NMPSIA: High Option Plan (Presbyterian network)

Coverage Period: 01/01/2017 – 06/30/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: Individual + Family | Plan Type: PPO**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.phs.org or by calling 505-923-5600 or toll-free at 1-888-275-7737.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network Preferred Providers $750/person per calendar year; $1,500/family per calendar year. Non-Preferred Providers: $1,500/person per calendar year; $3,000/family per calendar year. Does not apply to preventive care, outpatient prescription drugs, tobacco cessation benefits and these services from a preferred provider: office visits, outpatient x-ray or lab tests, allergy shots, acupuncture, spinal manipulation, ambulance transport, cardiac rehab, pulmonary rehab, urgent care facility, chemotherapy, radiation therapy and hospice. Copayments, a penalty for failure to obtain precertification, and non-eligible medical expenses do not count toward the deductible.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes, the medical plan Out-of-Pocket Limit includes Deductibles, Copayments and Coinsurance: In-network Preferred Provider: $3,750/person per calendar year; $7,500/family per calendar year. Non-Preferred Provider: $9,000/person per calendar year; $18,000/family per calendar year. The plan has an Outpatient Drug Out-of-Pocket Limit, meaning the most you pay for covered generic, preferred brand, non-preferred brand and Specialty drugs from in-network retail and mail order locations per calendar year is $3,100/person; $6,200/family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you pay for health care expenses.
What is not included in the out–of–pocket limit?	For the medical plan Out-of-Pocket Limit, premiums, balance-billed charges, health care this plan does not cover, charges in excess of annual maximum benefits, a penalty for failure to obtain precertification and outpatient retail/mail order drugs. Outpatient retail/mail order prescription (Rx) drug expenses accumulate to a separate Rx out-of-pocket limit.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.

Does this plan use a network of providers?	Yes. For a list of in-network Preferred providers within the state of New Mexico through Presbyterian Healthcare Services (PHS), see www.phs.org or call 505-923-5600 or toll free at 1-888-275-7737. For a list of Preferred providers outside of New Mexico through MultiPlan/PHCS network, see www.multiplan.com or call 505-923-5600 or toll free at 1-888-275-7737.	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. 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 I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about excluded services.

- Copayments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Coinsurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use in-network Preferred providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment/visit. Deductible does not apply.	30% coinsurance after deductible met.	In-network video visits: $10 copay/visit. 20% coinsurance after deductible for in-network office surgery including casts, splints and dressings.
	Specialist visit	$30 copayment/visit. Deductible does not apply.	30% coinsurance after deductible met.	20% coinsurance after deductible for in-network office surgery including casts, splints and dressings.
	Other practitioner office visit	Acupuncture & Chiropractor: $30 copayment/visit. Deductible does not apply. Naprapath: $50 copay/visit. Maximum benefit of $500/calendar year. Deductible does not apply.	30% coinsurance after deductible met. Naprapath: Not covered.	Acupuncture, spinal manipulation, massage therapy and rolfing combined maximum benefit is 30 visits/calendar year. Naprapath: benefit maximum is $500/calendar year.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
	Preventive care/screening/ immunization	No charge.	30% coinsurance, deductible waived.	Age & frequency guidelines apply to covered preventive care. Plan covers preventive services & supplies required by the Health Reform law.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible does not apply. Office/freestanding test: You pay the lesser of $30 copayment per day or the Plan's allowed charge amount and no charge for the test interpretation fee. Outpatient hospital test: You pay the lesser of $60 copayment per day or the Plan's allowed charge amount and no charge for the test interpretation fee.	30% coinsurance, after deductible met.	Coumadin lab (Prothrombin time test): $10 copay in-network.
	Imaging (CT/PET scans, MRIs)	Deductible does not apply. Office/freestanding test: You pay the lesser of $600 copayment per day or 20% of the Plan's allowed charge amount and no charge for the test interpretation fee. Outpatient hospital test: You pay the lesser of $600 copayment per day or 20% of the Plan's allowed charge amount and no charge for the test interpretation fee.	30% coinsurance, after deductible met.	Prior authorization required to avoid non-payment.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available from Express Scripts at www.express-scripts.com or call 1-800-498-4904.	Generic drugs	Non-Walgreens Retail Pharmacy for 30-day supply: $8 copay. At Walgreens: $15 copay. Mail Order for 90-day supply: $20 copayment.	You pay 100%. Plan reimburses no more than it would have paid had you used an In-Network Retail pharmacy.	No coverage for prescription medication that has an over the counter (OTC) equivalent (unless mandated by law to be covered). FDA approved contraceptives: no charge for over the counter, generic, (or brand name drugs where the physician has deemed the generic as not medically appropriate). Copay waived for formulary diabetes supplies and insulin at Non-Walgreens locations. Non-insulin, formulary diabetes oral drugs payable at usual generic cost at any participating retail or mail order pharmacy.- Call Express Scripts member services at 1-800-498-4904 for additional details. If you purchase a brand drug when generic drug is available, you pay the brand drug cost-sharing plus the difference in cost between the brand drug and the generic drug. If the cost of the drug is less than the copayment, you pay just the drug cost. Some prescriptions are subject to preapproval, quantity limits or step therapy requirements. Retail and Mail order drugs accumulate to the Outpatient Drug Out-of-Pocket Limit noted on page 1.
	Preferred brand drugs	Walgreens Retail Pharmacy for 30-day supply: 30% coinsurance with minimum $25 copay & maximum $55 copay; At Walgreens: 30% coinsurance with minimum $35 copay & maximum $70 copay; Mail Order for 90-day supply: $55 copayment.	You pay 100%. Plan reimburses no more than it would have paid had you used an In-Network Retail pharmacy.	
	Non-preferred brand drugs	Retail Pharmacy for 30-day supply: 70% coinsurance; Mail Order for 90-day supply: 70% coinsurance.	You pay 100%. Plan reimburses no more than it would have paid had you used an In-Network Retail pharmacy.	
	Specialty drugs	For up to a 30-day supply, you pay a $55 copay (for generic), $80 copay (for preferred) & $130 copay (for non-preferred).	Not covered.	Specialty drugs require preapproval by calling Express Scripts at 1-800-498-4904. For most specialty drugs, the contracted specialty drug mail-order pharmacy is required after two fills at retail. In certain cases, specialty drugs are covered only at the contracted mail order pharmacy. Specialty drugs obtained from in-network retail and mail order locations accumulate to the Outpatient Drug Out-of-Pocket Limit noted on page 1.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 copay plus 20% coinsurance, after deductible met.	30% coinsurance, after deductible met.	Precertification required to avoid non-payment.
	Physician/surgeon fees	20% coinsurance, after deductible met.	30% coinsurance, after deductible met.	Precertification required to avoid non-payment.
If you need immediate medical attention	Emergency room services	20% coinsurance, after deductible met.	20% coinsurance, after deductible met.	---none---
	Emergency medical transportation	$30 copay/trip. Deductible does not apply.	$30 copay/trip. Deductible does not apply.	Precertification required for inter-facility ambulance transport to avoid non-payment. If approved, no charge.
	Urgent care	$50 copay/visit. Deductible does not apply.	30% coinsurance, after deductible met.	The copayment includes all services and supplies in the urgent care facility such as x-ray, lab and physician fees.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/admission plus 20% coinsurance, after deductible met.	30% coinsurance, after deductible met.	Elective hospital admission requires precertification to avoid a $300 financial penalty or non-payment. Copay waived if re-admitted for same condition within 15 days of discharge.
	Physician/surgeon fee	20% coinsurance, after deductible met.	30% coinsurance, after deductible met.	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office/outpatient facility/physician: $30 copay. Deductible does not apply. Intensive Outpatient: After deductible met you pay $125 copay then 20% coinsurance. Partial hospitalization: After deductible met, you pay $250 copay plus 20% coinsurance.	30% coinsurance, after deductible met.	This Plan opted out of compliance with Mental Health Parity Addictions Equity Act. Elective partial hospitalization and day treatment requires precertification to avoid non-payment.
	Mental/Behavioral health inpatient services	Inpatient Admission: After deductible met, you pay $500 copay then 20% coinsurance. Residential Treatment Center: After deductible met you pay $250 copay then 20% coinsurance.	30% coinsurance, after deductible met.	This Plan opted out of compliance with Mental Health Parity Addictions Equity Act. Elective hospital admission and residential treatment center requires precertification to avoid a financial penalty or non-payment.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
	Substance use disorder outpatient services	Office/outpatient facility/physician: $30 copay. Deductible does not apply. Intensive Outpatient: After deductible met you pay $125 copay then 20% coinsurance. Partial hospitalization: After deductible met, you pay $250 copay plus 20% coinsurance.	30% coinsurance, after deductible met.	This Plan opted out of compliance with Mental Health Parity Addictions Equity Act. Elective partial hospitalization and day treatment requires precertification to avoid non-payment. Maximum 30 outpatient visits/year for substance abuse treatment. Lifetime maximum 30 inpatient days/year for substance abuse treatment for all services combined, including inpatient and outpatient services. All copays are based on per visit/stay/program, not per day.
	Substance use disorder inpatient services	Inpatient Admission: After deductible met, you pay $500 copay then 20% coinsurance. Residential Treatment Center: After deductible met you pay $250 copay then 20% coinsurance.	30% coinsurance, after deductible met.	This Plan opted out of compliance with Mental Health Parity Addictions Equity Act. Elective hospital admission and residential treatment center requires precertification to avoid non-payment. Lifetime maximum 30 inpatient days/year for substance abuse treatment for all services combined, including inpatient and outpatient services. Residential Treatment Center admission for adults age 18 and older only, is payable to a maximum of 60 days per calendar year and 30 days per admission. All copays are based on per visit/stay/program, not per day.
If you are pregnant	Prenatal and postnatal care	For initial office visit, copay applies, deductible does not apply, thereafter, no charge.	30% coinsurance, after deductible met.	There is no charge for services or treatment after initial office visit, including no charge for ultrasound, lab and diagnostic testing for in-network services.
	Delivery and all inpatient services	$500 copay/admission plus 20% coinsurance, after deductible met.	30% coinsurance, after deductible met.	Precertification required only if hospital stay is more than 48 hours for vaginal delivery or 96 hours for C-section.
If you need help recovering or have other special health needs	Home health care	20% coinsurance, after deductible met.	30% coinsurance, after deductible met.	Non-preferred provider max benefit 120 visits/calendar year. Precertification required to avoid non-payment.
	Rehabilitation services	Outpatient visits: $30 copay/visit. Deductible does not apply. Inpatient rehab. admit: $500 copay per admission plus 20% coinsurance, after deductible.	30% coinsurance, after deductible met.	After you pay $300 in copayments for in-network outpatient visits per injury per year, there is no charge for the remaining calendar year. Precertification required to avoid non-payment.
	Habilitation services	Not covered.	Not covered.	You pay 100% of these expenses.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
	Skilled nursing care	$500 copay/admission plus 20% coinsurance, after deductible met.	30% coinsurance, after deductible met.	Precertify admission to avoid a financial penalty or non-payment. Maximum benefit is 60 days per calendar year.
	Durable medical equipment	20% coinsurance, after deductible met.	30% coinsurance, after deductible met.	Durable medical equipment over $1,000 requires precertification to avoid non-payment. Insulin pump supplies (insertion sets and reservoirs): no charge from Preferred provider.
	Hospice service	No charge. Deductible does not apply.	30% coinsurance, after deductible met.	Max benefit is 10 days for each 6-month benefit period; 2 periods per lifetime. Precertification required to avoid non-payment.
If your child needs dental or eye care	Eye exam	Not covered.	Not covered.	You pay 100% of these expenses.
	Glasses	Not covered.	Not covered.	You pay 100% of these expenses.
	Dental check-up	Not covered.	Not covered.	You pay 100% of these expenses.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult) (Child)
- Eyeglasses
- Habilitation services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (Adult)
- Routine foot care

Other Covered Services
(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture, spinal manipulation, massage therapy & rolfing maximum benefit is 30 visits/calendar year; no coverage for maintenance chiropractic therapy.
- Bariatric Surgery (when precertified).
- Hearing aids: Under 21 years: no charge up to $2,200/ear thereafter you pay 90% coinsurance in any 36-month period; Age 21 and older: no charge up to $500 ; thereafter you pay 90% coinsurance in any 36-month period.
- Infertility treatment (limited treatment covered plus testing to determine the cause of infertility and certain surgical treatment procedures)
- Weight loss programs (when provided by a Physician, licensed nutritionist or registered dietitian).

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 the New Mexico Public Schools Insurance Authority (NMPSIA) at 1-800-548-3724. 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: If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact the Medical Plan Claims Administrator (Presbyterian) at 1-888-275-7737.

Does this Coverage Provide Minimum Essential Coverage? The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard? The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services: Spanish (Español): Para obtener asistencia en Español, llame al 1-888-275-7737. Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-275-7737.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- Amount owed to providers: $7,540
- Plan pays $5,250
- Patient pays $2,290

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	$7,540

Patient pays:

Deductibles	$750
Copays	$620
Coinsurance	$890
Limits or exclusions	$30
Total	$2,290

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- Amount owed to providers: $5,400
- Plan pays $3,880
- Patient pays $1,520

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	$5,400

Patient pays:

Deductibles	$750
Copays	$590
Coinsurance	$100
Limits or exclusions	$80
Total	$1,520

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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