

 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](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 1-855-593-7737 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>\$325</b> Single / <b>\$650</b> Two-person / <b>\$975</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> is covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items & 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> .
Are there other <a href="#">deductibles</a> for specific services?	Yes. <b>\$50</b> Single <b>\$100</b> Two-Person/Family	You must pay all the Pharmacy costs up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for covered services you use.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>\$3,500</b> Single/ <b>\$7,000</b> Two-person/ <b>\$10,500</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, health care this <a href="#">plan</a> doesn't cover, and penalty amounts.	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://www2.phs.org/php_directory?insurance_plans=AHP">https://www2.phs.org/php_directory?insurance_plans=AHP</a> H or call 1- 888-275-7737 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> ).
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)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$25 <a href="#">copayment</a> /visit Video Visit- No Charge.	Not covered	-----None-----
	<a href="#">Specialist</a> visit	\$40 <a href="#">copayment</a> /visit	Not covered	-----None-----
	<a href="#">Preventive care/screening</a> /immunization	No charge	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 <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	Not covered	Prior authorization may be required or benefits may be denied.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a> up to a max of \$200 per test/per day after <a href="#">deductible</a> is met	Not covered	
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="https://client.formularynavigator.com/Search.aspx?siteCode=0322075909">https://client.formularynavigator.com/Search.aspx?siteCode=0322075909</a></b>	Generic drugs (Tier 1)	\$5 <a href="#">copayment</a> (retail) / \$15 <a href="#">copayment</a> (mail order)	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)	30% <a href="#">coinsurance</a> (\$30 minimum up to \$90) (retail) / \$95 <a href="#">copayment</a> (mail order)	Not Covered	
	Non-preferred drugs (Tier 3)	40% <a href="#">coinsurance</a> (\$55 minimum up to \$125) (retail) / \$125 <a href="#">copayment</a> (mail order)	Not Covered	
	Self-Administered Specialty (Tier 4)	\$60 Generic \$85 Preferred Brand \$125 Non-Preferred	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	Not covered	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	Not covered	Facility claim only

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>	\$175 <a href="#">copayment</a> /visit	\$175 <a href="#">copayment</a> /visit	Waived if admitted into a hospital, then hospital <a href="#">copayment</a> applies.
	<a href="#">Emergency medical transportation</a>	\$30 <a href="#">copayment</a> /trip ground; \$100 <a href="#">copayment</a> /trip air	\$30 <a href="#">copayment</a> /trip ground; \$100 <a href="#">copayment</a> /trip air	-----None-----
	<a href="#">Urgent care</a>	\$50 <a href="#">copayment</a> /visit	\$50 <a href="#">copayment</a> /visit	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 <a href="#">copayment</a> /admission after <a href="#">deductible</a> is met	Not covered	Prior Authorization may be required or benefits may be denied.
	Physician/surgeon fees	No charge	Not covered	Prior Authorization may be required or benefits may be denied.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <a href="#">copayment</a> /visit	Not covered	-----None-----
	Inpatient services	\$500 <a href="#">copayment</a> /admission after <a href="#">deductible</a> is met	Not covered	Prior authorization may be required.
If you are pregnant	Office visits	\$25 <a href="#">copayment</a> initial visit only	Not covered.	Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> 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	Not covered	Prior Authorization is not required for gynecological or obstetrical ultrasounds.
	Childbirth/delivery facility services	\$500 <a href="#">copayment</a> /pregnancy after <a href="#">deductible</a> is met	Not covered	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	<a href="#">Home health care</a>	\$40 <a href="#">copayment</a> /physician services	Not covered	No charge for nursing services. Prior authorization may be required or benefits may be denied.
	<a href="#">Rehabilitation services</a>	Inpatient: \$500 <a href="#">copayment</a> /admission after <a href="#">deductible</a> is met; Outpatient: \$40 <a href="#">copayment</a> /visit	Not covered	Prior authorization may be required or benefits may be denied.
	<a href="#">Habilitation services</a>	\$40 <a href="#">copayment</a> /visit	Not covered	-----None-----
	<a href="#">Skilled nursing care</a>	\$500 <a href="#">copayment</a> /admission after <a href="#">deductible</a> is met	Not covered	Admission <a href="#">copayment</a> waived if readmitted within 15 days. Prior authorization may be required or benefits may be denied.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	Not covered	Prior authorization may be required or benefits may be denied.
	<a href="#">Hospice services</a>	No charge	Not covered	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	20% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	Not covered	Prior authorization may be required.
	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> .)		
<ul style="list-style-type: none"> <li>Cosmetic Surgery</li> <li>Dental Care (Adult)</li> <li>Dental check-up (Child)</li> <li>Eye exam (Child)</li> </ul>	<ul style="list-style-type: none"> <li>Glasses (Child)</li> <li>Infertility Treatment (Only limited services covered)</li> <li>Long-Term Care</li> <li>Non-Emergency Care When Traveling Outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>Private-Duty Nursing</li> <li>Routine Eye Care (Adult)</li> <li>Routine Foot Care</li> <li>Weight Loss Programs (Morbid obesity treatment only)</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric Surgery</li> </ul>	<ul style="list-style-type: none"> <li>Chiropractic Care</li> </ul>	<ul style="list-style-type: none"> <li>Hearing Aids</li> </ul>

**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 [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**

[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](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)		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	\$325	■ The plan's overall deductible	\$325	■ The plan's overall deductible	\$325
■ Specialist	\$40	■ Specialist	\$40	■ Specialist	\$40
■ Hospital (Facility)	\$500	■ Hospital (Facility)	\$500	■ Hospital (Facility)	\$500
■ Other	No Charge	■ Other	No Charge	■ Other	No Charge
<b>This EXAMPLE event includes services like:</b> 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> )		<b>This EXAMPLE event includes services like:</b> 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> )		<b>This EXAMPLE event includes services like:</b> 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> )	
<b>Total Example Cost</b>	<b>\$12,731</b>	<b>Total Example Cost</b>	<b>\$7,389</b>	<b>Total Example Cost</b>	<b>\$1,925</b>
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	\$325	Deductibles	\$325	Deductibles	\$53
Copayments	\$20	Copayments	\$155	Copayments	\$0
Coinsurance	\$209	Coinsurance	\$1,101	Coinsurance	\$13
<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
<b>The total Peg would pay is</b>	<b>\$614</b>	<b>The total Joe would pay is</b>	<b>\$1,636</b>	<b>The total Mia would pay is</b>	<b>\$67</b>

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