DETERMINED TO PLAN FOR THE HEALTH OF YOUR EMPLOYEES.

PRESBYTERIAN
Health Plan, Inc.



To help provide your business with more savings and flexibility, we offer level-funded healthcare coverage for employer groups with two to 50 enrolled subscribers. Level-funded products provide a cost-effective option for generally healthy employer groups and offer several coverage options.

Presbyterian Health Plan's level-funded plans offer:

- ***Choices*** – An assortment of plans with a range of monthly premium amounts.
- ***Flexibility*** – Small groups can select up to three plan options for enrollment.
- ***Savings*** – Credit opportunities if total group spend is less than claims funding during the plan year. (The total surplus payable at the end of the contract term will vary by group size. Please contact your account manager with questions.)
- ***Extras*** – Additional ancillary products including gym, vision and dental products.

Product Designs

Choose from 31 level-funded plan options, including traditional HMO, PPO and EPO products as well as cost-efficient Engage products for groups within the Central New Mexico area. All plans include comprehensive medical and pharmacy coverage options, including High Deductible Health Plans (HDHPs), across New Mexico's premier healthcare delivery network.

Level-Funded Plans Have Additional Federal and State Reporting Requirements:

- Patient-Centered Outcomes Research Institute (PCORI) – PCORI fees are calculated based on the average number of plan participants in a given year, and the fee is paid once per year. For information on PCORI fees, visit www.irs.gov/newsroom/patient-centered-outcomes-research-institute-fee.
- Small Group annual IRS 1094-B and 1095-B requirements – Small 2-50 groups with level-funded contracts are required to file 1095-B and 1094-B forms with IRS annually and make available to participants once a year. Presbyterian will assist by generating the 1095-B forms for the period in which the employer had coverage with Presbyterian. The employer will need to file the 1094-B with the IRS. For more information on the 1094-B and 1095-B reporting requirements, visit www.irs.gov/instructions/i109495b.
- New Mexico Vaccines for Children Purchasing Act (VPA) – VPA fees are calculated based on the number of dependents age 18 and younger enrolled on the plan on December 31. Presbyterian can assist with reporting of enrolled individuals to the New Mexico Department of Health annually, and employer groups will be billed directly on a quarterly basis for all dependents subject to the fee. For information on VPA fees, visit www.nmhealth.org/about/phd/idb/imp/vpa.

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PRESBYTERIAN
Health Plan, Inc.

2027 Level-Funded Small Group HMO Overview

HMO Benefits	Platinum Elite $250 w/Gym	Gold Elite $1,000 w/Gym	Gold Elite $2,500 w/Gym	Gold Premier $3,500 w/Gym	Silver $3,500 Advantage HDHP/HSA w/Gym*	Silver Premier $4,000 w/Gym	Bronze Elite $12,000 w/Gym
A **deductible (ded)** is the amount you pay before the plan pays for benefits with coinsurance (%). The family deductible is 2x the individual deductible.	$250 / $500	$1,000 / $2,000	$2,500 / $5,000	$3,500 / $7,000	$3,500 / $7,000	$4,000 / $8,000	$12,000 / $24,000
What do I pay for covered benefits?	**Copayment – Benefits with a copayment ($) are not subject to deductible. Copayment covers office visit ONLY. All other services are subject to deductible and or coinsurance.**** **Coinsurance – Benefits with a coinsurance (%) are subject to deductible first, and then you pay the applicable coinsurance (%) amount.**						
Preventive Care	You pay $0 (In-Network only). Plan pays 100% for Clinical Preventive Health Services such as physical exam, colonoscopy and routine immunizations.						
Primary Care Provider Visit	$20	$40	$40	$40	$40 with ded	$40	$50
Urgent Care	$20	$40	$40	$40	$40 with ded	$40	$50
Virtual Care – Mental Health, Primary Care, Specialist, Urgent Care Visits	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Specialist Visit	$40	$90	$90	$90	$50 with ded	$90	No charge after ded
Mental Health Outpatient Services	No charge	No charge	No charge	No charge	No charge after ded	No charge	No charge
Lab	No charge	No charge	No charge	No charge	$50 with ded	$50	No charge after ded
X-ray	No charge	No charge	No charge	No charge	$50 with ded	$100	No charge after ded
Imaging CT/PET/MRI	$500	$750	$750	$750	20%	$750	No charge after ded
Emergency Room Plans with copay ($) all services are included	$750	$1,200	$750	$1,000	$750 with ded	$1,200	No charge after ded
Ambulance Ground or Air	$250	$250	$250	$250	20%	$250	$250
Hospital Inpatient or Outpatient	20%	20%	20%	20%	20%	30%	**Inpatient:** 50% not subject to ded **Outpatient:** No charge after ded
Chiropractic and Acupuncture Limited to 20 visits each	$20	$40	$40	$40	$40 with ded	$40	$50
Rehabilitation Therapy Physical, Occupational and Speech	$20	$40	$40	$40	$40 with ded	$40	$50
Prescription Drugs per 30-day supply							
Tier 1: Preferred Generic	No charge	No charge	No charge	No charge	No charge after ded	No charge	No charge
Tier 2: Non-Preferred Generic	$5	$5	$5	$5	$15 with ded	$25	$25
Tier 3: Preferred Brand	$15	$15	$15	$15	$50 with ded	$50	$75
Tier 4: Non-Preferred Brand	$100	$100	$100	$100	$100 with ded	$100	$100
Tier 5: Specialty Pharmaceuticals	50%	50%	50%	50%	20%	30%	50%
Out-of-Pocket Maximum includes the deductible, copayments, coinsurance and prescription drug costs that you pay							
The family Out-of-Pocket Maximum is 2x the individual Out-of-Pocket Maximum.	$5,500 / $11,000	$12,000 / $24,000	$10,150 / $20,300	$8,500 / $17,000	$8,000 / $16,000	$12,000 / $24,000	$12,000 / $24,000
Wellness and Other Services							
Fitness Center Membership	You and your enrolled dependents (ages 18 and older) will have free access to more than 10,000 participating fitness centers.						
Vision	Presbyterian Health Plan is pleased to provide you with vision coverage options for your entire family. See flyer for details. (Administered by Davis Vision.)						
Dental	We have partnered with BenefitSource Dental Plan, Inc. to offer dental coverage for you and your family. See the dental flyer for details. (Underwritten and administered by Companion Life Insurance Company.)						

The benefit information provided is a brief summary, not a comprehensive description of benefits, limitations and/or exclusions. For more information, contact the plan at 1-800-356-2219 or refer to the Group Subscriber Agreement and/or Summary of Benefits and Coverage, which can be found online at www.phs.org/formsanddocuments.

***High Deductible Health Plans (HDHP)** - Qualified High Deductible Health Plans can be used with a member-owned, portable Health Savings Account (HSA). Through our partnership with HealthEquity, you can conveniently open an HSA to pay for your insurance deductible and qualified Out-of-Pocket medical expenses tax-free. To learn more, visit **www.healthequity.com** or call **1-866-346-5800**.

** Except for Silver $3,500 Advantage HDHP/HSA w/Gym. Copayments will not apply until the deductible has been met.

Effective: January 1, 2027

PRESBYTERIAN
Health Plan, Inc.

2027 Level-Funded Small Group PPO Overview

PPO Benefits	Platinum Elite $250 w/Gym	Gold Elite $1,000 w/Gym	Gold Elite $2,500 w/Gym	Gold Premier $3,500 w/Gym	Gold Preferred Access $4,000 w/Gym	Silver $3,500 Advantage HDHP/HSA w/Gym*	Silver Premier $4,000 w/Gym	Bronze Elite $12,000 w/Gym
A **deductible (ded)** is the amount you pay before the plan pays for benefits with coinsurance (%). The family deductible is 2x the individual deductible.	$250 / $500	$1,000 / $2,000	$2,500 / $5,000	$3,500 / $7,000	$4,000 / $8,000	$3,500 / $7,000	$4,000 / $8,000	$12,000 / $24,000
Coinsurance	20% / 50%	20% / 50%	20% / 50%	20% / 50%	30% / 30%	20% / 50%	30% / 50%	0% / 0%
What do I pay for covered benefits?	**Copayment – Benefits with a copayment ($) are not subject to deductible. Copayment covers office visit ONLY. All other services are subject to deductible and or coinsurance.**** **Coinsurance – Benefits with a coinsurance (%) are subject to deductible first, and then you pay the applicable coinsurance (%) amount.**							
Preventive Care	You pay $0 (In-Network only). Plan pays 100% for Clinical Preventive Health Services such as physical exam, colonoscopy and routine immunizations.							
Primary Care Provider Visit	$20	$40	$40	$40	$40	$40 with ded	$40	$50
Urgent Care	$20	$40	$40	$40	$40	$40 with ded	$40	$50
Virtual Care – Mental Health, Primary Care, Specialist, Urgent Care Visits	No charge	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Specialist Visit	$40	$90	$90	$90	$90	$50 with ded	$90	No charge after ded
Mental Health Outpatient Services	No charge	No charge	No charge	No charge	No charge	No charge after ded	No charge	No charge
Lab	No charge	No charge	No charge	No charge	No charge	$50 with ded	$50	No charge after ded
X-ray	No charge	No charge	No charge	No charge	$100	$50 with ded	$100	No charge after ded
Imaging CT/PET/MRI	$500	$750	$750	$750	$750	20%	$750	No charge after ded
Emergency Room Plans with copay ($) all services are included	$750	$1,200	$750	$1,000	$1,200	$750 with ded	$1,200	No charge after ded
Ambulance Ground or Air	$250	$250	$250	$250	$250	20%	$250	$250
Hospital Inpatient and Outpatient	20%	20%	20%	20%	30%	20%	30%	**Inpatient:** 50% not subject to ded **Outpatient:** No charge after ded
Chiropractic and Acupuncture Limited to 20 visits each	$20	$40	$40	$40	$40	$40 with ded	$40	$50
Rehabilitation Therapy Physical, Occupational and Speech	$20	$40	$40	$40	$40	$40 with ded	$40	$50
Prescription Drugs per 30-day supply								
Tier 1: Preferred Generic	No charge	No charge	No charge	No charge	No charge	No charge after ded	No charge	No charge
Tier 2: Non-Preferred Generic	$5	$5	$5	$5	$25	$15 with ded	$25	$25
Tier 3: Preferred Brand	$15	$15	$15	$15	$50	$50 with ded	$50	$75
Tier 4: Non-Preferred Brand	$100	$100	$100	$100	$100	$100 with ded	$100	$100
Tier 5: Specialty Pharmaceuticals	50%	50%	50%	50%	30%	20%	30%	50%
Out-of-Pocket Maximum includes the deductible, copayments, coinsurance and prescription drug costs that you pay.								
The family Out-of-Pocket Maximum is 2x the individual Out-of-Pocket Maximum.	$5,500 / $11,000	$12,000 / $24,000	$10,150 / $20,300	$8,500 / $17,000	$7,500 / $15,000	$8,000 / $16,000	$12,000 / $24,000	$12,000 / $24,000
Wellness and Other Services								
Fitness Center Membership	You and your enrolled dependents (ages 18 and older) will have free access to more than 10,000 participating fitness centers.							
Vision	Presbyterian Health Plan is pleased to provide you with vision coverage options for your entire family. See flyer for details. (Administered by Davis Vision.)							
Dental	We have partnered with BenefitSource Dental Plan, Inc. to offer dental coverage for you and your family. See the dental flyer for details. (Underwritten and administered by Companion Life Insurance Company.)							
The benefit information provided is a brief summary, not a comprehensive description of benefits, limitations and/or exclusions. For more information, contact the plan at 1-800-923-6980 or refer to the Group Subscriber Agreement and/or Summary of Benefits and Coverage, which can be found online at www.phs.org/formsanddocuments.								

*__High Deductible Health Plans (HDHP)__ - Qualified High Deductible Health Plans can be used with a member-owned, portable Health Savings Account (HSA). Through our partnership with HealthEquity, you can conveniently open an HSA to pay for your insurance deductible and qualified Out-of-Pocket medical expenses tax-free. To learn more, visit **www.healthequity.com** or call **1-866-346-5800**.

** Except for Silver $3,500 Advantage HDHP/HSA w/Gym. Copayments will not apply until the deductible has been met.

Effective: January 1, 2027

PRESBYTERIAN
Health Plan, Inc.

2027 Level-Funded Small Group Engage Overview

Engage Benefits	Platinum Engage $500 w/Gym with Limited Service Area	Gold Engage $1,500 w/Gym with Limited Service Area	Gold Engage $3,500 w/Gym with Limited Service Area	Gold Virtual Plus Plan Engage $5,000 w/Gym with Limited Service Area	Silver Engage $0 w/Gym with Limited Service Area	Silver Engage $4,000 w/Gym with Limited Service Area	Silver Engage $7,000 w/Gym with Limited Service Area
A **deductible (ded)** is the amount you pay before the plan pays for benefits with coinsurance (%). The family deductible is 2x the individual deductible.	$500 / $1,000	$1,500 / $3,000	$3,500 / $7,000	$5,000 / $10,000	$0 / $0	$4,000 / $8,000	$7,000 / $14,000
What do I pay for covered benefits?	**Copayment-Benefits with a copayment ($) are not subject to deductible. Copayment covers office visit ONLY. All other services are subject to deductible and/or coinsurance. Coinsurance-Benefits with a coinsurance (%) are subject to deductible first, and then you pay the applicable coinsurance (%) amount.**						
Preventive Care	You pay $0 (In-Network only). Plan pays 100% for Clinical Preventive Health Services such as physical exam, colonoscopy and routine immunizations.						
Primary Care Provider Visit	$10	$40	$40	$75 in person or $0 Virtual Care	$50	$40	$40
Urgent Care	$10	$40	$40	$75 in person or $0 Virtual Care	$50	$40	$40
Virtual Care – Mental Health, Primary Care, Specialist, Urgent Care Visits	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Specialist Visit	$40	$90	$90	$100 in person or $0 Virtual Care	$100	$90	$90
Mental Health Outpatient Services	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Lab	No charge	No charge	No charge	No charge	$100	$50	$50
X-ray	No charge	No charge	No charge	$100	$100	$100	$100
Imaging CT/PET/MRI	$500	$500	$500	$500	30%	$900	$500
Emergency Room Plans with copay ($) all services are included	$1,000	$750	$500	$750	$1,850	$900	30%
Ambulance Ground or Air	$250	$250	$250	$250	$250	$250	$250
Hospital Inpatient or Outpatient	20%	20%	20%	30%	$1,500 per day, 2-day max	30%	30%
Chiropractic and Acupuncture Limited to 20 visits each	$10	$40	$40	$50	$50	$40	$40
Rehabilitation Therapy Physical, Occupational and Speech	$10	$40	$40	**PT/OT:** $50 in person No charge with Sword or Bloom **Speech:** $50	$50	$40	$40
Prescription Drugs per 30-day supply							
Tier 1: Preferred Generic	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Tier 2: Non-Preferred Generic	$5	$5	$5	$10	$25	$25	$25
Tier 3: Preferred Brand	$15	$15	$15	$40	$50	$75	$50
Tier 4: Non-Preferred Brand	$100	$100	$100	$75	$125	$150	30%
Tier 5: Specialty Pharmaceuticals	50%	50%	50%	30% up to $500	50%	50%	30%
Out-of-Pocket Maximum includes the deductible, copayments, coinsurance and prescription drug costs that you pay							
The family Out-of-Pocket Maximum is 2x the individual Out-of-Pocket Maximum.	$4,500 / $9,000	$12,000 / $24,000	$12,000 / $24,000	$10,000 / $20,000	$12,000 / $24,000	$12,000 / $24,000	$12,000 / $24,000
Wellness and Other Services							
Fitness Center Membership	You and your enrolled dependents (ages 18 and older) will have free access to more than 10,000 participating fitness centers.						
Vision	Presbyterian Health Plan is pleased to provide you with vision coverage options for your entire family. See flyer for details. (Administered by Davis Vision.)						
Dental	We have partnered with BenefitSource Dental Plan, Inc. to offer dental coverage for you and your family. See the dental flyer for details. (Underwritten and administered by Companion Life Insurance Company.)						

The benefit information provided is a brief summary, not a comprehensive description of benefits, limitations and/or exclusions. For more information, contact the plan at 1-800-356-2219 or refer to the Group Subscriber Agreement and/or Summary of Benefits and Coverage, which can be found online at www.phs.org/formsanddocuments.

Effective: January 1, 2027

PRESBYTERIAN
Health Plan, Inc.

2027 Level-Funded Small Group EPO Overview

EPO Benefits	Platinum Smart Choice EPO $0 w/Gym with Limited Service Area	Gold Smart Choice EPO $0 w/Gym with Limited Service Area	Gold Smart Choice EPO $2,000 w/Gym with Limited Service Area	Gold Smart Choice EPO $3,500 w/Gym with Limited Service Area	Silver Smart Choice EPO $4,000 w/Gym with Limited Service Area
A **deductible (ded)** is the amount you pay before the plan pays for benefits with coinsurance (%). The family deductible is 2x the individual deductible.	$0 /$0	$0 / $0	$2,000 / $4,000	$3,500 / $7,000	$4,000 / $8,000
What do I pay for covered benefits?	**Copayment-Benefits with a copayment ($) are not subject to deductible. Copayment covers office visit ONLY. All other services are subject to deductible and/or coinsurance. Coinsurance-Benefits with a coinsurance (%) are subject to deductible first, and then you pay the applicable coinsurance (%) amount.**				
Preventive Care	You pay $0 (In-Network only). Plan pays 100% for Clinical Preventive Health Services such as physical exam, colonoscopy and routine immunizations.				
Primary Care Provider Visit	$20	$25	$30	$40	$40
Urgent Care	$20	$25	$30	$40	$40
Virtual Care – Mental Health, Primary Care, Specialist, Urgent Care Visits	No charge	No charge	No charge	No charge	No charge
Specialist Visit	$35	$40	$50	$90	$90
Mental Health Outpatient Services	No charge	No charge	No charge	No charge	No charge
Lab	$20	$25	$30	No charge	$50
X-ray	$35	$50	$50	No charge	$100
Imaging CT/PET/MRI	$200	$500	$250	$750	$750
Emergency Room Plans with copay ($) all services are included	$400	$500	$500	$1,000	$1,200
Ambulance Ground or Air	$250	$250	$250	$250	$250
Hospital Inpatient or Outpatient	$1,500	$2,500 per day, 3 day max	30%	20%	30%
Chiropractic and Acupuncture Limited to 20 visits each	$20	$25	$30	$40	$40
Rehabilitation Therapy Physical, Occupational and Speech	$20	$25	$30	$40	$40
Prescription Drugs per 30-day supply					
Tier 1: Preferred Generic	No charge	No charge	No charge	No charge	No charge
Tier 2: Non-Preferred Generic	$10	$30	$10	$5	$25
Tier 3: Preferred Brand	$40	$50	$40	$15	$50
Tier 4: Non-Preferred Brand	$75	$75	$75	$100	$100
Tier 5: Specialty Pharmaceuticals	30%	30% up to $500	30% up to $500	50%	50%
Out-of-Pocket Maximum includes the deductible, copayments, coinsurance and prescription drug costs that you pay					
The family Out-of-Pocket Maximum is 2x the individual Out-of-Pocket Maximum.	$3,000 / $6,000	$12,000 / $24,000	$6,500 / $13,000	$8,500 / $17,000	$12,000 / $24,000
Wellness and Other Services					
Fitness Center Membership	You and your enrolled dependents (ages 18 and older) will have free access to more than 10,000 participating fitness centers.				
Vision	Presbyterian Health Plan is pleased to provide you with vision coverage options for your entire family. See flyer for details. (Administered by Davis Vision.)				
Dental	We have partnered with BenefitSource Dental Plan, Inc. to offer dental coverage for you and your family. See the dental flyer for details. (Underwritten and administered by Companion Life Insurance Company.)				

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Effective: January 1, 2027

PRESBYTERIAN
Health Plan, Inc.

2027 Level-Funded Small Group Wellness Rewards HMO and PPO Overview

Wellness Rewards Benefits	Wellness Rewards w/Gym	Wellness Rewards Plus w/Gym
A **deductible (ded)** is the amount you pay before the plan pays for benefits with coinsurance (%). The family deductible is 2x the individual deductible.	$6,000 / $12,000	$6,000 / $12,000
What do I pay for covered benefits?	**Copayment-Benefits with a copayment ($) are not subject to deductible. Copayment covers office visit ONLY. All other services are subject to deductible and/or coinsurance. Coinsurance-Benefits with a coinsurance (%) are subject to deductible first, and then you pay the applicable coinsurance (%) amount.**	
Preventive Care	You pay $0 (In-Network only). Plan pays 100% for Clinical Preventive Health Services such as physical exam, colonoscopy and routine immunizations.	
Primary Care Provider Visit	$50	$10
Urgent Care	$50	$10
Virtual Care – Mental Health, Primary Care, Specialist, Urgent Care Visits	No Charge	No Charge
Specialist Visit	$90	$40
Mental Health Outpatient Services	No Charge	No Charge
Lab	$50	No Charge
X-ray	$50	$10
Imaging CT/PET/MRI	30%	20%
Emergency Room Plans with copay ($) all services are included	30%	20%
Ambulance Ground or Air	$250	$250
Hospital Inpatient or Outpatient	30%	20%
Chiropractic and Acupuncture Limited to 20 visits each	$50	$10
Rehabilitation Therapy Physical, Occupational and Speech	$50	$10
Prescription Drugs per 30-day supply		
Tier 1: Preferred Generic	No Charge	No Charge
Tier 2: Non-Preferred Generic	$25	$25
Tier 3: Preferred Brand	$50	$50
Tier 4: Non-Preferred Brand	$100	$100
Tier 5: Specialty Pharmaceuticals	50%	50%
Out-of-Pocket Maximum includes the deductible, copayments, coinsurance and prescription drug costs that you pay		
The family Out-of-Pocket Maximum is 2x the individual Out-of-Pocket Maximum.	$9,200 / $18,400	$8,000 / $16,000
Wellness and Other Services		
Fitness Center Membership	You and your enrolled dependents (ages 18 and older) will have free access to more than 10,000 participating fitness centers.	
Vision	Presbyterian Health Plan is pleased to provide you with vision coverage options for your entire family. See flyer for details. (Administered by Davis Vision.)	
Dental	We have partnered with BenefitSource Dental Plan, Inc. to offer dental coverage for you and your family. See the dental flyer for details. (Underwritten and administered by Companion Life Insurance Company.)	

The benefit information provided is a brief summary, not a comprehensive description of benefits, limitations and/or exclusions. For more information, contact the plan at 1-800-356-2219 or refer to the Group Subscriber Agreement and/or Summary of Benefits and Coverage, which can be found online at www.phs.org/formsanddocuments.

Effective: January 1, 2027

HMO	PPO	ENGAGE	EPO
9 plan options available	10 plan options available	7 plan options available	5 plan options available
Coverage within the PHP HMO network only, except for emergency coverage	Coverage in both the PHP PPO network and outside of the PHP PPO network	Coverage within the Engage network of providers	In-state coverage within the Engage network of providers
Over 17,000 providers within NM and surrounding areas	National In-Network coverage within the Aetna Network	PHP's most preferred providers	National In-Network coverage within the Aetna network of providers
		Available to groups within Bernalillo, Sandoval, Torrance, Valencia and Santa Fe Counties	

How Level-Funded Plans Work

Groups enrolled in a small group level-funded plan are quoted a monthly premium that is valid through the life of the annual contract. Premiums include allocations for claims funding, stop-loss coverage and administrative fees.

Claims Funding Premiums – Cover the cost of accrued claims by the group during the current rating period. If a surplus remains at the end of the contract period (claims paid are less than claims funding), Presbyterian Health Plan will credit a percentage (%) of the total surplus to the group following reconciliation. The total surplus payable will vary by group size. Groups are not responsible for accrued costs in excess of the claims funding (claims paid are more than claims funding).

Stop-Loss Coverage – Provides additional protection against high-cost claimants and costs in excess of claims funding in general. Stop-loss coverage is required on all level-funded contracts and must be purchased through Presbyterian Health Plan.

Administrative Fees – Cover all health plan services provided by Presbyterian Health Plan, including but not limited to enrollment administration, claims processing services, case management and account management services.

What Do Level-Funded Plans Include?

Fitness Pass – Members and enrolled dependents (ages 18 and older) have no-cost access to thousands of national, regional and local fitness, recreation and community centers. These facilities include all Defined Fitness locations in Albuquerque, Rio Rancho, Farmington and Santa Fe, as well as the nationwide Prime® Fitness network which includes select YMCA locations, Snap Fitness, Chuze, Curves and more. Discounted rates are also available from Genesis Health Clubs.

EAP Services – This program provides confidential support for complex personal challenges. Learning how to cope with stress at work and at home can improve overall well-being. Members and families living in the same household can get up to three complimentary assistance visits per situation. Services are short-term, confidential counseling sessions conducted by local licensed providers.

Estimate Your Cost of Care – Now members can better evaluate the cost of certain tests and procedures with our new Treatment Cost Estimator. This tool will provide estimates for many covered services and help find more convenient, lower-cost locations to obtain care.

Virtual Care – This no-cost option offers members a way to see a medical provider for non-emergency medical conditions via secure video through a smartphone, tablet or computer webcam. For details, visit www.phs.org/virtualpres.

Vision Products – Presbyterian provides vision coverage options for the entire family for an additional monthly premium.

Dental Products – Presbyterian and BenefitSource partnered to offer six PPO dental coverage options, each offering lower Out-of-Pocket costs when obtaining dental care within the network. Members are also covered when obtaining dental care from non-participating providers. For more information, contact BenefitSource at 1-888-862-8659 or visit www.benefitsource.org.

Presbyterian complies with civil rights laws and does not discriminate on the basis of protected status including but not limited to race, color, national origin, age, disability, or sexual orientation or gender expression. Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-855-592-7737 (TTY: 711) or speak to your provider. ATENCIÓN: Si prefiere hablar español, tiene a su disposición servicios gratuitos de asistencia lingüística. Además, están disponibles de forma gratuita ayuda y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-855-592-7737 (TTY: 711) o hable con su proveedor. SHOOH: Diné bee yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 1-855-592-7737 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih. For more information, visit **https://www.phs.org/nondiscrimination**.