

 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 1-800-923-6980 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 1-800-923-6980 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible ? | In-Network: \$1,600 /Individual / \$3,200 /Family. Out-of-Network: \$3,200 /Individual/ \$6,400 /Family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible . |
| Are there services covered before you meet your deductible ? | Yes. Preventive care , Covid-19 testing, treatment, vaccines, boosters and any service that has a copayment . | This plan covers some items & 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 ? | In Network: \$1,600 / Individual / \$3,200 / Family Out of Network: \$6,400 /Individual / \$12,800 / Family | The out of pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out of pocket limit until the overall family out of pocket limit has been met. |
| What is not included in the out-of-pocket limit ? | Premiums, balance billing charges, and health care this plan doesn't cover. | 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 Group PPO Network at https://www2.phs.org/providers/?insurance_plans=group-ppo or call 1-800-923-6980 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). Be aware, your network provider might use an out of network provider for some services (such as lab work). Check with your provider before you get services. |
| 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 |
|--|---|---|---|---|
| | | In-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 | No charge after deductible is met | 30% coinsurance after deductible is met | Telehealth service is No Charge after deductible is met. No charge for anything related to COVID-19, testing, vaccines, or medical treatment. Prior authorization is not required for gynecological or obstetrical ultrasounds. |
| | Specialist visit | No charge after deductible is met | 30% coinsurance after deductible is met | Telehealth service is No Charge after deductible is met. No charge for anything related to COVID-19 testing, vaccines, or medical treatment. Prior authorization is not required for gynecological or obstetrical ultrasounds. |
| | Preventive care/screening /immunization | No charge deductible does not apply | 30% coinsurance after deductible is met | 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. No charge for anything related to COVID-19 testing, vaccines, or medical treatment. |
| If you have a test | Diagnostic test (x-ray, blood work) | No charge after deductible is met | 30% coinsurance after deductible is met | Prior Authorization may be required or benefits may be denied. |
| | Imaging (CT/PET scans, MRIs) | No charge after deductible is met | 30% coinsurance after deductible is met | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|--|---|---|
| | | In-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 https://client.formularynavigator.com/Search.aspx?siteCode=0322075909 | Generic drugs (Tier 1) | No Charge after deductible is met / Mail Order benefits administered by OptumRx Home Delivery | No Charge after deductible is met / Mail Order benefits administered by OptumRx Home Delivery | Max 90-day supply at retail - Mail Order benefits administered by OptumRx Home Delivery. Tier 4 Self-Administered specialty limited to 30-day supply and Not covered at Mail. Preferred insulin or medically necessary alternative will not exceed \$25 copayment per 30-day supply. Prior authorization may be required or benefits may be denied. Pharmacy Transactions where Manufacturer discount or Copay assistance cards are used will count towards Deductible or Out of Pocket. Refer to the formulary for a complete listing and coverage details. |
| | Preferred brand drugs (Tier 2) | No Charge after deductible is met / Mail Order benefits administered by OptumRx Home Delivery | No Charge after deductible is met / Mail Order benefits administered by OptumRx Home Delivery | |
| | Non-preferred drugs (Tier 3) | No Charge after deductible is met / Mail Order benefits administered by OptumRx Home Delivery | No Charge after deductible is met / Mail Order benefits administered by OptumRx Home Delivery | |
| | Self-Administered Specialty (Tier 4) | No Charge after deductible is met (retail) - Limited to a 30-day supply / Not available (mail order) | Not Covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No Charge after deductible is met | 30% coinsurance after deductible is met | Prior Authorization may be required or benefits may be denied. |
| | Physician/surgeon fees | No Charge after deductible is met | 30% coinsurance after deductible is met | Prior Authorization may be required or benefits may be denied. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|---|---|---|
| | | In-network Provider (You will pay the least) | Out-of-network Provider (You will pay the most) | |
| If you need immediate medical attention | Emergency room care | No charge - after deductible is met | No charge - after deductible is met | No charge for anything related to COVID-19, testing, medical treatment, vaccines/boosters. Balance billing is not allowed for out-of-network care. |
| | Emergency medical transportation | No charge - after deductible is met | No charge - after deductible is met | No charge for anything related to COVID-19 testing, medical treatment, vaccines/boosters. Balance billing is not allowed for out-of-network care. |
| | Urgent care | No charge - after deductible is met | No charge - after deductible is met | No charge for anything related to COVID-19 testing, medical treatment, vaccines/boosters. Balance billing is not allowed for out-of-network care. There is No Charge after deductible is met for telehealth services. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No Charge after deductible is met | 30% coinsurance after deductible is met | Prior Authorization may be required or benefits may be denied. |
| | Physician/surgeon fees | No Charge after deductible is met | 30% coinsurance after deductible is met | Prior Authorization may be required or benefits may be denied. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | No Charge after deductible is met | 30% coinsurance after deductible is met | -----None----- |
| | Inpatient services | No Charge after deductible is met | 30% coinsurance after deductible is met | Prior authorization may be required or benefits may be denied. |
| If you are pregnant | Office visits | No Charge after deductible is met | 30% coinsurance after deductible is met | Prior Authorization is not required for gynecological or obstetrical ultrasounds. |
| | Childbirth/delivery professional services | No Charge after deductible is met | 30% coinsurance after deductible is met | Prior authorization may be required or benefits may be denied. Cost sharing does not apply for preventative services. Prior Authorization is not required for gynecological or obstetrical ultrasounds. |
| | Childbirth/delivery facility services | No Charge after deductible is met | 30% coinsurance after deductible is met | Prior authorization may be required or benefits may be denied. Cost sharing does not apply for preventative services. Prior Authorization is not required for gynecological or obstetrical ultrasounds. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|---|---|---|
| | | In-network Provider (You will pay the least) | Out-of-network Provider (You will pay the most) | |
| If you need help recovering or have other special health needs | Home health care | No Charge after deductible is met | 30% coinsurance after deductible is met | Prior authorization may be required or benefits may be denied. |
| | Rehabilitation services | No Charge after deductible is met | 30% coinsurance after deductible is met | Prior authorization may be required or benefits may be denied. |
| | Habilitation services | No Charge after deductible is met | 30% coinsurance after deductible is met | Prior authorization may be required or benefits may be denied. |
| | Skilled nursing care | No Charge after deductible is met | 30% coinsurance after deductible is met | Coverage is limited up to 60 days/ plan year. Prior authorization may be required or benefits may be denied. |
| | Durable medical equipment | No Charge after deductible is met | 30% coinsurance after deductible is met | Prior authorization may be required or benefits may be denied. |
| | Hospice services | No Charge after deductible is met | 30% coinsurance after deductible is met | Prior authorization may be required or benefits may be denied. |
| If your child needs dental or eye care | Children's eye exam | No Charge after deductible is met | 50% coinsurance after deductible is met | Coverage is limited to refraction eye exam associated with post cataract surgery or Keratoconus correction. |
| | Children's glasses | No Charge after deductible is met | 50% coinsurance after deductible is met | Coverage is limited to eyeglasses/contact lenses within 12 months following cataract surgery or the correction of Keratoconus. Prior authorization may be required. [|
| | Children's dental check-up | 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 | • Long-Term Care | • Routine Eye Care (Adult) | |
| • Dental Care (Adult) | • Non-Emergency Care When Traveling Outside the U.S. | • Routine Foot Care * Only covered when medically necessary for diabetes. See SPD for details. | |
| • Dental check-up (Child) | • Private-Duty Nursing | | |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | | |
| • Acupuncture (20 visits per calendar year unless for rehabilitative or habilitative svc) | • Chiropractic Care (20 visits per calendar year unless for rehabilitative or habilitative svc) | • Infertility Treatment (Diagnosis and medically indicated treatments for physical conditions causing infertility) | |
| • Bariatric Surgery (for patients with a Body Mass Index (BMI) of 35 kg/m2 or greater who are at high risk for increased morbidity due to specific obesity related comorbid medical conditions) | • Hearing Aids (1 per ear, every 3 years) | • Weight Loss Programs Includes coverage for drugs and programs if medically necessary for morbid obesity and obesity) | |

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](#). For more information about your rights, this notice, or assistance, contact: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, you may contact the Office of the Superintendent of Insurance Managed Health Care Bureau at 1-855-427-5674 or by email at mhcb.grievance@state.nm.us.

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 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 1-855-592-7737.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-592-7737.

如果需要中文的帮助, 请拨打这个号码 1-855-592-7737.

Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-592-7737.

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) | | Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition) | | Mia's Simple Fracture (in-network emergency room visit and follow up care) | |
|---|-----------------|---|----------------|---|----------------|
| ■ The plan's overall deductible | \$1,600 | ■ The plan's overall deductible | \$1,600 | ■ The plan's overall deductible | \$1,600 |
| ■ Specialist | 0% | ■ Specialist | 0% | ■ Specialist | 0% |
| ■ Hospital (Facility) | 0% | ■ Hospital (Facility) | 0% | ■ Hospital (Facility) | 0% |
| ■ Other | 0% | ■ Other | 0% | ■ Other | 0% |
| <p>This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)</p> | | <p>This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)</p> | | <p>This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)</p> | |
| Total Example Cost | \$12,731 | Total Example Cost | \$7,389 | Total Example Cost | \$1,925 |
| In this example, Peg would pay: | | In this example, Joe would pay: | | In this example, Mia would pay: | |
| <i>Cost Sharing</i> | | <i>Cost Sharing</i> | | <i>Cost Sharing</i> | |
| Deductibles | \$1,500 | Deductibles | \$1,500 | Deductibles | \$791 |
| Copayments | \$0 | Copayments | \$0 | Copayments | \$0 |
| Coinsurance | \$0 | Coinsurance | \$0 | Coinsurance | \$0 |
| <i>What isn't covered</i> | | <i>What isn't covered</i> | | <i>What isn't covered</i> | |
| Limits or exclusions | \$60 | Limits or exclusions | \$55 | Limits or exclusions | \$0 |
| The total Peg would pay is | \$1,560 | The total Joe would pay is | \$1,555 | The total Mia would pay is | \$791 |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.