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 medical coverage, or to get a copy of the complete terms of coverage, call 1-888-275-7737 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.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG- Glossary-508-MM.pdf or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Preferred Provider: $2,000 Individual / $4,000 Family Non-Preferred Provider: $4,000 Individual / $8,000 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. Office visits that charge a copayment, prescription drugs, and Preferred preventive care are covered before you meet your deductible. Covid-19 screening, testing, treatment, vaccines, boosters.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services 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?	Preferred Provider: $3,750 Individual / $7,500 Family Non-Preferred Provider: $9,000 Individual / $18,000 Family Out-of-pocket Pharmacy In-network: $3,100 Individual / $6,200 Family. Out-of-network: N/A.	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 limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balanced-billed charges, penalty amounts, prescription drugs, and healthcare 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 https://www2.phs.org/providers or call 1-866-670-0600 for a list of preferred 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
		Preferred Provider (You will pay the least)	Non-Preferred 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	$30 copayment/visit; deductible does not apply Telehealth $0 copayment	50% coinsurance	PHP Video Visits utilize a nationwide network of Providers at No Charge at Preferred Providers only. Not covered for Non-Preferred Providers
	Specialist visit	$60 copayment/visit; deductible does not apply	50% coinsurance	PHP Video Visits utilize a nationwide network of Providers at No Charge at Preferred Providers only. Not covered for Non-Preferred Providers
	Preventive care/screening/ immunization	No Charge; deductible does not apply	50% 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)	$35/$70 copayment/day; deductible does not apply	50% coinsurance	Copayment or actual allowed charge, whichever is less. $35 copayment applies at office visit or at freestanding lab. $70 copayment applies at outpatient hospital.
	Imaging (CT/PET scans, MRIs)	25% coinsurance of allowed charge up to $700 copayment/day, whichever is less, deductible does not apply	50% coinsurance	Requires Prior Authorization.

* For more information about limitations and exceptions, see the plan or policy document at www.phs.org.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred 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 up to 30-day supply	$5 copayment	Not covered	Enteral food products – 50% coinsurance Generic and Preferred Brand Diabetic supplies and insulin - $0 copayment Generic and Preferred Brand oral diabetic medication - $0 copayment
	Preferred brand drugs up to a 30-day supply	Minimum $25 copayment or 25% coinsurance of the medication cost, Maximum $60 copayment	Not covered	
	Non-preferred brand drugs up to a 30-day supply	Min $50 copayment or 70% coinsurance of the medication cost, Max $110 copayment	Not covered	Enteral food products – 50% coinsurance Non-preferred Brand diabetic supplies, insulin and oral medications – $30 copayment
	Specialty drugs up to a 30-day supply	$50 copayment Generic $70 copayment Preferred Brand $130 copayment Non-Preferred Brand	Not covered	
	Extended Days Supply up to a 90-day supply	$10 copayment Generic, Brands not covered	Not covered	
	Mail Order up to a 90-day supply	$10 copayment Generic $50 copayment Preferred Brand $100 copayment Non-preferred Brand	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	50% coinsurance	None
	Physician/surgeon fees	25% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$150 copayment/visit plus 25% coinsurance	$150 copayment/visit plus 25% coinsurance	None
	Emergency medical transportation	25% coinsurance	25% coinsurance	None
	Urgent care	$60 copayment/visit; deductible does not apply	50% coinsurance	None

* For more information about limitations and exceptions, see the plan or policy document at www.phs.org.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	50% coinsurance	Requires Prior Authorization
	Physician/surgeon fees	25% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copayment/visit; deductible does not apply	50% coinsurance	Includes office, home, outpatient, and Intensive Outpatient Programs (IOP) services; inpatient and partial hospitalization. IOP, inpatient, and partial hospitalization require Prior Authorization.
	Inpatient services	25% coinsurance	50% coinsurance	
If you are pregnant	Office visits	$30 copayment/visit; deductible does not apply	50% coinsurance	Copayment charged for initial visit only. 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.)
	Childbirth/delivery professional services	25% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	25% coinsurance	50% coinsurance	Requires Prior Authorization

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	25% coinsurance	50% coinsurance	Limited to 120 visits per year for Non-Preferred Provider.
	Rehabilitation services	$30 copayment/therapist visit; deductible does not apply. 25% coinsurance for other providers	50% coinsurance	Copayment applies to physical, occupational, and speech therapists. Other providers includes, but is not limited to, Chiropractors and Doctors of Oriental Medicine. Includes physical, occupational, and speech therapies (office/outpatient).
	Habilitation services	$30 copayment/visit; deductible does not apply	50% coinsurance	
	Skilled nursing care	25% coinsurance	50% coinsurance	Includes inpatient physical rehabilitation. Limited to 60 days per year. Requires Prior Authorization.
	Durable medical equipment	25% coinsurance	50% coinsurance	Support hose limited to 12 pair (or 24 hose), Mastectomy Bras up to 6 per calendar year. Prior Authorization needed for services over $1000.
	Hospice services	25% coinsurance	50% coinsurance	Respite care limited to 10 days for each 6-month hospice period, and 2 periods per lifetime. Bereavement counseling limited to 3 sessions during the hospice benefit period.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	If vision coverage purchased, see your vision plan information.
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	If dental coverage purchased, see your dental plan information.

* For more information about limitations and exceptions, see the plan or policy document at www.phs.org.

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, routine dental)
- Long term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (unless you are diabetic)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (max 30 visits/year combined withchiropractic)
- Bariatric surgery
- Chiropractic care (max 30 visits/year combined with acupuncture)
- Hearing aids (under 21 years of age)
- Infertility: Diagnosis Only - No Treatment
- 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: the plan at 1-800-432-0750, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the New Mexico Superintendent of Insurance toll-free at 1-855-427-5674 or www.osi.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 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 1-800-432-0750.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-432-0750. Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-432-0750.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-432-0750.
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** **$2,000**
- **Specialist copayments** **$60**
- **Hospital (facility) coinsurance** **25%**
- **Other coinsurance** **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	**$12,800**

In this example, Peg would pay:

Cost sharing	
Deductibles	$2,000
Copayments	$500
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,760**

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

- **The plan's overall deductible** **$2,000**
- **Specialist copayments** **$60**
- **Hospital (facility) coinsurance** **25%**
- **Other coinsurance** **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	$1,700
Copayments	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,060**

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

- **The plan's overall deductible** **$2,000**
- **Specialist copayments** **$60**
- **Hospital (facility) coinsurance** **25%**
- **Other coinsurance** **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	**$1,900**

In this example, Mia would pay:

Cost sharing	
Deductibles	$1,500
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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