PRESBYTERIAN UNM

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, [insert contact information]. 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 www.[insert].com or call 1-800-[insert] to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	LoboCare: $0/$0 In-Network: **$600/** Individual / **$1,200**/Family Out-of-Network: **$1,800**/Individual / **$3,600**/Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay
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.
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?	LoboCare/In-network: **$3,000**/Individual / **$6,000**/Family. Out-of-network: **$7,500**/Individual /**$15,000**/Family.	The out of pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, 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. See www.phs.org or call 1-866-574-9567 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
		LoboCare Provider (You will pay the least)	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	$25 copayment/visit Video visits-No charge	$30 copayment/visit Video visits-No charge	40% coinsurance Video visits-Not Covered	Deductible does not apply for copayment.
	Specialist visit	$35 copayment/visit	$45 copayment/visit	40% coinsurance	Deductible does not apply for copayment.
	Preventive care/screening/ immunization	No charge	No charge	40% coinsurance	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)	No charge	No charge	40% coinsurance	LoboCare and In-network deductible does not apply. Prior authorization/ Benefit certification may be required.
	Imaging (CT/PET scans, MRIs)	15% coinsurance	25% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		LoboCare Provider (You will pay the least)	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	$10 copayment (30-day retail) and $20 copayment (90-day retail and mail order)	$10 copayment (30-day retail) and $20 copayment (90-day retail and mail order)	Responsible for 100% of cost, then reimbursed the contracted rate less applicable copayment.	Tier 1, Tier 2 and Tier 3: Covers up to a 30-day supply (retail and mail order prescription); 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: 1-800- 232-6549. Please see the "Important Questions" section (page 1) of this document regarding the plan's out-of-pocket limit. Tier 4 Specialty network: Must use Accredo. Call 1-866-824-5662.
	Preferred brand drugs	25% coinsurance, $35 to max $70 (30-day retail) and 25% coinsurance, $87.50 to max $175 (90-day retail and mail order)	25% coinsurance, $35 to max $70 (30-day retail) and 25% coinsurance, $87.50 to max $175 (90-day retail and mail order)	Responsible for 100% of cost, then reimbursed the contracted rate less applicable copayment.	
	Non-preferred brand drugs	25% coinsurance, $55 to max $110 (30-day retail) and 25% coinsurance, $137.50 to max $275 (90-day retail and mail order)	25% coinsurance, $55 to max $110 (30-day retail) and 25% coinsurance, $137.50 to max $275 (90-day retail and mail order)	Responsible for 100% of cost, then reimbursed the contracted rate less applicable copayment.	
	Specialty drugs	20% coinsurance to max $250/ prescription. Copays for certain specialty medications may be set to the amount of any available manufacturer-funded copay assistance.	20% coinsurance to max $250/ prescription. Copays for certain specialty medications may be set to the amount of any available manufacturer-funded copay assistance.	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		LoboCare Provider (You will pay the least)	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	25% coinsurance	40% coinsurance	Benefit certification may be required.
	Physician/surgeon fees	15% coinsurance	25% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	$150 copayment/visit deductible does not apply.	$150 copayment/visit deductible does not apply.	$150 copayment/visit deductible does not apply.	----------None----------
	Emergency medical transportation	25% coinsurance emergency ground and air	25% coinsurance emergency ground and air	25% coinsurance emergency ground and air	No charge for inter-facility transfer ground and air.
	Urgent care	$75 copayment/visit deductible does not apply.	$75 copayment/visit deductible does not apply.	40% coinsurance	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	25% coinsurance	40% coinsurance	Benefit certification may be required.
	Physician/surgeon fees	15% coinsurance	25% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copayment/visit deductible does not apply.	$45 copayment/visit deductible does not apply	40% coinsurance	Residential treatment centers limited to 60 days per year. Not covered by LoboCare providers. IOP, Inpatient, and partial hospitalization may require prior authorization/ benefit certification.
	Inpatient services	15% coinsurance	25% coinsurance	40% coinsurance	
If you are pregnant	Office visits	$25 copayment first visit only	$30 copayment first visit only	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment,

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		LoboCare Provider (You will pay the least)	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	15% coinsurance	25% coinsurance	40% coinsurance	coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Benefit certification may be required.
	Childbirth/delivery facility services	15% coinsurance	25% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	15% coinsurance.	25% coinsurance.	40% coinsurance.	100 days/plan year.
	Rehabilitation services	$25 copayment/ visit deductible does not apply	$30 copayment/ visit deductible does not apply	40% coinsurance.	Includes physical, speech, occupational, and hearing therapies (office or outpatient); Max of 70 visits combined. Benefit certification may be required.
	Habilitation services	$25 copayment/ visit deductible does not apply	$30 copayment/ visit deductible does not apply	40% coinsurance.	
	Skilled nursing care	15% coinsurance.	25% coinsurance.	40% coinsurance.	60 days/plan year.
	Durable medical equipment	15% coinsurance.	25% coinsurance.	40% coinsurance.	Benefit certification may be required.
	Hospice services	15% coinsurance.	25% coinsurance.	40% coinsurance.	LoboCare services are limited to pediatric hospice only. Benefit certification may be required.
If your child needs dental or eye care	Children's eye exam	Not covered	No covered	Not covered	Covered under pediatric preventive services.
	Children's glasses	Not covered	Not covered	Not covered	----------None----------
	Children's dental check-up	Not covered	Not covered	Not covered	----------None----------

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 (Adult)
- Dental check-up (Child)
- Infertility Treatment
- Long-Term Care
- Private-Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care
- 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
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids for school aged children
- Non-Emergency Care When Traveling Outside the U.S.

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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 claim. 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: [insert applicable contact information from instructions].

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** [insert telephone number].]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

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	$600
Specialist *[cost sharing]*	$45
Hospital (facility) *[cost sharing]*	25%
Other *[cost sharing]*	25%

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	**$12,738**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$600
Copayments	$100
Coinsurance	$2,240
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,000**

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

The plan's overall deductible	$600
Specialist *[cost sharing]*	$45
Hospital (facility) *[cost sharing]*	25%
Other *[cost sharing]*	25%

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	$600
Copayments	$640
Coinsurance	$1,327
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,622**

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

The plan's overall deductible	$600
Specialist *[cost sharing]*	$45
Hospital (facility) *[cost sharing]*	25%
Other *[cost sharing]*	25%

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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$600
Copayments	$315
Coinsurance	$207
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,122**