2019 APS Three-Tier Option Plan Summary of Benefits

Administrative Services for the Albuquerque Public Schools self-funded medical plan are provided by Presbyterian Health Plan.		Tier I Presbyterian Preferred Network	Tier II Presbyterian Nationwide PPO Network	Tier III Out-of-Network[7]
Deductible	Annual Member Deductible (calendar year)			
	Single	$250	$1,500	$4,000
	Two-party	$500	$3,000	$8,000
	Family	$750	$4,500	$12,000
	• The deductible does not apply to Preventive Care Services or Prescription Drugs. • Copayments do not apply towards deductible. • Except for Preventive Care and those services where a copayment applies, the deductible must be met before benefit payment is made by the plan (coinsurance applies). • After each family member meets his or her individual plan deductible, the plan will pay a percentage of his or her claims and the member will pay applicable coinsurance until the out-of-pocket maximum is met. • After the family plan deductible has been met, the plan will pay a percentage of each individual's claims and the member(s) will pay applicable coinsurance until the out-of-pocket maximum is met. • Deductible amounts do not cross-accumulate between Tier I, Tier II and Tier III.			
Coinsurance		You pay 20% and the Plan pays 80% after the annual deductible is met	You pay 30% and the Plan pays 70% after the annual deductible is met	You pay 50% and the Plan pays 50% after the annual deductible is met
Out-of-Pocket Maximum	Annual Out-of-Pocket Maximum			
	Single	$3,000	$4,500	$8,500
	Two-Party	$6,000	$7,875	$14,875
	Family	$9,000	$11,250	$21,250
	• The medical plan copayments, deductible and coinsurance apply to the annual out-of-pocket maximum. • Prescription drug copayments or coinsurance do not apply to the medical plan out-of-pocket maximum. The prescription drug plan includes a separate out-of-pocket maximum. • After each family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of that individual's covered expenses. • After the family out-of-pocket maximum has been met, the plan will pay 100% of each family member's covered expenses. • Amounts do not cross apply between Tier I/Tier II and Tier III.			
Physician Services	Non-Specialist • Primary Care Physician (PCP) selection not required	$15 office visit copay	$25 office visit copay	50% coinsurance after deductible
	Specialist • Referral not required	$40 office visit copay	$40 office visit copay	50% coinsurance after deductible
	Surgery in Office	Included in office visit copay	Included in office visit copay	50% coinsurance after deductible
	Injectable drugs administered in physician's office	Copay based on place of service	Copay based on place of service	50% coinsurance after deductible
	Self-injectable drugs (specialty pharmaceuticals) can be ordered through the prescription drug plan	Refer to the prescription drug plan		
Preventive Care Services[1]	• Routine Physical • Annual women's exam • Annual men's exam including PSA • Related laboratory tests including x-rays (includes routine pap tests, cholesterol tests, urinalysis, mammogram, colonoscopy, etc.) • Well childcare including vision and hearing screenings (through age 21) • Immunizations • Health education and counseling (including smoking/tobacco cessation education) • Family planning	Plan pays 100%	Plan pays 100%	50% coinsurance after deductible

Women's Health Care	Contraceptive methods[1] (preferred agents) • Intrauterine devices (IUD) • Hormone contraceptive injections • Inserted contraceptive devices • Implanted contraceptive devices • Generic birth control Breast feeding support[6] • Supplies and counseling for one year after delivery	Plan pays 100% (prescription medications are covered under the prescription drug plan)	Plan pays 100% (prescription medications are covered under the prescription drug plan)	50% coinsurance after deductible
Outpatient Diagnostic Testing	Advanced Radiology[2] (i.e., PET, MRI, CT scans) • Medically necessary outpatient imaging tests	$100 copay per day, then 20% coinsurance after deductible	$100 copay per day, then 30% coinsurance after deductible	$100 copay per test, then 50% coinsurance after deductible
	Other Laboratory	Plan pays 100%	Plan pays 100%	50% coinsurance after deductible
	Other X-Rays	Plan pays 100%	Plan pays 100%	50% coinsurance after deductible
Hospital Services	Hospitalization[2] • Includes room and board, inpatient physician care–physician visits, surgeon, anesthesiologist, laboratory tests and X-Rays	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
	Inpatient Rehabilitation Services[2]	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
	Observation Stay[2]	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
Sleep Studies	Inpatient[2] Sleep labs (two nights)[2]	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
Surgical Services	Inpatient Surgery[2]	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
	Outpatient Surgery[2]	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
	Office Surgery	Included in office visit copay	Included in office visit copay	50% coinsurance after deductible
Urgent Care Services	Urgent Care Facility	$50 copay	$75 copay	$75 copay
	Non-urgent follow-up care	Subject to place of service copay or coinsurance	Subject to place of service copay or coinsurance	50% coinsurance after deductible
Emergency Services	Emergency Room[4]/Emergency observation treatment[4] • Hospital and Physician charges	$150 copay, then 20% coinsurance after Tier I deductible		
	Non-emergent follow-up care	Subject to place of service copay or deductible and coinsurance	Subject to place of service copay or deductible and coinsurance	50% coinsurance after deductible

Ambulance	Ambulance – Emergency Air Transport	20% coinsurance after Tier I deductible		
Maternity Services	Physician/Midwife Services • Delivery, prenatal and postnatal care	$40 copay – initial visit only, then the plan pays 100%	$40 copay – initial visit only, then the plan pays 100%	50% coinsurance after deductible
	Genetic Testing and Counseling	Copay based on place of service	Copay based on place of service	50% coinsurance after deductible
	Hospital Admission[2]	20% coinsurance after deductible (on the mother)	30% coinsurance after deductible (on the mother)	50% coinsurance after deductible (on the mother)
	Routine nursery care for newborn • If mother is covered under the plan • Baby is covered from birth but must be enrolled in the medical plan as quickly as possible but no later than 60 days from date of birth	Plan pays 100%	Plan pays 100%	50% coinsurance after deductible
	Extended stay charges for covered newborn • If baby is admitted to the hospital post-delivery	20% coinsurance after deductible (on the baby)	30% coinsurance after deductible (on the baby)	50% coinsurance after deductible (on the baby)
Behavioral/ Mental Health	Outpatient Services	$15 office visit copay	$25 office visit copay	50% coinsurance after deductible
	Inpatient Services[2] Partial Hospitalization[2] • Two partial hospitalizations equal one inpatient stay	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
Substance Abuse	Outpatient Services	$15 office visit copay	$25 office visit copay	50% coinsurance after deductible
	Inpatient Services[2]	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
	Partial Hospitalization[2] • Two partial hospitalizations equal one inpatient stay	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
	Residential Treatment Center[3] • Combined Tier I, Tier II and Tier III maximum of 60 days per calendar year	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
Other Services	Allergy Testing and Treatment	$40 office visit copay	$40 office visit copay	50% coinsurance after deductible
	Allergy Injections only	Plan pays 100%	Plan pays 100%	50% coinsurance after deductible
	Allergy Extract preparation	Plan pays 100%	Plan pays 100%	50% coinsurance after deductible
	Alternative Therapy[3] • Acupuncture, Chiropractic, Massage Therapy and Rolfing (combined Tier I, Tier II, and Tier III maximum of 25 visits per calendar year)	$40 copay per visit	$40 copay per visit	50% coinsurance after deductible

Other Services (continued)	Autism Spectrum Disorders[2]	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
	• Diagnosis and treatment of autism spectrum disorder for members 19 years of age or younger (or under 22 years of age if still enrolled in high school) • Well-baby and well-child screening for diagnosing the presence of autism spectrum disorder • The habilitative and rehabilitative treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy and applied behavioral analysis. Providers must be credentialed to provide such therapy. • Treatment must be prescribed by the member's treating physician in accordance with a treatment plan, and must be preauthorized by Presbyterian Health Plan			
	Biofeedback • For specified medical conditions only	$40 copay per visit	$40 copay per visit	50% coinsurance after deductible
	Cardiac Rehabilitation[2]	$0 copay per session	$40 copay per session	50% coinsurance after deductible
	Pulmonary Rehabilitation[2]	$0 copay per session	$40 copay per session	50% coinsurance after deductible
	Chemotherapy and/or Radiation Therapy	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
	Dialysis	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
	Diabetes Coverage • Office visit and diabetes education	Subject to place of service copay	Subject to place of service copay	50% coinsurance after deductible
	• Diabetes medication	Refer to the prescription drug plan		
	Diabetic supplies, equipment, appliances, and services[2] • Prescribed by the attending physician • Purchased through a Durable Medical Equipment (DME) provider	Plan pays 100%	30% coinsurance after deductible	50% coinsurance after deductible
	Durable Medical Equipment (DME), orthopedic appliances, prosthetics, and functional orthotics[2] • Medically necessary services, supplies and devices • Supplies limited to a 30-day supply during a 30-day period • Rental benefits may not exceed the purchase of a new unit • Support hose limited to 6 pair (or 12 hoses) per calendar year • Mastectomy bras limited to 3 per calendar year	20% coinsurance (deductible does not apply)	20% coinsurance (deductible does not apply)	50% coinsurance after deductible
	Hearing Aids (Coverage is limited to dependents under age 21 only)	The plan pays 100% of the covered charges (including fitting and dispensing services) up to a maximum of $2,200 every 36 months per hearing impaired ear		50% coinsurance after deductible
	Home Health Care[2]/Home Intravenous Service[2] (Tier III limited to 120 visits per calendar year) • Prescribed home physician services, nursing care and rehabilitative therapy	$40 copay per visit	$40 copay per visit	50% coinsurance after deductible
	Hospice	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible

Other Services (continued)	Bereavement Counseling[3] (Limited to 3 sessions during the hospice benefit period)	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
	Respite Care[3] (Limited to 5 continuous days for each 60 days of hospice care. No more than two respite stays allowed.)	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
	Infertility related services • Test performed in a laboratory • Test performed in a Non-Specialist Physician's office • Test performed in a Specialist Physician's office • (Refer to the Summary Plan Description for covered services)	Copays based on place of service	Copays based on place of service	50% coinsurance after deductible
	Physical, Occupational, and Speech Therapy[3] (combined Tier I, Tier II, and Tier III maximum of 60 visits per condition per calendar year)	$40 copay per visit up to a maximum of $400 per calendar year	$40 copay per visit up to a maximum of $600 per calendar year	50% coinsurance after deductible
	Skilled Nursing Facility[3] (combined Tier I, Tier II, and Tier III maximum of 60 days per condition per calendar year)	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
	Tobacco Cessation[3]	Plan pays 100%	Plan pays 100%	Not covered
	• Screening for tobacco use • At least two tobacco cessation attempts per year which include: • Four tobacco cessation counseling sessions of at least 10 minutes each (telephone counseling, group counseling or individual counseling) • No prior authorization required • Tobacco cessation medications prescribed by a health care provider are covered under the prescription drug plan			
	Dental Services[2] (For limited medical conditions only)	$150 copay, then 20% coinsurance after Tier I deductible		
Pre-Existing Conditions	Pre-Existing Condition Limitations	Not Applicable		
Lifetime Maximum	Not Applicable	Certain services are subject to calendar year maximum visits or days or are limited per condition		
Transplants[5]	Coverage for human organ transplants[5] • Case Management required • Refer to Summary Plan Description for complete details on transplant coverage • Maximums apply to covered travel and lodging services	20% coinsurance after deductible	30% coinsurance after deductible	Not covered
Prescription Drugs	Administered by Express Scripts. Call Express Scripts at 1-866-563-9297			

1. The Patient Protection and Affordable Care Act (also known as Health Care Reform) requires health plans to cover specific Preventive Care Services, including Women's Preventive Care Services, at no cost to the member when the services are provided by an In-Network Participating Provider. Although these services are covered at no charge, the provider may charge a copayment for other services provided during the office visit. Additionally, some covered Family Planning services, including male vasectomies, continue to require member cost-sharing. If you have questions regarding the Preventive Care Services that are covered under this plan, including Family Planning Services, or your cost for these services, please refer to your Summary Plan Description or contact Presbyterian Health Plan at the phone number listed on your ID card.
2. Pre-Admission Review and/or Prior Authorization is required; $300 penalty, reduction or denial may apply to facility and provider services if the required Pre- Admission Review and/or Prior Authorization is not obtained.
3. This benefit includes an annual visit limitation. See your Summary Plan Description for more information.
4. The Emergency Services copayment/deductible/coinsurance is waived if an inpatient hospital admission results; then the hospital admission deductible and coinsurance applies.
5. Transplants are covered by Tier I or Tier II Providers. Case Management Services for transplant patients must be obtained from Presbyterian Health Plan at the phone number listed on your ID card.
6. Patients are responsible for copayments or deductible and coinsurance related to place of service, ancillary services, and additional procedures performed at the same time. Prior Authorization rules still apply.
7. If you choose to receive routine care from Tier III providers, payments by the plan for Covered Services will be limited to Reasonable and Customary Charges. For care other than Urgent Care and Emergency Care, you will be responsible for any balance due to the provider above Reasonable and Customary Charges.