



 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 1-855-923-7521 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 1-855-923-7521 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible ? | \$3,500 Individual / \$7,000 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. Preventive care , Behavioral Health services, any benefit where there is no charge, Covid-19 testing, treatment and vaccines, and any service that has a copayment . | 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 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 ? | \$9,200 Individual / \$18,400 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 Docs. Engage Network https://www2.phs.org/providers?insurance_plans=engage or call 1-855-923-7521 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 provider network 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 | \$40 copayment /visit deductible does not apply | Not covered | There is zero cost-sharing for any telehealth service. Copayment does not include Medical Drugs which will have a separate charge. No cost sharing for COVID testing, treatment and vaccines. Prior authorization is not required for gynecological or obstetrical ultrasounds. |
| | Specialist visit | \$90 copayment /visit deductible does not apply | Not covered | |
| | Preventive care/screening /immunization | No charge deductible does not apply | Not covered | 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. There is zero cost-sharing for any telehealth service. Copayment does not include Medical Drugs which will have a separate charge. No cost sharing for COVID testing, treatment and vaccines. Prior authorization is not required for gynecological or obstetrical ultrasounds. |
| If you have a test | Diagnostic test (x-ray, blood work) | No charge deductible does not apply | Not covered | Prior authorization may be required or benefits may be denied. |
| | Imaging (CT/PET scans, MRIs) | \$500 copayment /test deductible does not apply | 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) | |
| <p>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=0324498195</p> | Preferred Generic Drugs (Tier 1) | No charge (retail) per 30-day supply, No charge (mail order); deductible does not apply | Not covered | 90-day maximum supply (retail). Mail Order benefits administered by Optum Rx Home Delivery |
| | Non-Preferred Generic Drugs (Tier 2) | \$5 copayment (retail) per 30-day supply, \$15 copayment (mail order); deductible does not apply | Not covered | 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. |
| | Preferred Brand Drugs (Tier 3) | \$15 copayment (retail) per 30-day supply, \$45 copayment (mail order); deductible does not apply | Not covered | Out-of-Network prescription drugs are covered in urgent situations. The In-Network cost share applies. This plan accepts cost-sharing accumulation for any third-party payment (such as a drug manufacturer's coupon) and the rebate amount is applied towards your cost-sharing. |
| | Non-preferred Drugs (Tier 4) | \$100 copayment (retail) per 30-day supply, \$300 copayment (mail order); deductible does not apply | Not covered | Certain prescription drugs for preventive care, the treatment of mental illness, behavioral health, or substance use disorders will be covered at No Charge to you, when obtained from a participating pharmacy. See your plan's covered drug list for details. |
| | Self-Administered Specialty Drugs (Tier 5) | 50% coinsurance (retail) after deductible is met, Not available (mail order) | Not covered | Refer to the Formulary for a complete listing and coverage details. Self-Administered Specialty Drugs (Tier 5) limited to 30-day supply and Mail ordered 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 | Not covered | You may be subject to additional facility/clinic fees. Please check with your provider. Prior authorization may be required or benefits may be denied. |
| | Physician/surgeon fees | 20% coinsurance | Not covered | |
| If you need immediate medical attention | Emergency room care | \$500 copayment /visit deductible does not apply | \$500 copayment /visit deductible does not apply | No cost sharing for COVID testing, treatment and vaccines. Balance billing is not allowed for out-of-network care. |
| | Emergency medical transportation | \$250 copayment Ground and Air deductible does not apply | \$250 copayment Ground and Air deductible does not apply | No cost sharing for COVID testing, treatment and vaccines. Balance billing is not allowed for out-of-network care. |
| | Urgent care | \$40 copayment /visit deductible does not apply | \$40 copayment /visit deductible does not apply | No cost sharing for COVID testing, treatment and vaccines. Balance billing is not allowed for out-of-network care. There is zero cost sharing for any telehealth services. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance | Not covered | You may be subject to additional facility/clinic fees. Please check with your provider. Prior authorization may be required or benefits may be denied. |
| | Physician/surgeon fees | 20% coinsurance | Not covered | |
| If you need mental health, behavioral health, or substance use disorder services | Outpatient services | No charge deductible does not apply | Not covered | You may be subject to additional facility/clinic fees. Please check with your provider. There is no in-network cost-sharing for Behavioral Health Services or Drugs. Acute Medical Detoxification Benefits are Covered and will cover no less than 30 days Inpatient in an Alcohol Dependency Treatment Center and no less than 30 Outpatient visits for Alcohol Dependency Treatment. |
| | Inpatient services | No charge deductible does not apply | 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 are pregnant | Office visits | \$300 copayment /pregnancy deductible does not apply | Not covered | Cost sharing does not apply for preventive services. Prior authorization is not required for gynecological or obstetrical ultrasounds. |
| | Childbirth/delivery professional services | 20% coinsurance | Not covered | You may be subject to additional facility/clinic fees. Please check with your provider. Prior authorization may be required or benefits may be denied. Cost sharing does not apply for preventive services. Prior authorization is not required for gynecological or obstetrical ultrasounds. |
| | Childbirth/delivery facility services | 20% coinsurance | Not covered | |
| If you need help recovering or have other special health needs | Home health care | 20% coinsurance | Not covered | Coverage is limited to 100 days/ plan . Prior authorization may be required or benefits may be denied. |
| | Rehabilitation services | \$40 copayment /visit deductible does not apply | Not covered | There are no limits on services for habilitative or rehabilitative services. Prior authorization may be required or benefits may be denied. |
| | Habilitation services | \$40 copayment /visit deductible does not apply | Not covered | You may be subject to additional facility/clinic fees. Please check with your provider. There are no limits on services for habilitative or rehabilitative services. Please check with your provider. Prior authorization may be required or benefits may be denied. |
| | Skilled nursing care | 20% coinsurance | Not covered | Coverage is limited up to 60 days/ plan year. Prior authorization may be required or benefits may be denied. |
| | Durable medical equipment | 20% coinsurance | Not covered | Prior authorization may be required or benefits may be denied. |
| | Hospice services | 20% coinsurance | Not covered | Prior authorization may be required or benefits may be denied. |
| If your child needs dental or eye care | Children's eye exam | No charge deductible does not apply | \$55.00 copayment /visit deductible does not apply | One eye refraction exam associated with post cataract surgery or keratoconus correction per year is covered; additional charges may apply. |
| | Children's glasses | No charge deductible does not apply | \$40.00 copayment /visit deductible does not apply | Eyeglasses and contact lenses within 12 months following cataract surgery, correction of keratoconus or when related to Genetic Inborn Errors of Metabolism is limited to once a year; additional charges may apply. Prior authorization may be required or benefits may be denied. |
| | 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
- Dental Care (Adult)
- Dental check-up (Child) – Coverage is available in the Insurance Market and can be purchased as a stand-alone product.
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Private-Duty Nursing
- Routine Foot Care * only covered when medically necessary for diabetes. See GSA for details.

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

- Abortion Services (excepted and non-excepted)
- Acupuncture (20 visits per Calendar Year unless for Rehabilitation or Habilitative Services)
- 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)
- Chiropractic Care (20 visits per Calendar Year unless for Rehabilitation or Habilitative Services)
- Hearing Aids (one per ear, every three years)
- Infertility Treatment (Diagnosis and medically indicated treatments for physical conditions causing infertility)
- Routine Eye Care (Adult) limited to one eye exam per year (available with the purchase of the vision rider)
- 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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or <http://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 visit www.osi.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 1-855-923-7521.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-923-7521.

如果需要中文的帮助, 请拨打这个号码 1-855-923-7521..

Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-923-7521.

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 plans overall deductible | \$3,500 | ■ The plans overall deductible | \$3,500 | ■ The plans overall deductible | \$3,500 |
| ■ Specialist | \$90 | ■ Specialist | \$90 | ■ Specialist | \$90 |
| ■ Hospital (Facility) | 20% | ■ Hospital (Facility) | 20% | ■ Hospital (Facility) | 20% |
| ■ Other | 20% | ■ Other | 20% | ■ Other | 20% |
| <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 | \$12,700 | Total Example Cost | \$5,600 | Total Example Cost | \$2,800 |
| 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 | \$3,500 | Deductibles | \$800 | Deductibles | \$300 |
| Copayments | \$300 | Copayments | \$900 | Copayments | \$1,200 |
| Coinsurance | \$1,000 | 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 | \$20 | Limits or exclusions | \$0 |
| The total Peg would pay is | \$4,860 | The total Joe would pay is | \$1,720 | The total Mia would pay is | \$1,500 |

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