may be required.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u> <u>deductible</u> does NOT apply	Not covered	Prior authorization may be required.
	<u>Hospice services</u>	20% <u>coinsurance</u> /admission after <u>deductible</u> is paid	Not covered	Prior authorization may be required. Waived if transferred directly from an inpatient facility.
	Children's eye exam	Included in office visit <u>copayment</u>	Not covered	
If your child needs dental or eye care	Children's glasses	50% <u>coinsurance</u> , <u>deductible</u> applies	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.
	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.)

<ul style="list-style-type: none"><li>• Cosmetic Surgery</li><li>• Dental Care (Adult)</li><li>• Dental check-up (Child)</li><li>• Hearing aids (Adult)</li><li>• Home Births</li></ul>	<ul style="list-style-type: none"><li>• Long-Term Care</li><li>• Non-Emergency Care When Traveling Outside the U.S.</li><li>• Private-Duty Nursing</li></ul>	<ul style="list-style-type: none"><li>• Routine Eye Care (Adult)</li><li>• Routine Foot Care * Only covered when medically necessary for diabetes. See SPD for details.</li><li>• Weight Loss Programs</li></ul>
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### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric Surgery</li></ul>	<ul style="list-style-type: none"><li>• Chiropractic Care</li><li>• Hearing Aids for school aged children</li></ul>	<ul style="list-style-type: none"><li>• Infertility Treatment</li></ul>
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**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](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](http://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](http://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](mailto: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, kwijjigo holne' 1-800-356-2219.

Learn more about Presbyterian's Notice of Nondiscrimination, go to [www.phs.org/nondiscrimination.aspx](http://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	\$500
Specialist copayment	\$50
Hospital (Facility) coinsurance	20%
Other coinsurance	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$50
Coinsurance	\$2,400
<i>What isn't covered</i>	
Limits or exclusions	\$30
<b>The total Peg would pay is</b>	<b>\$2,980</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	\$500
Specialist copayment	\$50
Hospital (Facility) coinsurance	20%
Other coinsurance	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$190
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$550</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	\$500
Specialist copayment	\$50
Hospital (Facility) coinsurance	20%
Other coinsurance	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$530
Coinsurance	\$140
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,170</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.