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 including your plan's Plan document, visit www.phs.org or call toll-free 1-888-275-7737. 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 www.healthcare.gov/sbc-glossary or call Presbyterian Health Care Services (PHS) 505-923-5600 or toll free at 1-888-275-7737 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network Preferred Providers per calendar year: **$750**/individual; **$1,500**/family. Non-Preferred Providers per calendar year: **$1,500**/individual; **$3,000**/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, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care, outpatient prescription drugs, emergency room, ambulance transport, dental and the following services performed by in-network preferred providers: office visits (other than behavioral health visits), outpatient x-ray or lab tests, imaging, vision, telehealth, allergy shots, insulin pump supplies, acupuncture, spinal manipulation, cardiac rehab, pulmonary rehab, urgent care facility, chemotherapy, radiation therapy, hospice, and tobacco counseling are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $50/individual, $150/family per year for either the High Option or Low Option Dental plans. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-network Preferred Provider per calendar year: **$4,100**/person; **$8,200**/family. Non-Preferred Provider per calendar year: **$9,500**/person; **$19,000**/family. The out-of-pocket limit on outpatient drugs is the most you pay for covered generic, preferred brand, non-preferred brand & essential health benefit specialty drugs from in-network retail & mail order locations per calendar year and is **$3,000**/person**; $6,000**/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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	For the Medical Plan: Premiums, balance billing charges, health care this plan doesn't cover, a penalty for failure to obtain preauthorization, outpatient retail/mail order drug expenses (which have a separate out-of-pocket limit), certain non-essential specialty pharmacy drugs, and out-of-network deductibles, copayments and coinsurance except an ER visit in cases of an emergency. Outpatient retail/mail order prescription (Rx) drug expenses accumulate to a separate Rx out-of-pocket limit.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. For a list of in-network Preferred providers within the state of New Mexico through Presbyterian Healthcare Services (PHS), see www.phs.org or call Presbyterian at 505-923-5600 or toll-free at 1-888-275-7737. For a list of Preferred providers outside of New Mexico through MultiPlan/PHCS network, see www.multiplan.com or call 505-923-5600 or toll free at 1-888-275-7737.	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). Be aware, your network provider 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 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 Preferred Provider (You will pay the least)	Out-of-Network Non-Preferred Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**$25** copayment/visit. Deductible does not apply.	**40%** coinsurance.	In-network telehealth video visits: No charge. Deductible does not apply. **20%** coinsurance after deductible for in-network office surgery including casts, splints and dressings.
	Specialist visit	**$50** copayment/visit. Deductible does not apply.	**40%** coinsurance.	**20%** coinsurance after deductible for in-network office surgery including casts, splints and dressings.
	Preventive care/screening/ immunization	**No charge**. Deductible does not apply.	**40%** coinsurance. Deductible does not apply.	Plan covers preventive services and supplies required by the Health Reform law. Details at: https://www.healthcare.gov/what-are-my-preventive-care-benefits/. Age and frequency guidelines apply to covered preventive care. 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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Preferred Provider (You will pay the least)	Out-of-Network Non-Preferred Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	Deductible does not apply. **Office/freestanding test**: You pay the lesser of **$30** copayment per day or the Plan's allowed amount and no charge for the test interpretation fee. **Outpatient hospital test:** You pay the lesser of **$60** copayment per day or the Plan's allowed amount and no charge for the test interpretation fee.	**40%** coinsurance.	Coumadin lab (Prothrombin time test): **$10** copayment/test in-network.
	Imaging (CT/PET scans, MRIs)	You pay the lesser of **$600** copayment per day or **20%** of the Plan's allowed amount and no charge for the test interpretation fee. Deductible does not apply.	**40%** coinsurance.	Preauthorization of imaging tests is required to avoid a financial penalty.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at CVS Caremark at www.caremark.com or call 1-877-787-0652.	Generic drugs	**Retail Pharmacy** for 30-day supply: **$10** copayment/prescription. **Mail Order and 90-day Retail** for a 90-day supply: **$22** copayment/prescription. Deductible does not apply. No charge for FDA-approved generic contraceptives.	You pay 100%. Plan reimburses no more than it would have paid had you used an In-Network Retail pharmacy. Deductible does not apply.	More information about prescription drug coverage is available at CVS Caremark at www.caremark.com or call 1-877-787-0652. • No coverage for prescription medication that has an over-the-counter (OTC) equivalent (unless mandated by law to be covered). • If you purchase a brand drug when generic drug is available, you pay the brand drug cost sharing plus the difference in cost between the brand drug and the generic drug. If the cost of the drug is less than the copayment, you pay just the drug cost. • Some prescriptions are subject to preauthorization, quantity limits or step therapy requirements. • Retail and Mail order drugs accumulate to the Outpatient Drug Out-of-Pocket Limit noted on page 1.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Preferred Provider (You will pay the least)	Out-of-Network Non-Preferred Provider (You will pay the most)	
If you need drugs to treat your illness or condition **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.caremark.com or call 1-877-787-0652.	Preferred brand drugs	**Retail Pharmacy** for 30-day supply: **30%** coinsurance with **minimum $30 & maximum $60** per prescription; **Mail Order and 90-day Retail** for 90-day supply: **$60** copayment/prescription. Deductible does not apply. No charge for FDA-approved brand name contraceptives if a generic is medically inappropriate.	You pay 100%. Plan reimburses no more than it would have paid had you used an In-Network Retail pharmacy. Deductible does not apply.	• No coverage for prescription medication that has an over-the-counter (OTC) equivalent (unless mandated by law to be covered). • If you purchase a brand drug when generic drug is available, you pay the brand drug cost sharing plus the difference in cost between the brand drug and the generic drug. • If the cost of the drug is less than the copayment, you pay just the drug cost. • Some prescriptions are subject to preauthorization, quantity limits or step therapy requirements. • Retail and Mail order drugs accumulate to the Outpatient Drug Out-of-Pocket Limit noted on page 1.
	Non-preferred brand drugs	Retail Pharmacy for 30-day supply: **70%** coinsurance; **Mail Order and 90-day Retail** for 90-day supply: **70%** coinsurance. Deductible does not apply.	You pay 100%. Plan reimburses no more than it would have paid had you used an In-Network Retail pharmacy. Deductible does not apply.	
	Specialty drugs	For up to a 30-day supply, you pay a **$55** copayment/prescription (for generic), **$80** copayment/prescription (for preferred) and **$130** copayment/prescription (for non-preferred). Deductible does not apply. No charge for certain non-essential specialty drugs on the PrudentRx Specialty Drug List if you enroll in the program. If the specialty drug is not included on the Specialty Drug List, you will pay 30% coinsurance. If you opt out of PrudentRx, you will pay 30% coinsurance. To enroll, contact PrudentRx at 1-800-578-4403.	You pay 100%. Plan reimburses no more than it would have paid had you used an In-Network Retail pharmacy. Deductible does not apply.	• Specialty drugs require preauthorization by calling CVS Specialty Pharmacy at 1-866-387-2573. For most specialty drugs, the contracted specialty drug mail-order pharmacy is required. • These drugs must be filled via the CVS Specialty Pharmacy. Call 1-866-387-2573. • Specialty drugs that are essential health benefits and obtained from in-network retail and mail order locations accumulate to the Outpatient Drug Out-of-Pocket Limit noted on page 1. • Certain specialty drugs are filled through the PrudentRx program and exclusively dispensed by CVS Specialty Pharmacy. The PrudentRx Specialty Drug list is available at 1-800-578-4403. Non-essential health benefit specialty pharmacy drugs under the PrudentRx program do not accumulate to the Outpatient Drug Out-of-Pocket Limit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**20%** coinsurance.	**40%** coinsurance.	Preauthorization of outpatient surgery is required to avoid a financial penalty.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Preferred Provider (You will pay the least)	Out-of-Network Non-Preferred Provider (You will pay the most)	
	Physician/ surgeon fees	**20%** coinsurance.	**40%** coinsurance.	Preauthorization of outpatient surgery is required to avoid a financial penalty.
If you need immediate medical attention	Emergency room care	**$450** copayment/visit. Deductible does not apply.	**$450** copayment/visit. Deductible does not apply.	Physician/provider's professional fees may be billed separately.
	Emergency medical transportation	**$50** copayment per trip. Deductible does not apply.	**$50** copayment per trip. Deductible does not apply.	Preauthorization required for inter-facility ambulance transport to avoid a financial penalty. If approved, there is no charge.
	Urgent care	**$50** copayment/visit. Deductible does not apply.	**40%** coinsurance.	The copayment includes all services and supplies such as x-ray, lab and physician fees.
If you have a hospital stay	Facility fee (e.g., hospital room)	**20%** coinsurance.	**40%** coinsurance.	Elective hospital admission requires preauthorization to avoid a financial penalty. Copayment waived if re-admitted for same condition within 15 days of discharge.
	Physician/ surgeon fees	**20%** coinsurance.	**40%** coinsurance.	Elective hospital admission requires preauthorization to avoid a financial penalty.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Office visit: No charge**. **Other Outpatient: No charge**.	**40%** coinsurance.	This Plan opted out of compliance with Mental Health Parity Addictions Equity Act. Elective partial hospitalization, day treatment, hospital admission and residential treatment center admission requires preauthorization to avoid non-payment. • Plan covers services related to the diagnosis and treatment of Autism Spectrum Disorder (ASD) regardless of age.
	Inpatient services	**No charge**.	**40%** coinsurance.	
If you are pregnant	Office visits	No charge for preventive services required by the Health Reform law related to prenatal care for all females. Deductible does not apply. For initial office visit, **$25** copayment/visit, deductible does not apply; thereafter, no charge.	**40%** coinsurance.	Cost sharing does not apply for preventive services. There is no charge for services or treatment after initial office visit, including no charge for ultrasound, lab and diagnostic testing for in-network services.
	Childbirth delivery professional services	**20%** coinsurance.	**40%** coinsurance.	Ultrasound payable as a diagnostic test. Preauthorization required to avoid a financial penalty, if hospital stay is longer than 48 hours for vaginal delivery or 96 hours for C-section.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Preferred Provider (You will pay the least)	Out-of-Network Non-Preferred Provider (You will pay the most)	
	Childbirth delivery facility services	**20%** coinsurance.	**40%** coinsurance.	Preauthorization required to avoid a financial penalty, if hospital stay is longer than 48 hours for vaginal delivery or 96 hours for C-section.
If you need help recovering or have other special health needs	Home health care	**20%** coinsurance.	**40%** coinsurance.	Non-preferred provider max benefit 120 visits/calendar year. Preauthorization of home health care is required to avoid a financial penalty.
	Rehabilitation services	**Outpatient visits**: **$25** copayment/visit **up to $250**/year, thereafter no charge for the remaining calendar year. Deductible does not apply. **Inpatient rehab. admit: 20%** coinsurance.	**40%** coinsurance.	Preauthorization of rehabilitation services is required to avoid a financial penalty. After you pay **$250** in copayments for in-network outpatient visits per injury per year, there is no charge for the remaining calendar year. Plan covers services related to the diagnosis and treatment of Autism Spectrum Disorder (ASD) regardless of age.
	Habilitation services	Not covered.	Not covered.	You must pay 100% of these expenses, even in-network.
	Skilled nursing care	**20%** coinsurance.	**40%** coinsurance.	Preauthorization of an admission is required to avoid a financial penalty. Maximum benefit 60 days/calendar yr.
	Durable medical equipment	**20%** coinsurance. No charge for breastfeeding pump & supplies and supplies for insulin pump.	**40%** coinsurance.	Durable medical equipment over $1,000 requires preauthorization to avoid a financial penalty.
	Hospice services	**No charge**. Deductible does not apply.	**40%** coinsurance.	Respite care max benefit is 10 days for each 6-month benefit period; 2 periods per lifetime. Preauthorization required to avoid a financial penalty.
If your child needs dental or eye care	Children's eye exam	**$10** copayment/visit. Deductible does not apply.	Not covered.	These vision expenses are available if you elect a separate Vision plan.
	Children's glasses	**$15** copayment/eyeglasses. Deductible does not apply.	Not covered.	These vision expenses are available if you elect a separate Vision plan. Some types of lenses may be eligible for higher out-of-network provider reimbursement.
	Children's dental check-up	**No charge**. Dental deductible does not apply.	Your coinsurance varies on the dental plan option you elect. Deductible does not apply.	Medical deductible does not apply. These dental expenses are available if you elect a separate Dental plan.

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
- Habilitation services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care

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

- Acupuncture (acupuncture, spinal manipulation/chiropractic, massage therapy and rolfing combined maximum benefit is 30 visits/calendar year.)
- Bariatric surgery
- Chiropractic care (combined with acupuncture above).
- Dental care (Adult) (Child) when you elect a separate Dental plan
- Hearing aids: Under 21 years: No charge up to $2,200/ear thereafter you pay 90% coinsurance in any 36-month period; Age 21 and older: No charge up to $500 thereafter you pay 90% coinsurance in any 36-month period.
- Infertility treatment (limited treatment covered plus testing to determine the cause of infertility and certain surgical treatment procedures).
- Routine eye care (Adult) (Child) when you elect a separate Vision plan
- Weight loss programs (when provided by a Physician, licensed nutritionist or registered dietitian).

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 Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or 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 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 the: **Medical Plan Claims Administrator (Presbyterian Healthcare Services (PHS)), at 505-923-5600 or toll free at 1-888-275-7737** or visit www.phs.org. Additionally, a consumer assistance program can help you file your appeal. You may also contact the NM Office of the Superintendent of Insurance Managed Health Care Bureau at 1-855-427-5674 or by email at mhcb.grievance@state.nm.us . This website lists states with a Consumer Assistance Program: https://www.cms.gov/cciio/resources/consumer-assistance-grants/.

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 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 1-888-275-7737. Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-275-7737.

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** **$750**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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	**$12,700**

In this example, Peg would pay:

Cost sharing	
Deductibles	$750
Copayments	$140
Coinsurance	$1,860
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$2,770**

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

- **The plan's overall deductible** **$750**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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	**$5,600**

In this example, Joe would pay:

Cost sharing	
Deductibles	$0
Copayments	$770
Coinsurance	$780
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,550**

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

- **The plan's overall deductible** **$750**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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	**$2,800**

In this example, Mia would pay:

Cost sharing	
Deductibles	$630
Copayments	$870
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,500**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.