

# Summary of Benefits

The following are the highlights of the EPO plan administered by Presbyterian Health Plan, Inc. for County of Bernalillo employees statewide. These benefits are effective 7/1/18 through 6/30/2019. The specific terms of coverage, limitations and exclusions are detailed in Sections 2, 4, and 5 of the Summary Plan Description.

BENEFITS	EPO PLAN	
	Benefit Highlights	In-network and out-of-state MP/PHCS Provider Care
	Copayments/Co-insurance vary depending on service; see below	
	Member deductible (Plan Year) Single Family	\$200 \$600
	Out-of-Pocket Maximum (Plan Year) Includes medical and Rx cost sharing Single Family	\$3,000 \$6,000
	Lifetime maximum	Unlimited (Certain services are subject to Plan Year and/or lifetime maximums or are limited per condition.)
Physician Services	Office visit Primary/Gyn care	\$30 office visit Copayment/Adult <sup>5</sup> \$15 office visit Copayment/Child <sup>5</sup>
	Video visits	\$0 Copayment <sup>5</sup>
	Specialty care	\$60 office visit Copayment/Adult <sup>5</sup> \$50 office visit Copayment/Child <sup>5</sup>
	On-campus student health center	\$30 office visit Copayment/Adult <sup>5</sup> \$15 office visit Copayment/Child <sup>5</sup>
	Preventive services Routine physicals Well child care including vision and hearing screening (through age 26) Immunizations Adult wellness Health education programs	No Copayment <sup>5</sup> No Copayment <sup>5</sup> No Copayment <sup>5</sup> No Copayment <sup>5</sup> Fees Vary (based on service)
	Women's Preventive Services Contraceptive Methods • Intrauterine Devices (IUD) • Hormone Contraceptive Injections • Inserted Contraceptive Devices • Implanted Contraceptive Devices Breastfeeding support, supplies and counseling (for one year after delivery)	No Copayment <sup>5</sup>
	Laboratory	No Copayment <sup>5</sup>
	X-ray	No Copayment <sup>5</sup>
	Allergy testing and treatment	20% Coinsurance
	Allergy injections by a nurse	No Copayment <sup>5</sup>
	Allergy extract preparation	20% Coinsurance

BENEFITS	EPO PLAN	
	Benefit Highlights	In-network and out-of-state MP/PHCS Provider Care
<b>Hospital Services</b>	Hospitalization (includes room and board, Inpatient Physician care – Physician visits, surgeon, and anesthesiologist) <sup>3</sup>	\$500 Copayment per Admission/Adult <sup>5</sup> \$350 Copayment per Admission/Child <sup>5</sup>
	Inpatient rehabilitation services <sup>3</sup>	\$500 Copayment per Admission/Adult <sup>5</sup> \$350 Copayment per Admission/Child <sup>5</sup>
	Laboratory	No Copayment <sup>5</sup>
	X-ray	No Copayment <sup>5</sup>
	MRI/PET Scans <sup>3</sup>	\$150 Copayment per test/Adult <sup>5</sup> \$100 Copayment per test/Child <sup>5</sup>
	CT Scans <sup>3</sup>	\$125 Copayment per test/Adult <sup>5</sup> \$ 75 Copayment per test/Child <sup>5</sup>
	Hospital Observation Services (no Admission)	No Copayment <sup>5</sup>
	Surgery – Outpatient (no Hospital Admission) – Facility claim only	\$500 Copayment per visit/Adult \$200 Copayment per visit/Child
<b>Maternity Services</b>	Physician/midwife services (delivery, prenatal/postnatal care) Note: Copayment does not include laboratory or x-ray services.	\$30 Copayment <sup>5</sup>
	Hospital Admission <sup>3</sup>	\$500 Copayment per pregnancy <sup>5</sup>
	Routine nursery care for newborns	No Copayment <sup>5</sup>
<b>Emergency Services</b>	Emergency room visit <sup>2</sup> (Copayment is for the office visit only, all other services subject to deductible and coinsurance)	\$200 Copayment <sup>5</sup>
	Urgent Care center (Copayment is for the office visit only, all other services subject to deductible and coinsurance)	\$40 Copayment per visit/Adult <sup>5</sup> \$10 Copayment per visit/Child <sup>5</sup>
	Ambulance <sup>1</sup> Ground transportation Air ambulance	\$ 50 Copayment per trip <sup>5</sup> \$100 Copayment per trip <sup>5</sup>
<b>Mental Health</b>	Outpatient services <sup>5</sup>	\$25 office visit Copayment/Adult <sup>5</sup> \$10 office visit Copayment/Child <sup>5</sup>
	Inpatient services <sup>3</sup> Partial Hospitalization <sup>3</sup>	\$500 Copayment per Admission/Adult <sup>5</sup> \$350 Copayment per Admission/Child <sup>5</sup>
	Facility based intensive Outpatient program	\$25 office visit Copayment/Adult <sup>5</sup> \$10 office visit Copayment/Child <sup>5</sup>
<b>Substance Abuse</b>	Outpatient services <sup>3,5</sup>	\$25 office visit Copayment/Adult <sup>5</sup> \$10 office visit Copayment/Child <sup>5</sup>
	Acute Inpatient Hospital services <sup>3</sup> Partial Hospitalization <sup>3</sup>	\$500 Copayment per Admission/Adult <sup>5</sup> \$350 Copayment per Admission/Child <sup>5</sup>
	Facility based intensive Outpatient program	\$25 office visit Copayment/Adult <sup>5</sup> \$10 office visit Copayment/Child <sup>5</sup>
	Residential Treatment Centers	Not Covered

BENEFITS	EPO PLAN	
	Benefit Highlights	In-network and out-of-state MP/PHCS Provider Care
<b>Autism Spectrum Disorder (Habilitative)</b>	PCP <sup>3</sup> Specialist <sup>3</sup> Outpatient Physical Therapy <sup>3</sup> Outpatient Speech Therapy <sup>3</sup> Applied Behavioral Analysis (ABA) <i>Diagnosis and Treatment for all children up to age 19 or up to age 22 if still attending high school.</i>	\$15 office visit Copayment <sup>5</sup> \$50 office visit Copayment <sup>5</sup> \$40 office visit Copayment <sup>5</sup> - Child \$40 office visit Copayment <sup>5</sup> - Child \$40 office visit Copayment <sup>5</sup>
<b>Other Services</b>	Biofeedback (for specified medical conditions only)	\$30 office visit Copayment/Adult <sup>5</sup> \$15 office visit Copayment/Child <sup>5</sup>
	Cardiac or pulmonary rehabilitation (Up to 24 sessions per plan year) – will not be combined with other rehab therapies	\$50 office visit Copayment/Adult <sup>5</sup> \$40 office visit Copayment/Child <sup>5</sup>
	Chemotherapy and/or radiation therapy	No Copayment <sup>5</sup>
	Chiropractic (Not Combined annual limit of 18 visits) <sup>4</sup> Acupuncture (Not Combined annual limit of 18 visits) <sup>4</sup>	\$50 office visit Copayment/Adult <sup>5</sup> \$50 office visit Copayment/Adult <sup>5</sup>
	Dental services (for specified medical conditions only) Inpatient <sup>3</sup>  Outpatient	\$500 Copayment per Admission/Adult <sup>5</sup> \$350 Copayment per Admission/Child <sup>5</sup>  \$60 office visit Copayment/Adult <sup>5</sup> \$50 office visit Copayment/Child <sup>5</sup>
	Dialysis	20% Coinsurance
	Durable Medical Equipment, orthotics, prosthetics and appliances <sup>3</sup>	20%
	Injectable drugs received in the office <sup>3</sup> If billed in conjunction with an office visit	Included in office visit Copayment based on the location of the services (PCP, Specialist, etc.)
	If provided by a nurse and no office visit is billed	No Copayment <sup>5</sup>
	Home health care <sup>3</sup>	No Copayment <sup>5</sup>
	Hearing Aids (for school aged children under 18 or 21 years of age if still attending high school) up to 36 months per hearing impaired ear.	20% Coinsurance
	Hospice <sup>3</sup>	\$500 Copayment per Admission/Adult <sup>5</sup> \$350 Copayment per Admission/Child <sup>5</sup> In home: No Copayment <sup>5</sup>
Infertility related services (only limited services covered)	50% Coinsurance	
Physical, occupational and speech therapy (Limited to 24 visits for each service)	\$50 office visit Copayment/Adult <sup>5</sup> \$40 office visit Copayment/Child <sup>5</sup>	

BENEFITS	EPO PLAN	
	Benefit Highlights	In-network and out-of-state MP/PHCS Provider Care
Other Services (continued)	Skilled nursing facility (Admission Copayment waived if readmitted within 15 days) <sup>3</sup> Limited to 60 days per plan year	\$500 Copayment per Admission/Adult <sup>5</sup> \$350 Copayment per Admission/Child <sup>5</sup>
	Sleep disorder studies Inpatient <sup>3</sup> Home/Sleep lab (2 nights)	\$500 Copayment per Admission <sup>5</sup> \$50 Copayment per test <sup>5</sup>
	Smoking cessation (including hypnotherapy, acupuncture, related test, and any counseling programs not eligible under preventive)	Applicable Copayment or Coinsurance based on place of service.
Transplants <sup>3</sup> (No Lifetime Maximum)	Coverage for human organ transplants <sup>3</sup> (refer to booklet for details on transplant coverage and call for case management services)	\$500 Copayment per Admission/Adult <sup>5</sup> \$350 Copayment per Admission/Child <sup>5</sup>
Prescription Drugs	Generic Drugs Preferred brand drugs Non-preferred drugs Specialty drugs	Administered by Express Scripts – Contact at 1-855-315-3413

<sup>1</sup> Ambulance copayment is waived if transportation is medically necessary and results in a hospital admission.

<sup>2</sup> The \$200 emergency care is waived if a hospital admission results. Then, the hospital admission copayment applies. Copay is for the ER visit only; other services are subject to deductible and coinsurance.

<sup>3</sup> **Prior authorization** may be required. See Section 2 of the Summary Plan Description for prior authorization requirements.

<sup>4</sup> This benefit includes an annual maximum payment, annual visit limitation, lifetime visit limitation and/or lifetime maximum payment. Refer to Sections 2 and 4 of the Summary Plan Description.

<sup>5</sup> Not subject to the Deductible.