



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 1-800-275-7737 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.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 <u>deductible</u> ?	Preferred Provider: \$1,000 Individual / \$2,000 Family Non-Preferred Provider: \$1,500 Individual / \$3,000 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Office visits that charge a <u>copayment</u> , <u>prescription drugs</u> , and <u>Preferred preventive care</u> are covered before you meet your <u>deductible</u> . Covid-19 screening, testing, treatment, vaccines, boosters.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Preferred Provider: \$4,000 Individual / \$8,000 Family Non-Preferred Provider: \$9,000 Individual / \$18,000 Family <u>Out-of-pocket</u> Pharmacy In-network: \$3,100 Individual / \$6,200 Family. Out-of-network: N/A.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balanced-billed</u> charges, penalty amounts, <u>prescription drugs</u> , and healthcare this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="https://www2.phs.org/providers">https://www2.phs.org/providers</a> or call 1-866-670-0600 for a list of <u>preferred providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</u> network. You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> 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 <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> 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
		<a href="#">Preferred Provider</a> (You will pay the least)	<a href="#">Non-Preferred Provider</a> (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$20 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply Telehealth \$0 <a href="#">copayment</a>	30% <a href="#">coinsurance</a>	PHP Video Visits utilize a nationwide network of Providers at No Charge at <a href="#">Preferred Providers</a> only. Not covered for <a href="#">Non-Preferred Providers</a>
	<a href="#">Specialist</a> visit	\$40 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply Telehealth \$0 <a href="#">copayment</a>	30% <a href="#">coinsurance</a>	PHP Video Visits utilize a nationwide network of Providers at No Charge at <a href="#">Preferred Providers</a> only. Not covered for <a href="#">Non-Preferred Providers</a>
	<a href="#">Preventive care/screening</a> / immunization	No Charge; <a href="#">deductible</a> does not apply	30% <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.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$30/ \$60 <a href="#">copayment</a> <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	<a href="#">Copayment</a> or actual <a href="#">allowed charge</a> , whichever is less. \$30 <a href="#">copayment</a> applies at office visit or at freestanding lab. \$60 <a href="#">copayment</a> applies at outpatient hospital.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a> of allowed charge up to \$600 <a href="#">copayment</a> /day, whichever is less; <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	Requires <a href="#">Prior Authorization</a> .

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.phs.org](http://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)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="https://client.formularynavigator.com/Search.aspx?siteCode=0322075909">Prescription drug coverage</a> is available at <a href="https://client.formularynavigator.com/Search.aspx?siteCode=0322075909">https://client.formularynavigator.com/Search.aspx?siteCode=0322075909</a>	Generic Drugs up to 30-day supply	\$5 <a href="#">copayment</a>	Not covered	Enteral food products – 50% <a href="#">coinsurance</a> Generic and Preferred Brand Diabetic supplies and insulin - \$0 <a href="#">copayment</a> Generic and Preferred Brand oral diabetic medication - \$0 <a href="#">copayment</a>
	Preferred Brand Drugs up to a 30-day supply	Minimum \$30 <a href="#">copayment</a> or 25% <a href="#">coinsurance</a> of the medication cost, Maximum \$70 <a href="#">copayment</a>	Not covered	
	Non-preferred Brand Drugs up to a 30-day supply	Min \$60 <a href="#">copayment</a> or 70% <a href="#">coinsurance</a> of the medication cost, Max \$125 <a href="#">copayment</a>	Not covered	Enteral food products – 50% <a href="#">coinsurance</a> Non-preferred Brand diabetic supplies, insulin and oral medications – \$30 <a href="#">copayment</a>
	<a href="#">Specialty Drugs</a> up to a 30-day supply	\$75 <a href="#">copayment</a> Generic \$100 <a href="#">copayment</a> Preferred Brand \$200 <a href="#">copayment</a> Non-Preferred Brand	Not covered	None
	Extended Days Supply up to a 90-day supply	\$10 <a href="#">copayment</a> Generic, Brands not covered	Not covered	None
	Mail Order up to a 90-day supply	\$10 <a href="#">copayment</a> Generic \$60 <a href="#">copayment</a> Preferred Brand \$120 <a href="#">copayment</a> Non-preferred Brand	Not covered	None
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$150 <a href="#">copayment</a> /visit plus 20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$300 <a href="#">copayment deductible</a> does not apply	\$300 <a href="#">copayment deductible</a> does not apply	None
	<a href="#">Emergency medical transportation</a>	\$30 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply	\$30 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply	None
	<a href="#">Urgent care</a>	\$50 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	None

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.phs.org](http://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)	\$500 <a href="#">copayment</a> / admission plus 20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Requires <a href="#">Prior Authorization</a>
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	Includes office, home, outpatient, and Intensive Outpatient Programs (IOP) services; inpatient and partial hospitalization.  Partial hospitalization is \$250 <a href="#">copayment</a> plus 20% <a href="#">coinsurance</a> . IOP is \$125 <a href="#">copayment</a> plus 20% <a href="#">coinsurance</a> .  IOP, inpatient, and partial hospitalization require <a href="#">Prior Authorization</a> .
	Inpatient services	\$500 <a href="#">copayment</a> / admission plus 20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
If you are pregnant	Office visits	\$20 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	<a href="#">Copayment</a> charged for initial visit only. <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	\$500 <a href="#">copayment</a> / admission plus 20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Requires <a href="#">Prior Authorization</a>

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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	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Limited to 120 visits per year for <u>Non-Preferred Provider</u> .
	<a href="#">Rehabilitation services</a>	\$20 <a href="#">copayment</a> /therapist visit; <a href="#">deductible</a> does not apply. 20% <a href="#">coinsurance</a> for other providers	30% <a href="#">coinsurance</a>	<a href="#">Copayment</a> applies to physical, occupational, and speech therapists. Other providers includes, but is not limited to, Chiropractors and Doctors of Oriental Medicine. \$20 <a href="#">copayment</a> applies up to \$500; thereafter No Charge for the remaining calendar year. Includes physical, occupational, and speech therapies (office/outpatient).
	<a href="#">Habilitation services</a>	\$20 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	\$500 <a href="#">copayment</a> / admission plus 20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Support hose limited to 12 pair (or 24 hose), Mastectomy Bras up to 6 per calendar year. <a href="#">Prior Authorization</a> needed for services over \$1000.
	<a href="#">Hospice services</a>	\$500 <a href="#">copayment</a> / admission plus 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> Outpatient: No charge	30% <a href="#">coinsurance</a>	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 <a href="#">plan</a> information.
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	If dental coverage purchased, see your dental <a href="#">plan</a> information.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.phs.org](http://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 with chiropractic)
- 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](http://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](http://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](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 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](http://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](http://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, kwijigo holne' 1-800-432-0750.

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	\$1,000
■ 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*)

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

Cost sharing	
Deductibles	\$1,000
Copayments	\$700
Coinsurance	\$2,000
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,760</b>

### Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$1,000
■ 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*)

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

Cost sharing	
Deductibles	\$800
Copayments	\$1,900
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,720</b>

### Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,000
■ 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*)

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

Cost sharing	
Deductibles	\$200
Copayments	\$1,000
Coinsurance	\$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.

