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, call 1-866-574-9567 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/sbc-glossary/ or call 1-866-574-9567 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	LoboCare/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 https://www2.phs.org/providers?insurance_plans=unm-employees **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
		Lobo Care Provider (You will pay the least)	In-network Provider	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 Virtual Visits/Telehealth $25 copayment/visit	$30 copayment/visit Virtual Visits/Telehealth $30 copayment/visit	40% coinsurance Virtual Visits/Telehealth Not Covered	Deductible does not apply for copayment. Prior Authorization is not required for gynecological or obstetrical ultrasounds.
	Specialist visit	$35 copayment/visit Virtual Visits/Telehealth $35 copayment/visit	$45 copayment/visit Virtual Visits/Telehealth $45 copayment/visit	40% coinsurance Virtual Visits/Telehealth Not Covered	Deductible does not apply for copayment. Prior Authorization is not required for gynecological or obstetrical ultrasounds.
	Preventive care/screening/immunization	No charge	No charge	40% coinsurance (No Copay if using a National Network Provider)	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
		Lobo Care Provider (You will pay the least)	In-network Provider	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 https://www.caremark.com/	Generic drugs (Tier 1)	$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 https://www.caremark.com/ or call 1-877-745-4394 Tier 4 Specialty network: Must use CVS Specialty. Call 1-800-237-2767 or visit https://www.cvsspecialty.com/.
	Preferred brand drugs (Tier 2)	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 (Tier 3)	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 (Tier 4)	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	Please see the "Important Questions" section (page 1) of this document regarding the plan's out-of-pocket limit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	25% coinsurance	40% coinsurance	Prior authorization/ Benefit certification may be required.
	Physician/surgeon fees	15% coinsurance	25% coinsurance	40% coinsurance	Prior authorization/ Benefit certification may be required.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Lobo Care Provider (You will pay the least)	In-network Provider	Out-of-network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$150 copayment/visit	$150 copayment/visit	$150 copayment/visit	Deductible does not apply to copayment.
	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	$75 copayment/visit	40% coinsurance	Deductible does not apply to copayment. Video Visits are covered through the Virtual National Carrier 24/7 $10 copayment.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	25% coinsurance	40% coinsurance	Prior authorization/ Benefit certification may be required.
	Physician/surgeon fees	15% coinsurance	25% coinsurance	40% coinsurance	Prior authorization/ Benefit certification may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copayment/visit	$10 copayment/visit	40% coinsurance	Deductible does not apply to copayment. 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	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.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Lobo Care Provider (You will pay the least)	In-network Provider	Out-of-network Provider (You will pay the most)	
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, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Authorization is not required for gynecological or obstetrical ultrasounds.
	Childbirth/delivery professional services	15% coinsurance	25% coinsurance	40% coinsurance	Prior authorization/ Benefit certification may be required. Authorization is not required for gynecological or obstetrical ultrasounds.
	Childbirth/delivery facility services	15% coinsurance	25% coinsurance	40% coinsurance	Prior authorization/ Benefit certification may be required. Authorization is not required for gynecological or obstetrical ultrasounds.
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	$30 copayment/visit	40% coinsurance	Includes physical, speech, occupational, and hearing therapies (office or outpatient); Max of 70 visits combined. If determined medically necessary, additional visits may be approved. Benefit Certification may be required.
	Habilitation services	$25 copayment/visit	$30 copayment/visit	40% coinsurance	
	Skilled nursing care	15% coinsurance	25% coinsurance	40% coinsurance	60 days/plan year.
	Durable medical equipment	15% coinsurance	25% coinsurance	40% coinsurance	Prior authorization/ Benefit certification may be required.
	Hospice services	15% coinsurance	25% coinsurance	40% coinsurance	Prior authorization/ Benefit certification may be required. LoboCare services are limited to pediatric hospice only.
If your child needs dental or eye care	Children's eye exam	15% coinsurance	25% coinsurance	40% coinsurance	Covered under pediatric preventive services.
	Children's glasses	15% coinsurance	25% coinsurance	40% coinsurance	Not Covered
	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	• Infertility Treatment	• Routine Eye Care (Adult)
• Dental Care (Adult)	• Long-Term Care	• Routine Foot Care
• Dental check-up (Child)	• Private-Duty Nursing	• Weight Loss Programs (Unless formedically 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	• Chiropractic Care	• Non-Emergency Care When Traveling Outside the U.S.
• Bariatric Surgery	• Hearing Aids up to $2,500 every 36 months per hearing impaired ear	

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 appeal. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan.

Does this plan provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, Tricare, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit

Does this plan meet Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standard, you may be eligible for a premium tax credits to help you pay for a plan through the Marketplace.

Language Access Services:
Para obtener asistencia en Español, llame al 1-866-574-9567.
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-574-9567.
如果需要中文的帮助，请拨打这个号码 1-866-574-9567.
Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-574-9567.
Learn more about Presbyterian's Notice of Nondiscrimination, go to www.phs.org/nondiscrimination.aspx.

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	**$45**
Hospital (Facility)	**25%**
Other	**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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$600
Copayments	$40
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,900

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	**$45**
Hospital (Facility)	**25%**
Other	**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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$600
Copayments	$500
Coinsurance	$700
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$1,820

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

The plan's overall deductible	**$600**
Specialist	**$45**
Hospital (Facility)	**25%**
Other	**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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$600
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,200

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