Coverage for: Individual or Family | Plan Type: HMO

APS EPO Plan

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. 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:
Whatisthe overall deductible?	\$500 /Individual \$1,000 /Two Party \$1,250 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> is covered before you meet your <u>deductible</u> .	This plan 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 plan 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</u> <u>limit</u> for this <u>plan</u> ?	Yes. \$4,000 Individual/ \$8,000 Two Party/ \$12,000 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. Prescription drugs have a separate out-of-pocket limit.
What is not included in the out-of-pocket limit?	Premiums, <u>balance billing</u> charges, prescription drugs and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.phs.org or call 1-800-356-2219 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>network provider</u> might 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. The Aetna Network is Available Outside of New Mexico for dependents ages 17 – 26.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> 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	Services You May Need What You Will Pay		Limitations, Exceptions, &		
Medical Event	Sorrioso rou may mosa	In-network Provider	Out-of-network Provider	Other Important Information	
	Primary care visit to treat an injury or illness	\$20 <u>copayment</u> /visit Video visit - No charge	Not covered	None	
If you visit a health care <u>provider's</u> office or clinic	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 copayment. All other CAT, MRI, and PET scans at a hospital require a 20% coinsurance. Deductible 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 prescription drug coverage is available	Generic drugs	20% coinsurance, maximum \$10 copayment/prescription (retail up to 1 month supply) \$20 copayment/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	
from Express Scripts: 1-866-563-9297	Preferred brand drugs	30% coinsurance, minimum \$50 copayment and maximum \$100 copayment/prescription (retail up to 1 month supply) \$150 copayment/prescription home delivery and Walgreens (up to 3 month supply)	Not covered	Necessary alternative will not exceed \$0 for a 1 month supply. Certain prescription drugs for the treatment of mental illness, behavioral health, or substance abuse disorders will be covered at	
	Non-preferred brand drugs	40% coinsurance, minimum \$100 copayment and maximum \$175 copayment/ prescription (retail up to 1 month supply) \$300 copayment/prescription Home delivery and Walgreens (up to 3 month supply)	Not covered	No Charge to you, when obtained from a participating pharmacy. Contact Express Scripts for more information.	

Common	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other	
Medical Event		In-network Provider	Out-of-network Provider	Important Information
	Specialty drugs	Specialty medications must be filled through Accredo, the Express Scripts home delivery specialty pharmacy 1 month supply of specialty medications • \$100 copayment for generic specialty medications • \$125 copayment for preferred brand specialty medications • \$200 copayment for Non-preferred brand specialty medications If it is determined that it is appropriate for you to receive greater than a 1 month supply of your specialty medication, your copayment will be based on the quantity of medication ordered. Copayments for certain specialty medications may be set to 30% coinsurance or the amount of any available manufacturer-funded copayment assistance.	Not covered	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. 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.
	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible is paid	Not covered	Prior authorization may be required.
surgery	Physician/surgeon fees	20% <u>coinsurance</u> after <u>deductible</u> is paid	Not covered	Prior authorization may be required.
If you need immediate medical attention	Emergency room care Emergency medical	\$350 <u>copayment</u> /visit 20% <u>coinsurance</u>	\$350 copayment/visit 20% coinsurance	All services inclusive of copayment. Waived if admitted into a hospital, then hospital 20% coinsurance applies after deductible. Inter-facility transport no charge.
	transportation Urgent care	ground; air \$50 <u>copayment</u> /visit	ground; air \$50 copayment/visit	All services inclusive of copayment.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, &	
		In-network Provider	Out-of-network Provider	Other Important Information	
If you have a hospital	Facility fee (e.g., hospital room)	20% <u>coinsurance</u> /admission after <u>deductible</u> is paid	Not covered	Prior authorization may be required.	
stay	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	Outpatient services	No charge	Not covered	None	
health, or substance abuse services	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 copayment, coinsurance, or deductible may apply.	
ii you are pregnant	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.	
	Home health care	\$50 <u>copayment</u> /visit	Not covered	Prior authorization may be required.	
If you need help recovering or have	Rehabilitation services	\$20 <u>copayment</u> /visit \$320 annual maximum	Not covered	Prior authorization may be required.	
other special health needs	Habilitation services	\$20 <u>copayment</u> /visit \$320 annual maximum	Not covered		
	Skilled nursing care	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% coinsurance deductible does NOT apply	Not covered	Prior authorization may be required.	
	Hospice services	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 copayment	Not covered	Coverage is limited to refraction eye exam associated with post cataract surgery or Keratoconus correction	
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.)

Cosmetic Surgery

Long-Term Care

Routine Eve 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.

Hearing aids (Adult) Home Births

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

Chiropractic Care

Infertility Treatment

Bariatric Surgery

Hearing Aids for school aged children

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 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. 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:

The total Peg would pay is



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.

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Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		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 deductibleSpecialist copaymentHospital (Facility) coinsurance	\$500 \$50 20%	The plan's overall deductibleSpecialist copaymentHospital (Facility) coinsurance	\$500 \$50 20%	The plan's overall deductibleSpecialist copaymentHospital (Facility) coinsurance	\$500 \$50 20%	
Other coinsurance 20%		Other coinsurance	20%	Other coinsurance	20%	
This EXAMPLE event includes services Specialist office visits (prenatal care) Childbirth/Delivery Professional Service Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood Specialist visit (anesthesia)	S	This EXAMPLE event includes services Primary care physician office visits (includes ase education) Diagnostic tests (blood work) Prescription drugs Durable medical equipment (glucose medical)	luding	This EXAMPLE event includes services lile Emergency room care (including medical supplies) Diagnostic test (x-ray) Durable medical equipment (crutches) Rehabilitation services (physical therapy)	ke:	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800	
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	\$0	Deductibles	\$500	
Copayments	\$50	Copayments	\$190	Copayments	\$530	
Coinsurance	\$2,400	Coinsurance	\$300	Coinsurance	\$140	
What isn't covered		What isn't covered		What isn't covered		
Limits or exclusions	\$30	Limits or exclusions	\$60	Limits or exclusions	\$0	

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

\$550

The total Mia would pay is

The total Joe would pay is

\$2,980

\$1,170