



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](http://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 <a href="#">deductible</a> ?	In-Network: <b>\$1,000</b> Individual / <b>\$2,000</b> Family. Out-of-Network: <b>\$1,500</b> Individual / <b>\$3,000</b> Family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> Behavioral Health services and any benefit where there is no charge, Covid-19 testing, treatment and vaccines, and any service that have a <a href="#">copayment</a> are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive care</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered preventive services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits">www.healthcare.gov/coverage/preventive-care-benefits</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	In-Network: <b>\$5,000</b> Individual / <b>\$10,000</b> Family. Out-of-Network: <b>\$10,000</b> Individual / <b>\$20,000</b> Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limit</a> until the overall family <a href="#">out-of-pocket limit</a> has been met..
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums, <a href="#">balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="https://www.phs.org/">https://www.phs.org/</a> or call 1-800-923-6980 for a list of participating providers.	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">provider network</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$30 <a href="#">copayment</a> /visit <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a> Telehealth /Video visits 50% <a href="#">coinsurance</a>	Video Visits with contracted providers through our national vendor are \$0 copay and paid at 100% in network. Telehealth appointments with a contracted network provider, including Presbyterian Medical Group providers, or out of network provider require members to pay a normal copay or cost share in network or out of network.
	<a href="#">Specialist</a> visit	\$60 <a href="#">copayment</a> /visit <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	-----None-----
	<a href="#">Preventive care/screening</a> /immunization	No charge <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for. There is zero cost-sharing for any telehealth service. <a href="#">Copayment</a> does not include Medical Drugs which will have a separate charge. No cost sharing for COVID-19 testing, treatment and vaccines. Prior authorization is not required for gynecological or obstetrical ultrasounds.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	Prior authorization may be required or benefits may be denied.
	Imaging (CT/PET scans, MRIs)	PET/MRI: \$200 <a href="#">copayment</a> /test; CT: \$125 <a href="#">copayment</a> /test <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="#">phs.org/formsanddocuments</a>	Preferred Generic Drugs (Tier 1)	\$10 <a href="#">copayment</a> (retail) / \$20 <a href="#">copayment</a> (mail order) <a href="#">deductible</a> does not apply	Not covered	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)	\$40 <a href="#">copayment</a> (retail) / \$80 <a href="#">copayment</a> (mail order) <a href="#">deductible</a> does not apply	Not covered	

	Non-preferred drugs (Tier 3)	\$75 <a href="#">copayment</a> (retail) / \$200 <a href="#">copayment</a> (mail order) <a href="#">deductible</a> does not apply	Not covered	
	Self-Administered Specialty (Tier 4)	20% up to a maximum of \$400 per prescription (retail) <a href="#">deductible</a> does not apply / Not available (mail order)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	50% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	Prior authorization may be required or benefits may be denied.
	Physician/surgeon fees	20% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	50% <a href="#">coinsurance</a> after <a href="#">deductible</a> 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	<a href="#">Emergency room care</a>	\$300 <a href="#">copayment</a> /visit <a href="#">deductible</a> does not apply	\$300 <a href="#">copayment</a> /visit	Waived if admitted into a hospital, then hospital <a href="#">copayment</a> applies.
	<a href="#">Emergency medical transportation</a>	\$50 <a href="#">copayment</a> ground; \$100 <a href="#">copayment</a> air; No charge inter-facility <a href="#">deductible</a> does not apply	\$50 <a href="#">copayment</a> ground; \$100 <a href="#">copayment</a> air; No charge inter-facility <a href="#">deductible</a> does not apply	-----None-----
	<a href="#">Urgent care</a>	\$75 <a href="#">copayment</a> /visit <a href="#">deductible</a> does not apply	\$75 <a href="#">copayment</a> /visit <a href="#">deductible</a> does not apply	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Prior Authorization may be required or benefits may be denied.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	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 <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	There is no cost-sharing for behavioral health services or drugs.
	Inpatient services	No charge <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	Prior authorization may be required or benefits may be denied. There is no cost-sharing for behavioral health services or drugs.
If you are pregnant	Office visits	\$30 <a href="#">copayment</a> /visit <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> does apply.
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Deductible</a> does apply.
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Prior authorization may be required. <a href="#">Deductible</a> does apply.

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	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Prior authorization may be required or benefits may be denied.
	<a href="#">Rehabilitation services</a>	\$75 <a href="#">copayment</a> //visit <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	Coverage is limited up to 24 visits not combined/contract year. Prior authorization may be required or benefits may be denied.
	<a href="#">Habilitation services</a>	\$30 <a href="#">copayment</a> //visit <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	-----None-----
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Coverage is limited up to 30 days/ <a href="#">plan</a> year. Prior authorization may be required or benefits may be denied.
	<a href="#">Durable medical equipment</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Prior authorization may be required or benefits may be denied.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Prior authorization may be required or benefits may be denied.
If your child needs dental or eye care	Children's eye exam	Included in office visit <a href="#">copayment deductible</a> does not apply	Not covered	Coverage is limited to refraction eye exam associated with post cataract surgery or Keratoconus correction
	Children's glasses	50% <a href="#">coinsurance</a>	Not covered	Coverage is limited to eyeglasses/contact lenses within 12 months following cataract surgery, correction of Keratoconus or when related to Genetic Inborn Errors of Metabolism. 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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
• 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	• Weight Loss Programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> 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
• Bariatric Surgery	• Hearing Aids	

**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 <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](http://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](http://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](mailto: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](http://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	\$1000
■ Specialist	\$60
■ Hospital (Facility)	20%
■ Other	20%

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*)

<b>Total Example Cost</b>	<b>\$12,738</b>
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$750
Copayments	\$100
Coinsurance	\$1,792
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,702</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$1000
■ Specialist	\$60
■ Hospital (Facility)	20%
■ Other	20%

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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,060
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$1,115</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$1000
■ Specialist	\$60
■ Hospital (Facility)	20%
■ Other	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,009</b>
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$29
Copayments	\$630
Coinsurance	\$7
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$667</b>

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