PRESBYTERIAN **City of Rio Rancho HDHP FAM**

**Coverage for:** Individual or Family | **Plan Type:** PPO

**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 1-877-752-4164 or visit www.phs.org for medical and call 1-800-232-6549 or visit www.express-scripts.com for pharmacy. 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 1-877-752-4164 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | In-Network: **$2,500**/Individual / **$5,000**/Family<br>Out-of-Network: **$5,000**/Individual / **$10,000**/Family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. Annual deductible is based on calendar year. |
| **Are there services covered before you meet your deductible?** | Yes. preventive care is covered before you meet your deductible. | This plan covers some items and 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. Annual deductible is based on calendar year. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | In Network: **$2,500**/ Individual / **$5,000**/ Family<br>Out of Network: **$10,000** /Individual / **$20,000**/ 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. Annual out-of-pocket limit is based on calendar year. |
| **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/PHP_directory?insurance_plans=AHPH or call 1-877-752-4164** 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 | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met. Video visits: Deductible may apply and coinsurance | ----------None---------- |
| | Specialist visit | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met | ----------None---------- |
| | Preventive care/screening/immunization | No charge | 30% coinsurance after deductible 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** | Diagnostic test (x-ray, blood work) | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met | Prior authorization may be required. |
| | Imaging (CT/PET scans, MRIs) | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met | |

| 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 drugs to treat your illness or condition** More information about prescription drug coverage is available at www.express-scripts.com | Generic drugs (Tier 1) | 0% coinsurance after deductible (30-day retail)/0% coinsurance after deductible (90-day mail order) | 30% coinsurance after deductible (30-day retail)/ Not Covered (90- mail order) | Tier 1, Tier 2 and Tier 3: Covers up to a 30-day supply (retail); 90-day supply (mail order prescription). Not all drugs are covered or have quantity limits. For more info go to www.express-scripts.com or call 1-866-217-3774.<br><br>Please see the "Important Questions" section (page 1) of this document regarding the plan's out-of-pocket limit. |
| | Preferred brand drugs (Tier 2) | 0% coinsurance after deductible (30-day retail)/0% coinsurance after deductible (90-day mail order) | 30% coinsurance after deductible (30-day retail)/ Not Covered (90- day mail order) | |
| | Non-preferred drugs (Tier 3) | 0% coinsurance after deductible (30-day retail)/0% coinsurance after deductible (90-day mail order) | 30% coinsurance after deductible (30-day retail)/ Not Covered (90- day mail order) | |
| | Self-Administered Specialty (Tier 4) | Same costs as other generic, preferred brand, and non-preferred brand drugs<br><br>Visit www.express-scripts.com | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met | Prior authorization may be required. |
| | Physician/surgeon fees | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met | Prior authorization may be required. |
| **If you need immediate medical attention** | Emergency room care | 0% coinsurance after deductible is met | 0% coinsurance after deductible is met | ----------None---------- |
| | Emergency medical transportation | 0% coinsurance after deductible is met | 0% coinsurance after deductible is met | The member will be responsible for any balance due above Reasonable and Customary Charges for out-of- network air ambulance service. |
| | Urgent care | 0% coinsurance after deductible is met | 0% coinsurance after deductible is met | ----------None---------- |

| 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 have a hospital stay** | Facility fee (e.g., hospital room) | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met | Prior authorization may be required. |
| | Physician/surgeon fees | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met | Prior authorization may be required. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met | ----------None---------- |
| | Inpatient services | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met | Prior authorization may be required. |
| **If you are pregnant** | Office visits | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met | ----------None---------- |
| | Childbirth/delivery professional services | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met | Depending on the type of services, a copayment, coinsurance, or deductible may apply. |
| | Childbirth/delivery facility services | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met | Prior authorization may be required. |
| **If you need help recovering or have other special health needs** | Home health care | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met | Prior authorization may be required. |
| | Rehabilitation services | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met | Coverage is limited up to 80 visits combined/calendar year; combined in- and out-if-network. Prior authorization may be required. |
| | Habilitation services | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met | Prior authorization may be required. |
| | Skilled nursing care | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met | Coverage is limited up to 60 days/calendar year. Prior authorization may be required. |
| | Durable medical equipment | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met | Prior authorization may be required. |
| | Hospice services | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met | Prior authorization may be required. |

| 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 your child needs dental check-up or eye care** | Children's eye exam | 0% coinsurance after deductible is met | Not Covered | Coverage is limited to refraction eye exam associated with post cataract surgery or Keratoconus correction. |
| | Children's glasses | 0% coinsurance after deductible is met | Not Covered | Coverage is limited to eyeglasses/contact lenses within 12 months following cataract surgery or the correction of Keratoconus. Prior authorization may be required. Deductible does apply. |
| | Children's dental check-up | Not covered | Not covered | ----------None---------- |

## Excluded Services and 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 |
| • Dental check-up (Child) | • Private-Duty Nursing | • Weight Loss Programs |
| • Infertility Treatment | | |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Acupuncture | • Chiropractic Care | • Hearing Aids for school aged children |
| • Bariatric Surgery | | |

**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 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 1-855-592-7737.
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 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** | **$2,500** |
| **Specialist** | **0%** |
| **Hospital (Facility)** | **0%** |
| **Other** | **0%** |

**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** | **$12,700** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,500 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | $2,560 |

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

| | |
|---|---|
| **The plan's overall deductible** | **$2,500** |
| **Specialist** | **0%** |
| **Hospital (Facility)** | **0%** |
| **Other** | **0%** |

**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** | **$5,600** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,500 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | $2,520 |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| **The plan's overall deductible** | **$2,500** |
| **Specialist** | **0%** |
| **Hospital (Facility)** | **0%** |
| **Other** | **0%** |

**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** | **$2,800** |

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,500 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | $2,500 |

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