



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. 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 deductible?	In-network: \$500 Individual / \$1,000 Double / \$1,500 Family Out-of-network: \$2,800 Individual / \$5,600 Double / \$8,400 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 is covered before you meet your deductible .	This plan covers some items & services even if you haven't 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?	Yes. \$50 Single \$100 Two-Person/Family	You must pay all the Pharmacy costs up to the deductible amount before this plan begins to pay for covered services you use.
What is the out-of-pocket limit for this plan?	In-network: \$3,500 Individual / \$7000 2-party / \$10,500 Family Out-of-network: \$7,000 Individual / \$14000 2-party / \$21,000 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, health care this plan doesn't cover, and penalty amounts.	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 https://www2.phs.org/php_dir/ectory?insurance_plans=AHPH or call 1- 888-275-7737 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).
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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$30 <u>copayment</u> /visit Video Visits No Charge	50% <u>coinsurance</u> after <u>deductible</u> is met Video Visits- Not Covered	-----None-----
	<u>Specialist</u> visit	\$50 <u>copayment</u> /visit	50% <u>coinsurance</u> after <u>deductible</u> is met	-----None-----
	<u>Preventive</u> care/screening/immunization	No charge	50% <u>coinsurance</u> after <u>deductible</u> is met	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u> after <u>deductible</u> is met	50% <u>coinsurance</u> after <u>deductible</u> is met	Prior authorization may be required or benefits may be denied.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u> up to a max of \$200 per test/per day after <u>deductible</u> is met	50% <u>coinsurance</u> after <u>deductible</u> is met	
If you need drugs to treat your illness or condition <u>More information about prescription drug coverage is available at</u> https://client.formularynavigator.com/Search.aspx?siteCode=0322075909	Generic drugs (Tier 1)	\$5 <u>copayment</u> (retail) / \$15 <u>copayment</u> (mail order)	\$5 <u>copayment</u> (retail) / \$15 <u>copayment</u> (mail order)	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% <u>coinsurance</u> (\$30 minimum up to \$90) (retail) / \$95 <u>copayment</u> (mail order)	30% <u>coinsurance</u> (\$30 minimum up to \$90) (retail) / \$95 <u>copayment</u> (mail order)	
	Non-preferred drugs (Tier 3)	40% <u>coinsurance</u> (\$55 minimum up to \$125) (retail) / \$125 <u>copayment</u> (mail order)	40% <u>coinsurance</u> (\$55 minimum up to \$125) (retail) / \$125 <u>copayment</u> (mail order)	
	Self-Administered Specialty (Tier 4)	\$60 Generic \$85 Preferred Brand \$125 Non-Preferred	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 after deductible is met	50% coinsurance after deductible is met	Prior Authorization may be required or benefits may be denied.
	Physician/surgeon fees	Included in Facility Fee charges	50% coinsurance after deductible is met	Prior Authorization may be required or benefits may be denied.
If you need immediate medical attention	Emergency room care	\$175 copayment /visit	\$175 copayment /visit	Waived if admitted into a hospital, then hospital copayment will apply.
	Emergency medical transportation	20% coinsurance after deductible is met	20% coinsurance after deductible is met	-----None-----
	Urgent care	\$50 copayment /visit	\$50 copayment /visit	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	\$1000 copayment /admission after deductible is met	50% coinsurance after deductible is met	Prior Authorization may be required or benefits may be denied.
	Physician/surgeon fees	Included in Facility Fee charges	50% coinsurance after deductible is met	Prior Authorization may be required or benefits may be denied.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 copayment /visit	50% coinsurance after deductible is met	-----None-----
	Inpatient services	\$1,000 copayment /admission after deductible is met	50% coinsurance after deductible is met	Prior authorization may be required.
If you are pregnant	Office visits	\$30 copayment initial visit only	50% coinsurance after deductible is met	Depending on the type of services, a copayment , coinsurance , or deductible 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	50% coinsurance after deductible is met	Prior Authorization is not required for gynecological or obstetrical ultrasounds.
	Childbirth/delivery facility services	\$1,000 copayment /admission after deductible is met	50% coinsurance after deductible is met	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	Home health care	\$50 <u>copayment</u> /physician services	50% <u>coinsurance</u> after <u>deductible</u> is met	No charge for nursing services. Prior authorization may be required or benefits may be denied.
	Rehabilitation services	Inpatient: \$1,000 <u>copayment</u> /admission ; Outpatient: \$50 <u>copayment</u> /visit	50% <u>coinsurance</u> after <u>deductible</u> is met	Prior authorization may be required or benefits may be denied.
	Habilitation services	\$50 <u>copayment</u>	50% <u>coinsurance</u> after <u>deductible</u> is met	-----None-----
	Skilled nursing care	\$1,000 <u>copayment</u> /admission after <u>deductible</u> is met	50% <u>coinsurance</u> after <u>deductible</u> is met	Admission copayment waived if readmitted within days. Prior authorization may be required or benefits may be denied.
	Durable medical equipment	25% <u>coinsurance</u> after <u>deductible</u> is met	50% <u>coinsurance</u> after <u>deductible</u> is met	Prior authorization may be required or benefits may be denied.
	Hospice services	No charge	50% <u>coinsurance</u> after <u>deductible</u> is met	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	25% <u>coinsurance</u> after <u>deductible</u> is met	50% <u>coinsurance</u> after <u>deductible</u> is met	Coverage is limited to eyeglasses/contact lenses within 12 months following cataract surgery or the correction of Keratoconus. Prior authorization may be required.
	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	• Glasses (Child)	• Private-Duty Nursing
• Dental Care (Adult)	• Infertility Treatment (Only limited services covered)	• Routine Eye Care (Adult)
• Dental check-up (Child)	• Long-Term Care	• Routine Foot Care
• Eye exam (Child)	• Non-Emergency Care When Traveling Outside the U.S.	• Weight Loss Programs (Morbid obesity treatment only)

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

• Acupuncture	• Chiropractic Care	• Hearing Aids
• Bariatric Surgery		

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. 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 by email at 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.

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	\$500
Specialist	\$50
Hospital (Facility)	\$1000
Other	No Charge

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*)

Total Example Cost **\$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$20
Coinsurance	\$209
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$789

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

The plan's overall deductible	\$500
Specialist	\$50
Hospital (Facility)	\$1000
Other	No Charge

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*)

Total Example Cost **\$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$107
Copayments	\$545
Coinsurance	\$27
What isn't covered	
Limits or exclusions	\$55
The total Joe would pay is	\$734

Mia's Simple Fracture (in-network emergency room visit and follow up care)

The plan's overall deductible	\$500
Specialist	\$50
Hospital (Facility)	\$1000
Other	No Charge

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost **\$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$0
Coinsurance	\$166
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$666

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