

 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 1-877-752-4164 or visit [www.phs.org](http://www.phs.org) for medical and call 1-800-232-6549 or visit [www.express-scripts.com](http://www.express-scripts.com) for pharmacy. 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 1-877-752-4164 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	In-Network: <b>\$2,500</b> /Individual / <b>\$5,000</b> /Family Out-of-Network: <b>\$5,000</b> /Individual / <b>\$10,000</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 plan begins to pay. Annual <a href="#">deductible</a> is based on calendar year.
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 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 plan 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> . Annual <a href="#">deductible</a> is based on calendar year.
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>\$2,500</b> / Individual / <b>\$5,000</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. Annual <a href="#">out-of-pocket limit</a> is based on calendar year.
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=AH">https://www2.phs.org/PHP_directory?insurance_plans=AH</a> <a href="#">PH</a> or call 1-877-752-4164 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	0% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met. Video visits: <a href="#">Deductible</a> may apply and <a href="#">coinsurance</a>	-----None-----
	<a href="#">Specialist</a> visit	0% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	-----None-----
	<a href="#">Preventive care/screening</a> /immunization	No charge	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> 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 plan will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	0% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	Prior authorization may be required.
	Imaging (CT/PET scans, MRIs)	0% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	

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 need drugs to treat your illness or condition</b> More information about <a href="http://www.express-scripts.com">prescription drug coverage</a> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a>	Generic drugs (Tier 1)	0% <a href="#">coinsurance</a> after <a href="#">deductible</a> (30-day retail)/0% <a href="#">coinsurance</a> after <a href="#">deductible</a> (90-day mail order)	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> (30-day retail)/ Not Covered (90- mail order)	Tier 1, Tier 2 and Tier 3: Covers up to a 30-day supply (retail); 90-day supply (mail order prescription). Not all drugs are covered or have quantity limits. For more info go to <a href="http://www.express-scripts.com">www.express-scripts.com</a> or call 1-866-217-3774.  Please see the "Important Questions" section (page 1) of this document regarding the plan's out-of-pocket limit.
	Preferred brand drugs (Tier 2)	0% <a href="#">coinsurance</a> after <a href="#">deductible</a> (30-day retail)/0% <a href="#">coinsurance</a> after <a href="#">deductible</a> (90-day mail order)	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> (30-day retail)/ Not Covered (90- day mail order)	
	Non-preferred drugs (Tier 3)	0% <a href="#">coinsurance</a> after <a href="#">deductible</a> (30-day retail)/0% <a href="#">coinsurance</a> after <a href="#">deductible</a> (90-day mail order)	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> (30-day retail)/ Not Covered (90- day mail order)	
	Self-Administered Specialty (Tier 4)	Same costs as other generic, preferred brand, and non-preferred brand drugs  Visit <a href="http://www.express-scripts.com">www.express-scripts.com</a>	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	0% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	Prior authorization may be required.
	Physician/surgeon fees	0% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	Prior authorization may be required.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	0% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	-----None-----
	<a href="#">Emergency medical transportation</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	0% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	The member will be responsible for any balance due above Reasonable and Customary Charges for out-of- network air ambulance service.
	<a href="#">Urgent care</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	0% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	-----None-----

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 a hospital stay	Facility fee (e.g., hospital room)	0% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	Prior authorization may be required.
	Physician/surgeon fees	0% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	Prior authorization may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	-----None-----
	Inpatient services	0% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	Prior authorization may be required.
If you are pregnant	Office visits	0% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	-----None-----
	Childbirth/delivery professional services	0% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply.
	Childbirth/delivery facility services	0% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	Prior authorization may be required.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	Prior authorization may be required.
	<a href="#">Rehabilitation services</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	Coverage is limited up to 80 visits combined/calendar year; combined in- and out-if-network. Prior authorization may be required.
	<a href="#">Habilitation services</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	Prior authorization may be required.
	<a href="#">Skilled nursing care</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	Coverage is limited up to 60 days/calendar year. Prior authorization may be required.
	<a href="#">Durable medical equipment</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	Prior authorization may be required.
	<a href="#">Hospice services</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	Prior authorization may be required.

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 your child needs dental check-up or eye care	Children's eye exam	0% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	Not Covered	Coverage is limited to refraction eye exam associated with post cataract surgery or Keratoconus correction.
	Children's glasses	0% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met	Not Covered	Coverage is limited to eyeglasses/contact lenses within 12 months following cataract surgery or the correction of Keratoconus. Prior authorization may be required. Deductible does apply.
	Children's dental check-up	Not covered	Not covered	-----None-----

## Excluded Services and 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>• Infertility Treatment</li></ul>	<ul style="list-style-type: none"><li>• Long-Term Care</li><li>• Non-Emergency Care When Traveling Outside the U.S.</li><li>• Private-Duty Nursing</li></ul>	<ul style="list-style-type: none"><li>• Routine Eye Care (Adult)</li><li>• Routine Foot Care</li><li>• Weight Loss Programs</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 for school aged children</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 [appeal](#). 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 1-855-592-7737.

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)		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	\$2,500	■ The plan's overall deductible	\$2,500	■ The plan's overall deductible	\$2,500
■ Specialist	0%	■ Specialist	0%	■ Specialist	0%
■ Hospital (Facility)	0%	■ Hospital (Facility)	0%	■ Hospital (Facility)	0%
■ Other	0%	■ Other	0%	■ Other	0%
<p><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>)</p>		<p><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>)</p>		<p><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>)</p>	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Peg would pay:</b>		<b>In this example, Joe would pay:</b>		<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$2,500	Deductibles	\$2,500	Deductibles	\$2,500
Copayments	\$0	Copayments	\$0	Copayments	\$0
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$0
<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	\$20	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$2,560</b>	<b>The total Joe would pay is</b>	<b>\$2,520</b>	<b>The total Mia would pay is</b>	<b>\$2,500</b>

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