



**Presbyterian Native American Clear Cost Turquoise 3 with  
Extra Savings with Limited Service Area On Exchange**

Coverage for: Individual or Family | Plan Type: HMO




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 1-855-923-7528 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 1-800-923-7528 to request a copy.

Important Questions	Answers	Why this Matters:
<b>What is the overall deductible?</b>	IHCP: \$0/\$0 In Network: \$500/Individual / \$1,000/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 plan, 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> .
<b>Are there other deductibles for specific services?</b>	Yes. <a href="#">Preventive care</a> , Behavioral Health services Covid- 19 testing, treatment, or vaccines.	This plan covers some items and services even if you haven't 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> .
<b>Is there an out-of-pocket limit on my expenses?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is not included in the out-of-pocket limit?</b>	IHCP: \$0/\$0 In-network: \$2,400/Individual / \$4,800/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.
<b>Is there an overall annual limit on what the plan pays?</b>	Premiums, <a href="#">balance billing</a> charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Does this plan use a network of providers?</b>	Yes. See Individual and Family or Group HMO/POS Network at <a href="https://www2.phs.org/providers/?insurance_plans=IFGHP">https://www2.phs.org/providers/?insurance_plans=IFGHP</a> or call 1-800-923- 7528 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="#">network provider</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.
<b>Do you need a referral to see a specialist?</b>	No.	You can see the <a href="#">specialist</a> you choose without a referral.

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HIOS ID: 57173NM0300003-13

 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
		IHCP Provider(You will pay the least)	Non-IHCP Provider In-Network Provider	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 <a href="#">deductible</a> does not apply	\$7 <a href="#">copayment</a> /visit <a href="#">deductible</a> does not apply	Not Covered	There is zero <a href="#">cost sharing</a> for any telehealth service. Cost share does not include Medical drugs which will have a separate charge. No charge for anything related to Covid-19 testing, vaccines or medical treatment. Prior Authorization is not required for gynecological or obstetrical ultrasounds  You may have to pay for services that aren't preventative. Then check what your <a href="#">plan</a> will pay for. There is zero <a href="#">cost sharing</a> for any telehealth services. Prior Authorization is not required for gynecological or obstetrical ultrasounds
	Specialist visit	No charge <a href="#">deductible</a> does not apply	\$20 <a href="#">copayment</a> /visit <a href="#">deductible</a> does not apply	Not Covered	
	<a href="#">Preventive care</a> /Screening/Immunization	No charge <a href="#">deductible</a> does not apply	No charge <a href="#">deductible</a> does not apply	Not Covered	
If you have a test	Diagnostic test (x-ray, blood work)	No charge <a href="#">deductible</a> does not apply	\$20 <a href="#">copayment</a> /visit <a href="#">deductible</a> does not apply	Not Covered	Prior Authorization may be required or benefits may be denied.
	Imaging (CT/PET scans, MRIs)	No charge <a href="#">deductible</a> does not apply	\$20 <a href="#">copayment</a> /visit <a href="#">deductible</a> does not apply	Not Covered	

Common Medical Event	Services You May Need	What you will pay			Limitations, Exceptions & other Important information
		IHCP Provider(You will pay the least)	Non-IHCP Provider In-Network Provider	Out-of-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness</b> <b>More information about prescription drug coverage is available at:</b> <a href="#">Formulary Search (formularynavigator.com)</a>	Generic Drugs ( <b>Tier 1</b> )	No charge <a href="#">deductible</a> does not apply	\$5 <a href="#">copayment</a> (retail) per 30-day supply/ \$15 <a href="#">copayment</a> (mail order) <a href="#">deductible</a> does not apply	Not Covered	90-day maximum supply (retail).  Preferred insulin or medically necessary alternative will not exceed \$25 <a href="#">copayment</a> per 30-day supply.
	Preferred Brand Drugs ( <b>Tier 2</b> )	No charge <a href="#">deductible</a> does not apply	\$10 <a href="#">copayment</a> (retail) per 30-day supply/ \$30 <a href="#">copayment</a> (mail order) <a href="#">deductible</a> does not apply	Not Covered	Out-of-Network prescription drugs are covered in urgent situations. The In-Network cost share applies.
	Non-Preferred Drugs ( <b>Tier 3</b> )	No charge <a href="#">deductible</a> does not apply	\$100 <a href="#">copayment</a> with <a href="#">deductible</a> (retail) per 30-day supply/ \$300 <a href="#">copayment</a> with <a href="#">deductible</a> (mail order)	Not Covered	Prior authorization may be required or benefits may be denied.
	Preferred Specialty Drugs ( <b>Tier 4</b> )	No charge <a href="#">deductible</a> does not apply	\$50 <a href="#">copayment</a> <a href="#">deductible</a> does not apply Limited to 30-day supply max/Not Covered mail order	Not Covered	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 Specialty Drugs ( <b>Tier 5</b> )	No charge <a href="#">deductible</a> does not apply	\$125 <a href="#">copayment</a> <a href="#">deductible</a> does not apply Limited to 30-day supply max/Not Covered mail order	Not Covered	Refer to the Formulary for a complete listing and coverage details.
<b>If you have outpatient surgery</b>  <b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge <a href="#">deductible</a> does not apply	\$60 <a href="#">copayment</a> <a href="#">deductible</a> does not apply	Not Covered	Prior Authorization may be required or benefits may be denied.
	Physician/surgeon fees	No charge <a href="#">deductible</a> does not apply	\$60 <a href="#">copayment</a> <a href="#">deductible</a> does not apply	Not Covered	

Common Medical Event	Services You May Need	What you will pay			Limitations, Exceptions & other Important information
		IHCP Provider(You will pay the least)	Non-IHCP Provider In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room services	No charge <a href="#">deductible</a> does not apply	\$75 <a href="#">copayment deductible</a> with	\$75 <a href="#">copayment deductible</a> with	No charge for anything related to Covid-19 testing, vaccines or medical treatment. There is zero <a href="#">cost sharing</a> for any telehealth service. Cost share does not include Medical drugs which will have a separate charge. Prior Authorization is not required for gynecological or obstetrical ultrasounds. <a href="#">Balance billing</a> is not allowed for out-of-network care.
	Emergency medical transportation	No charge <a href="#">deductible</a> does not apply	\$60 <a href="#">copayment deductible</a> /Ground & Air does not apply	\$60 <a href="#">copayment deductible</a> /Ground & Air does not apply	
	Urgent care	No charge <a href="#">deductible</a> does not apply	\$20 <a href="#">copayment deductible</a> does not apply;	\$20 <a href="#">copayment deductible</a> does not apply;	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge <a href="#">deductible</a> does not apply	\$75 <a href="#">copayment deductible</a> with	Not Covered	Prior Authorization may be required or benefits may be denied.
	Physician/surgeon fee	No charge <a href="#">deductible</a> does not apply	\$75 <a href="#">copayment deductible</a> with	Not Covered	
If you have mental health, behavioral health, or substance use disorder services	Mental/Behavioral health outpatient services	No charge <a href="#">deductible</a> does not apply	No charge <a href="#">deductible</a> does not apply	Not Covered	There is no cost-sharing for behavioral health services or drugs. Acute Medical Detoxification benefits are covered & will cover no less than 30 outpt visits for alcohol dependency treatment.
	Mental/Behavioral health inpatient services	No charge <a href="#">deductible</a> does not apply	No charge <a href="#">deductible</a> does not apply	Not Covered	There is no cost-sharing for behavioral health services or drugs. Acute Medical Detoxification benefits are covered & will cover no less than 30 days in an alcohol dependency treatment center.

Common Medical Event	Services You May Need	What you will pay			Limitations, Exceptions & other Important information
		IHCP Provider(You will pay the least)	Non-IHCP Provider In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge <a href="#">deductible</a> does not apply	No charge <a href="#">deductible</a> does not apply	Not Covered	<a href="#">Cost sharing</a> does not apply for preventative services. Prior Authorization is not required for gynecological or obstetrical ultrasounds. Prior authorization may be required or benefits may be denied.
	Childbirth/delivery professional services	No charge <a href="#">deductible</a> does not apply	\$75 <a href="#">copayment</a> with <a href="#">deductible</a>	Not Covered	
	Childbirth/delivery facility services	No charge <a href="#">deductible</a> does not apply	\$75 <a href="#">copayment</a> with <a href="#">deductible</a>	Not Covered	
If you need help recovering or have other special health needs	Home health care	No charge <a href="#">deductible</a> does not apply	\$7 <a href="#">copayment</a> /visit <a href="#">deductible</a> does not apply	Not Covered	Coverage is limited to 100 days/ <a href="#">plan</a> year. Prior authorization may be required or benefits may be denied.
	Rehabilitation services	No charge <a href="#">deductible</a> does not apply	\$7 <a href="#">copayment</a> /visit <a href="#">deductible</a> does not apply	Not Covered	Prior Authorization may be required or benefits may be denied.
	Habilitation services	No charge <a href="#">deductible</a> does not apply	\$7 <a href="#">copayment</a> /visit <a href="#">deductible</a> does not apply	Not Covered	
	Skilled nursing care	No charge <a href="#">deductible</a> does not apply	\$20 <a href="#">copayment</a> <a href="#">deductible</a> does not apply	Not Covered	Coverage is limited to 60 days/ <a href="#">plan</a> year. Prior authorization may be required or benefits may be denied.
	Durable medical equipment	No charge <a href="#">deductible</a> does not apply	\$20 <a href="#">copayment</a> <a href="#">deductible</a> does not apply	Not Covered	Prior Authorization may be required or benefits may be denied.
	Hospice service	No charge <a href="#">deductible</a> does not apply	\$20 <a href="#">copayment</a> <a href="#">deductible</a> does not apply	Not Covered	

Common Medical Event	Services You May Need	What you will pay			Limitations, Exceptions & other Important information
		IHCP Provider(You will pay the least)	Non-IHCP Provider In-Network Provider	Out-of-Network Provider (You will pay the most)	
If your child needs Dental or Eyecare	Eye exam	No charge <a href="#">deductible</a> does not apply	No charge <a href="#">deductible</a> does not apply	Not Covered	One Eye Refraction associated with post cataract surgery or Keratoconus correction/year is covered; additional charges may apply
	Glasses	No charge <a href="#">deductible</a> does not apply	No charge <a href="#">deductible</a> does not apply	Not Covered	Eyeglasses & contact lenses within 12mo following cataract surgery or the correction of keratoconus or related Genetic Inborn errors of metabolism is limited to once/yr; additional charges may apply
	Dental check-up	Not Covered	Not Covered	Not Covered	Not Covered

## 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)
- 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 35kg/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 year every three years)
- Infertility Treatment (Diagnosis and medically indicated treatments for physical conditions causing infertility)
- 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](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 [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](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 visit [www.osi.state.nm.us](http://www.osi.state.nm.us).

**Does this Coverage 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 Coverage Meet the Minimum Value Standard? No;** 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'ehgoshika 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000
<a href="#">Specialist</a> [ <a href="#">cost sharing</a> ]	\$60
Hospital (facility) [ <a href="#">cost sharing</a> ]	\$150
Other [ <a href="#">cost sharing</a> ]	\$125

#### 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>\$12,700</b>
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#### In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$3000
<a href="#">Copayments</a>	\$800
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,860</b>

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

The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000
<a href="#">Specialist</a> [ <a href="#">cost sharing</a> ]	\$60
Hospital (facility) [ <a href="#">cost sharing</a> ]	\$150
Other [ <a href="#">cost sharing</a> ]	\$125

#### 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>\$5,600</b>
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#### In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1700
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,720</b>

### Mia's Simple Fracture

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

The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000
<a href="#">Specialist</a> [ <a href="#">cost sharing</a> ]	\$60
Hospital (facility) [ <a href="#">cost sharing</a> ]	\$150
Other [ <a href="#">cost sharing</a> ]	\$125

#### 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>\$2,800</b>
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#### In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$400
<a href="#">Copayments</a>	\$800
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,200</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services. Note: These numbers assume the patient received care from an IHCP provider or with IHCP referral at a non-IHCP. If you receive care from a non-IHCP provider without a referral from an IHCP your costs may be higher