



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 1-855-593-7737 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.healthcare.gov/sbc-glossary/> or call 1-855-593-7737 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|--|
| What is the overall deductible ? | In-network: \$500 Individual / \$1,000 Double / \$1,500 Family Out-of-network: \$2,800 Individual / \$5,600 Double / \$8,400 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 is covered before you meet your deductible . | 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? | Yes. \$50 Single \$100 Two-Person/Family | You must pay all the Pharmacy costs up to the deductible amount before this plan begins to pay for covered services you use. |
| What is the out-of-pocket limit for this plan ? | In-network: \$3,500 Individual / \$7,000 2-party / \$10,500 Family Out-of-network: \$7,000 Individual / \$14,000 2-party / \$21,000 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, health care this plan doesn't cover, and penalty amounts. | 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=aso-hmo-aso-ppo-aso-hdhp or call 1-888-275-7737 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. |

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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 | \$30 copayment /visit Video Visits No Charge | 50% coinsurance after deductible is met Video Visits- Not Covered | -----None----- |
| | Specialist visit | \$50 copayment /visit | 50% coinsurance after deductible is met | -----None----- |
| | Preventive care/screening /immunization | No charge | 50% 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. |
| If you have a test | Diagnostic test (x-ray, blood work) | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met | Prior authorization may be required or benefits may be denied. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance up to a max of \$200 per test/per day after deductible is met | 50% coinsurance after deductible is met | |
| 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) | \$5 copayment (retail) / \$15 copayment (mail order) | \$5 copayment (retail) / \$15 copayment (mail order) | Tier 1, Tier 2 and Tier 3 Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription) Tier 4 Mail order is not covered. Prior authorization for some drugs may be required. |
| | Preferred brand drugs (Tier 2) | 30% coinsurance (\$30 minimum up to \$90) (retail) / \$95 copayment (mail order) | 30% coinsurance (\$30 minimum up to \$90) (retail) / \$95 copayment (mail order) | |
| | Non-preferred drugs (Tier 3) | 40% coinsurance (\$55 minimum up to \$125) (retail) / \$125 copayment (mail order) | 40% coinsurance (\$55 minimum up to \$125) (retail) / \$125 copayment (mail order) | |
| | Self-Administered Specialty (Tier 4) | \$60 Generic \$85 Preferred Brand \$125 Non-Preferred | Not covered | |

| 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 have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met | Prior Authorization may be required or benefits may be denied. |
| | Physician/surgeon fees | Included in Facility Fee charges | 50% coinsurance after deductible is met | Prior Authorization may be required or benefits may be denied. |
| If you need immediate medical attention | Emergency room care | \$175 copayment /visit | \$175 copayment /visit | Waived if admitted into a hospital, then hospital copayment will apply. |
| | Emergency medical transportation | 20% coinsurance after deductible is met | 20% coinsurance after deductible is met | -----None----- |
| | Urgent care | \$50 copayment /visit | \$50 copayment /visit | -----None----- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$1000 copayment /admission after deductible is met | 50% coinsurance after deductible is met | Prior Authorization may be required or benefits may be denied. |
| | Physician/surgeon fees | Included in Facility Fee charges | 50% 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 | \$30 copayment /visit | 50% coinsurance after deductible is met | -----None----- |
| | Inpatient services | \$1,000 copayment /admission after deductible is met | 50% coinsurance after deductible is met | Prior authorization may be required. |
| If you are pregnant | Office visits | \$30 copayment initial visit only | 50% coinsurance after deductible is met | Depending on the type of services, a copayment , coinsurance , or deductible may apply. Cost sharing does not apply for preventative services. Prior Authorization is not required for gynecological or obstetrical ultrasounds. |
| | Childbirth/delivery professional services | No charge | 50% coinsurance after deductible is met | Prior Authorization is not required for gynecological or obstetrical ultrasounds. |
| | Childbirth/delivery facility services | \$1,000 copayment /admission after deductible is met | 50% coinsurance after deductible is met | Prior authorization may be required or benefits may be denied. 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 | \$50 copayment /physician services | 50% coinsurance after deductible is met | No charge for nursing services. Prior authorization may be required or benefits may be denied. |
| | Rehabilitation services | Inpatient: \$1,000 copayment /admission ; Outpatient: \$50 copayment /visit | 50% coinsurance after deductible is met | Prior authorization may be required or benefits may be denied. |
| | Habilitation services | \$50 copayment | 50% coinsurance after deductible is met | -----None----- |
| | Skilled nursing care | \$1,000 copayment /admission after deductible is met | 50% coinsurance after deductible is met | Admission copayment waived if readmitted within days. Prior authorization may be required or benefits may be denied. |
| | Durable medical equipment | 25% coinsurance after deductible is met | 50% coinsurance after deductible is met | Prior authorization may be required or benefits may be denied. |
| | Hospice services | No charge | 50% 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 | Not covered | Not covered | -----None----- |
| | Children's glasses | 25% coinsurance 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 | • Glasses (Child) | • Private-Duty Nursing |
| • Dental Care (Adult) | • Infertility Treatment (Only limited services covered) | • Routine Eye Care (Adult) |
| • Dental check-up (Child) | • Long-Term Care | • Routine Foot Care |
| • Eye exam (Child) | • Non-Emergency Care When Traveling Outside the U.S. | • Weight Loss Programs (Morbid obesity treatment only) |

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

- | | | |
|---------------------|---------------------|----------------|
| • Acupuncture | • Chiropractic Care | • Hearing Aids |
| • Bariatric Surgery | | |

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 [claim](#). Your [plan](#) documents also provide complete information on how 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

[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 1-888-275-7737.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-275-7737.

如果需要中文的帮助, 请拨打这个号码 1-888-275-7737.

Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-275-7737.

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 | \$500 | ■ The plan's overall deductible | \$500 | ■ The plan's overall deductible | \$500 |
| ■ Specialist | \$50 | ■ Specialist | \$50 | ■ Specialist | \$50 |
| ■ Hospital (Facility) | \$1000 | ■ Hospital (Facility) | \$1000 | ■ Hospital (Facility) | \$1000 |
| ■ Other | No Charge | ■ Other | No Charge | ■ Other | No Charge |
| 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>) | | 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>) | | 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>) | |
| 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 | \$500 | Deductibles | \$107 | Deductibles | \$500 |
| Copayments | \$20 | Copayments | \$545 | Copayments | \$0 |
| Coinsurance | \$209 | Coinsurance | \$27 | Coinsurance | \$166 |
| <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 | \$789 | The total Joe would pay is | \$734 | The total Mia would pay is | \$666 |

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