




APS Open Access Plan High and Low Option Comparison

 PRESBYTERIAN		In-Network Care	Out-of- Network ⁴	In-Network Care	Out-of- Network ⁴
	Member Copay/Coinsurance	Varies depending on service; see below			
	Member Deductible (Calendar Year)				
	Single	None	\$300	\$150	\$300
	Two - Party		\$600	\$300	\$600
	Family		\$900	\$450	\$900
	Out-of-Pocket Max (Calendar Year)				
	Single	\$2,000	\$3,500	\$2,000	\$4,000
	Two – Party	\$4,000	\$7,000	\$4,000	\$8,000
	Family	\$6,000	\$10,500	\$6,000	\$12,000
	Lifetime maximum	Unlimited (Certain services are subject to Calendar Year and/or lifetime maximums or are limited per condition.)			
	Pre-existing Limitation (Does not apply to pregnancy, newborns, and newly adopted children)	<ul style="list-style-type: none"> • No Pre-ex if prior creditable coverage • New enrollees – 6 months • Late enrollees – 18 months 			
Physician Services	Office Visit				
	Non-Specialist	\$25 office visit Copay	30%	20%	40%
	Specialty care	\$35 office visit Copay	30%	20%	40%
	Surgery in Office	Included in office visit Copay	30%	20%	40%
	Preventive services (Deductible waived)				
	Routine physicals	No Copay	30% ⁵	Plan pays 100%	40% (deductible waived for certain test)
	Well child care including vision and hearing screening (through age 17) and Immunizations				
	Adult Wellness and Related Testing (including routine Pap tests, cholesterol tests, urinalysis, Mammogram, Colonoscopy etc.) and Immunizations	No Copay	30% ⁵	Plan pays 100% up to maximum of \$250. After \$250, deductible and 20% Coinsurance apply	40% (deductible waived for certain test)
	Family Planning				
	Birth Control injections,	Included in office visit copay	30%	20%	40%
	Insertion/removal of birth control devices				
	Surgical sterilization in office				


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Physician Services (continued)	Allergy Testing and Treatment	\$35 office visit copay	30%	20%	40%
	Allergy injections only	No copay	30%	20%	40%
	Allergy extract preparation	No copay	30%	20%	40%
Outpatient Diagnostic Testing	PET ¹ , MRI ¹ , CT Scans ¹	\$50 Copay per test	30%	20%	40%
	Other Laboratory	No Copay	30%	20%	40%
	Other X-rays	No Copay	30%	20%	40%
Hospital Services	Hospitalization ¹ (includes room and board, Inpatient Physician care- Physician visits, surgeon, anesthesiologist, laboratory & x-ray)	\$750 Copay per Admission	30% ²	20%	40% ²
	Inpatient rehabilitation services ¹	\$750 Admission Copay	30% ²	20%	40% ²
	Observation Stay	\$75 Copay	30%	20%	40%
Sleep Studies	Inpatient ¹	\$750 Admission Copay	30% ²	20%	40% ²
	Sleep Labs (two nights)	\$100 Copay	30%	20%	40%
Surgical Services	Inpatient Surgery ¹	Covered as part of Hospitalization	30% ²	20%	40%
	Outpatient Surgery ¹	\$100	30%	20%	40%
	Office Surgery	Included in office visit Copay	30%	20%	40%
Maternity Services	Physician/midwife services (delivery, prenatal, postnatal care)	\$35 copay – initial visit only; all other visits no copay	30%	20%	40%
	Genetic Testing and counseling	Copay based on Service	30%	20%	40%
	Hospital Admission ¹	\$750 Copay per pregnancy	30% ²	20%	40% ²
	Routine nursery care for newborns	No Copay	30%	20%	40%
	Home Birth	No Copay	30%	20%	40%
Urgent and Emergency Services	Urgent Care Facility	\$40 Copay	30%	20%	40%
	Emergency room visit -Hospital charges	\$120 Copay	30%	20%	40%
	Emergency room – Physician charges	No Copay	30%	20%	40%
	Ambulance – Emergency Air Transport	No Copay No Copay	30% 30%	20% 20%	40% 40%

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Mental Health	Outpatient services ¹	\$35 Copay per visit	30%	20%	40%
	Inpatient services ¹	\$750 Copay per admission	30% ²	20%	40% ²
	Partial Hospitalization ¹ (waived if admitted inpatient) two partial hospitalizations equal one inpatient day	\$750 Copay per admission	30% ²	20%	40% ²
Substance Abuse	Outpatient services ¹	\$35 Copay per visit	30%	20%	40%
	Inpatient services ¹	\$750 Copay per Admission	30% ²	20%	40% ²
	Partial Hospitalization ¹ (waived if admitted inpatient) two partial hospitalizations equal one inpatient day	\$750 Copay per Admission	30% ²	20%	40% ²
Other Services	Alternative therapy ³ (e.g. Acupuncture, Chiropractic, Massage therapy, and Rolwing)	\$35 Copay per visit	30%	20%	40%
	(\$1,500 combined In-Network and Out-of-Network Calendar Year maximum)		(20 Visits per Calendar Year)		
	Biofeedback (for specified medical conditions only)	\$35 Copay per visit	30%	20%	40%
	Cardiac or Pulmonary Rehabilitation – Outpatient	\$35 Copay	30%	20%	40%
	Chemotherapy and/or Radiation Therapy	No Copay	30%	20%	40%
	Dialysis	No Copay	30%	20%	40%
	Dental Services (for specified medical conditions only)	Copay based on service	30%	20%	40%
	Durable Medical Equipment Prosthetics and Orthotics and appliances ¹	15%	30%	20%	40%
	Hearing Aids – (Limited to school aged children under 18 years old (or under 21 years of age if still attending high school).	No Copay	No Copay	No Copay	No Copay
	The plan pays 100% of the allowed amount up to a maximum of \$2,200 every 36 months “per hearing impaired ear”				
Home health care ¹	No Copay	30%	20%	40%	
Hospice ¹ Bereavement counseling (<i>limited to 3 sessions during the Hospice benefit period</i>) Respite care (<i>limited to 5 continuous days for each 60 days of Hospice care. No more than two respite stays allowed</i>)	No Copay	30%	20%	40%	

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Other Services (Continued)	Infertility related services	Copay based on service	30%	20% (Diagnostic only)	40% (Diagnostic only)
	Physical, Occupational and Speech Therapy ^{1,3}	\$35 copay per visit <i>(combined maximum of 60 visits per condition per Calendar Year)</i>	30%	20%	40%
	Restorative Speech Therapy	50%	50%	50%	50%
	Skilled Nursing Facility ^{1,3}	\$750 Admission Copay <i>(max. 60 days per Calendar Year)</i> <i>Admission copay waived if admitted within 72 hours</i>	30%	20%	40% ²
	Smoking cessation	50%	50%	20%	40%
		<i>(Lifetime maximum of \$500 per member includes medication)</i>			
Trans- plants	Coverage for human organ transplants ^{1,3} (refer to booklet for complete details on transplant coverage and call for case management services)	Applicable Copay based on place of service	No benefit	20%	No benefit
		<i>(Lifetime maximum of \$500,000)</i>			
Prescription Drugs	Administered by Express Scripts ⁵ . Call Express Scripts at 1-877-849-5529				

¹ Certain services are not covered if Benefit Certification is not obtained from the plan administrator. See Section 2 of the Summary Plan Description for a list of services requiring Benefit Certification.

² Admission review is required for Inpatient Admissions. You pay a \$300 penalty for all facility services if approval is not obtained.

³ This benefit includes an annual maximum payment, annual visit limitation, and/or lifetime visit limitation. See Section 2 and 4 of the Summary Plan Description for more details.

⁴ If you choose to receive routine care from Out-of-Network Providers, payments by Presbyterian Health Plan for Covered Services will be **limited** to Reasonable and Customary Charges. For care other than Emergency or Urgent care, you will be responsible for any balance due above Reasonable and Customary charges

⁵ Not subject to the Deductible.

Health Management

Presbyterian Health Plan provides members a number of tools to help better manage all health conditions, including:

- Direct access to medical advice any time, day or night through NurseAdvice New Mexico – 1-866-221-9679.
- Help with managing chronic conditions through our internal disease management program Presbyterian Healthy Solutions – (505) 923-5487 or 1-800-841-9705.
- An online WebMD Health Manager site featuring up-to-date health information and resources to help create a personalized health improvement – www.phs.org/phs.healthplans/online.
- Useful diabetes education and support through our Certified Diabetes Educators via the Diabetes Resource Line – (505) 923-5017 or toll-free at 1-866-634-2617.