PRESBYTERIAN

APS Three Tier Option Plan

Coverage for: Individual, Individual+Spouse, 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 1-888-275-7737 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/glossary/ or call 1-888-275-7737 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier I: $250 single/ $500 two-person/ $750 family. Tier II: $1,500 single/$3,000 two-person/$4,500 family. Tier III (out-of-network): $4,000 single/$8,000 two-person/ $12,000 family. The Tier I and Tier II in-network deductibles don't apply to preventive care or services where a copay is listed.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. The deductible starts over on January 1st each year. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. There are separate deductibles for Tier I (Presbyterian Preferred Network) providers, Tier II (Presbyterian Nationwide PPO Network) providers, and Tier III (out-of-network) providers. The deductibles do not cross-accumulate between tiers.
Are there services covered before you meet your deductible?	Yes; in-network preventive care and in-network services where a copay is listed.	If you see an in-network provider, this plan covers some items and services even if you haven't yet met the deductible amount. But a copayment may apply.
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 out-of-pocket limit for Tier I: $3,000 single/ $6,000 two-party/ $9,000 family. In-network out-of pocket limit for Tier II: $4,500 single/ $7,875 two-party/ $11,250 family. Tier III (out-of-network) out-of-pocket limit: $8,500 single/ $14,875 two-party/ $21,250 family.	The in-network out of pocket limit is the most you could pay during a coverage period (each calendar year) for your share of the cost of covered services. This limit helps you plan for health care expenses. The out-of-pocket limit cross-applies between Tier I (Presbyterian Preferred Network) providers and Tier II (Presbyterian Nationwide PPO Network) providers. It does not cross-apply with Tier III (out-of-network) services.

What is not included in the out-of-pocket limit?	Premiums, prescription drug payments, penalty amounts and health care this plan doesn't cover. In addition, certain specialty pharmacy drugs are considered non-essential health benefits under the Affordable Care Act (ACA), and fall outside the out-of-pocket limits.	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, and you will pay the least if you use Tier I providers. See www.phs.org/aps or call (888) 275-7737 to locate Tier I and Tier II participating providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services, or your Tier I provider may use a Tier II provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan. Remember that you will pay the least out of pocket cost if you see a Tier I specialist.

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
		Tier I Provider	Tier II Provider	Tier III Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit	$25 copay/visit	50% coinsurance: Tier III deductible applies	None
	Specialist visit	$40 copay/visit	$40 copay/visit	50% coinsurance: Tier III deductible applies	None
	Preventive care/screening/ immunization	No Charge	No Charge	50% coinsurance: Tier III deductible applies	None
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	No Charge	50% coinsurance: Tier III deductible applies	None
	Imaging (CT/PET scans, MRIs)	$100 copay/day(free-standing facility), or 20% coinsurance: Tier I deductible applies (outpatient dept of hospital)	$100 copay/day(free-standing facility), or 30% coinsurance: Tier II deductible applies (outpatient dept of hospital)	50% coinsurance: Tier III deductible applies	Prior Approval is required. Failure to obtain Prior Approval may result in a denial of coverage.
If you need drugs to treat your illness or condition Information about prescription drug coverage is available from Express Scripts: 1-866-563-9297	Generic drugs	Retail: 20% coinsurance, minimum $10 and maximum $25 (up to 34 day supply); Home delivery and Walgreens: $25 (up to 90 day supply)		Not covered	Prescription drug benefits are administered for Albuquerque Public Schools by Express Scripts. Insulin and Diabetic Supplies: $0 copayment Maintenance (long-term) medications: A maximum of two 30-day fills of maintenance medications are allowed at a retail pharmacy. Then, maintenance medications require a 90-day fill either via Express Scripts home delivery or at a Walgreens pharmacy.
	Preferred brand drugs	Retail: 30% coinsurance, minimum $35 and maximum $65 (up to 34 day supply); Home delivery and Walgreens: $70 (up to 90 day supply)		Not covered	
	Non-preferred brand drugs	Retail: 40% coinsurance, minimum $70 and maximum $140 (up to 34 day supply); Home delivery and Walgreens: $150 (up to 90 day supply)		Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier I Provider	Tier II Provider	Tier III Provider	
	Specialty drugs Specialty medications must be filled through Accredo, the Express Scripts home delivery specialty pharmacy	30 day supply of specialty medications $70 for generic specialty medications $100 for preferred brand specialty medications $150 for non-preferred brand specialty medications Copays for certain specialty medications may be set to the maximum of the current plan design ($150) or the amount of any available manufacturer-funded copay assistance.		Not covered	Specialty medications: 30-day fills of specialty medications must be filled using Accredo, the Express Scripts home delivery specialty pharmacy. Please see the "Important Questions" section (page 2) of this document regarding the plan's out-of-pocket limit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance: Tier I deductible applies	30% coinsurance: Tier II deductible applies	50% coinsurance: Tier III deductible applies	Prior Approval is required. Failure to obtain Prior Approval may result in a denial of coverage.
	Physician/surgeon fees	20% coinsurance: Tier I deductible applies	30% coinsurance: Tier II deductible applies	50% coinsurance: Tier III deductible applies	Prior Approval is required. Failure to obtain Prior Approval may result in a denial of coverage.
If you need immediate medical attention	Emergency room care	$250 copay/visit	$250 copay/visit	$250 copay/visit	Emergency room copay waived if admitted to the hospital. Emergency services are covered at the Tier I provider level regardless of where the services are received. Medical Drugs are not subject to deductible or coinsurance when issued in the ER.
	Emergency medical transportation	20% coinsurance: Tier I deductible applies	20% coinsurance: Tier I deductible applies	20% coinsurance: Tier I deductible applies	Emergency medical transportation services are covered at the Tier I provider level regardless of whether the ambulance service is a contracted provider.
	Urgent care	$50 copay/visit	$75 copay/visit	$75 copay/visit	Out-of-network Urgent Care services are covered at Tier II copayment.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier I Provider	Tier II Provider	Tier III Provider	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance: Tier I deductible applies	30% coinsurance: Tier II deductible applies	50% coinsurance: Tier III deductible applies	Prior Approval is required. Failure to obtain Prior Approval may result in a denial of coverage.
	Physician/surgeon fees	20% coinsurance: Tier I deductible applies	30% coinsurance: Tier II deductible applies	50% coinsurance: Tier III deductible applies	Prior Approval is required. Failure to obtain Prior Approval may result in a denial of coverage.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/visit	$25 copay/visit	50% coinsurance: Tier III deductible applies	Prior Approval is required for inpatient services. Failure to obtain Prior Approval may result in a denial of coverage.
	Inpatient services	20% coinsurance: Tier I deductible applies	30% coinsurance: Tier II deductible applies	50% coinsurance: Tier III deductible applies	
If you are pregnant	Office visits	$40 copay - initial visit only, then No Charge	$40 copay - initial visit only, then No Charge	50% coinsurance: Tier III deductible applies	Tier I and Tier II copay only due for first pre-natal visit.
	Childbirth/delivery professional services	20% coinsurance: Tier I deductible applies	30% coinsurance: Tier II deductible applies	50% coinsurance: Tier III deductible applies	Home Births Not Covered
	Childbirth/delivery facility services	20% coinsurance: Tier I deductible applies	30% coinsurance: Tier II deductible applies	50% coinsurance: Tier III deductible applies	Home Births Not Covered
If you need help recovering or have other special health needs	Home health care	$40 copay/visit	$40 copay/visit	50% coinsurance: Tier III deductible applies	Prior Approval is required. Failure to obtain Prior Approval may result in a denial of coverage.
	Rehabilitation services	$15 copay/visit up to $240 annual maximum	$25 copay/visit up to $500 annual maximum	50% coinsurance: Tier III deductible applies	Coverage is limited to 60 days/visits per calendar year.
	Habilitation services	$15 copay/visit up to $240 annual maximum	$25 copay/visit up to $500 annual maximum	50% coinsurance: Tier III deductible applies	Coverage is limited to 60 days/visits per calendar year.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier I Provider	Tier II Provider	Tier III Provider	
	Skilled nursing care	20% coinsurance: Tier I deductible applies	30% coinsurance: Tier II deductible applies	50% coinsurance: Tier III deductible applies	Includes inpatient physical rehabilitation. Coverage is limited to 60 days/visits per calendar year.
	Durable medical equipment	20% coinsurance: Deductible does not apply	20% coinsurance: Deductible does not apply	50% coinsurance: Tier III deductible applies	Prior Approval is required. Failure to obtain Prior Approval may result in a denial of coverage.
	Hospice services	20% coinsurance: Tier I deductible applies	30% coinsurance: Tier II deductible applies	50% coinsurance: Tier III deductible applies	Prior Approval is required. Failure to obtain Prior Approval may result in a denial of coverage.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not covered	Not Covered Under Medical Plan
	Children's glasses	Not Covered	Not Covered	Not covered	Not Covered Under Medical Plan
	Children's dental check-up	Not Covered	Not Covered	Not covered	Not Covered Under Medical Plan

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
- Dental Care
- Hearing aids (adult)
- Home Births
- Long term care
- Private duty nursing
- Routine eye care and vision exams
- Routine foot care (unless you are diabetic)
- Weight loss programs (Unless for Medically necessary treatment for morbid obesity)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (maximum 25 visits/year)
- Chiropractic care (maximum 25 visits/year)
- Hearing aids (child)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact Presbyterian Health Plan at 1-888-275-7737. You may also contact your state insurance department, the U.S. Department of

Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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.

You may also submit your Concerns in writing to the above noted address. You may also contact the Office of the Superintendent of Insurance (OSI) by mail to the Office of the Superintendent of Insurance, P.O. Box 1689, Santa Fe, New Mexico 87504-1689; or Email to mhcb.grievance@state.nm.us. You may fax to the OSI, ATTN: Superintendent at 1-505-827-4734; or Complete an on-line Complaint Form available at http://www.osi.state.nm.us.

Language Access Services:

See Multi-Language insert at the end of this document.

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	$250
Specialist *[cost sharing]*	$40
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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*)

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$80
Coinsurance	$2,482
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,872**

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

The plan's overall deductible	$250
Specialist *[cost sharing]*	$40
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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*)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$140
Coinsurance	$330
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$530**

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

The plan's overall deductible	$250
Specialist *[cost sharing]*	$40
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$410
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$410**

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

Notice of Nondiscrimination and Accessibility

Discrimination is Against the Law

Presbyterian Healthcare Services complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Presbyterian Healthcare Services does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Presbyterian Healthcare Services:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Presbyterian Customer Service Center at (505) 923-5420, 1-855-592-7737, TTY: 711.

If you believe that Presbyterian Healthcare Services has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance. You can file a grievance in person, or by mail, fax, or email. If you need help filing a grievance, the Privacy Officer and Civil Rights Coordinator is available to help you.

Presbyterian Privacy Officer and Civil Rights Coordinator
P.O. Box 27489
Albuquerque, NM 87125

Phone: 1-866-977-3021, TTY: 711
Fax: (505) 923-5124
Email: **info@phs.org**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201

Phone: 1-800-368-1019, 1-800-537-7697 (TDD)
Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

PRESBYTERIAN

Aviso de no discriminación y accesibilidad

La discriminación es contra la ley

Presbyterian Health Services (Presbyterian) cumple con todas las leyes de derechos civiles federales aplicables y no discrimina sobre la base de la raza, color, nacionalidad, edad, discapacidad o sexo.

Presbyterian no excluye a las personas ni las trata de manera diferente en base a la raza, color, nacionalidad, edad, discapacidad o sexo.

Presbyterian:

- brinda ayudas y servicios gratuitos a personas con discapacidades para que se comuniquen efectivamente con nosotros, como intérpretes calificados de lenguaje de señas e información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos)
- brinda servicios de idioma gratuito a personas cuyo idioma principal no es el inglés, como intérpretes calificados e información escrita en otros idiomas

Si necesita estos servicios, comuníquese con el Centro de servicio al miembro de Presbyterian llamando al (505) 923-5420, 1-855-592-7737, TTY: 711.

Si cree que Presbyterian no le ha brindado estos servicios o lo ha discriminado en otra manera en base a la raza, color, nacionalidad, edad, discapacidad o sexo, puede presentar una queja llamando al Oficial de privacidad de Presbyterian y Coordinadora de derechos civiles, P.O. Box 27489, Albuquerque, NM, 87125, o llame al 1-866-977-3021, TTY: 711, fax (505) 923-5124 o **info@phs.org**. Puede presentar una queja en persona o por correo, correo electrónico, o a los números de teléfono anteriores. Si necesita ayuda para presentar una queja, llame al 1-866-977-3021 y un representante del cliente le ayudará.

También puede presentar una queja a la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los EE.UU. electrónicamente a través del portal de quejas de la Oficina de Derechos Civiles en **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,** o por correo o teléfono a:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Línea telefónica gratis: 1-800-368-1019, 1-800-537-7697 (TDD)
Los formularios de quejas están disponibles en **https://www.hhs.gov/ocr/office/file/index.html**.

PRESBYTERIAN

Multi-Language Interpreter Services

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 505-923-5420, 1-855-592-7737 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 505-923-5420, 1-855-592-7737 (TTY: 711).
Navajo	Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh éí ná hóló, kojį' hódíílnih 505-923-5420, 1-855-592-7737 (TTY: 711)
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 505-923-5420, 1-855-592-7737 (TTY: 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 505-923-5420, 1-855-592-7737 (TTY: 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 505-923-5420, 1-855-592-7737 (TTY: 711).。
Arabic	ملحوظة: إذا كنت تتحدث اذكر لالغة، فإن خدمات لمساعدة للاغوية تتوافر لكب للمجان. اتصل برقم (TTY:711), 505-923-5420 1-855-592-7737 رقم هاتف لصم وللبكم.
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 505-923-5420, 1-855-592-7737 (TTY: 711) 번으로 전화해 주십시오.
Tagalog Filipino	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 505-923-5420, 1-855-592-7737 (TTY: 711).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。505-923-5420, 1-855-592-7737 (TTY: 711) まで、お電話にてご連絡ください。
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 505-923-5420, 1-855-592-7737 (ATS: 711).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 505-923-5420, 1-855-592-7737 (TTY: 711).
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 505-923-5420, 1-855-592-7737 (телетайп: 711).
Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 505-923-5420, 1-855-592-7737 (TTY: 711) पर कॉल करें।
Farsi	توجه: اگر به زبان انگلیسی صحبت می کنید، سرویس های دستیار زبان به صورت رایگان در اختیارتان قرار می گیرند. با شماره 505-923-5420، 1-855-592-7737 (TTY: 711) تماس بگیرید.
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 505-923-5420, 1-855-592-7737 (TTY: 711).

PRESBYTERIAN