This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.phs.org. or by calling 1-855-593-7737.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$325 Single / $650 Two-person / $975 Family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
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.
Is there an out–of–pocket limit on my expenses?	Yes. $3500 Single/$7000 Two-person/$10500 Family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the costs of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed 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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers ?	Yes. See **www.phs.org or call 1-888-275-7737** for a list of **participating providers**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist ?	No. You do not need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit Video Visit-No Charge.	Not covered	Not subject to deductible.
	Specialist visit	$40 copay/visit	Not covered	Not subject to deductible.
	Other practitioner office visit	$40 copay/visit for acupuncture, chiropractor and naprapathy	Not covered	acupuncture/chiropractor is limited to 25 visits per Calendar Year combined. Naprapathy limited to $500 per Calendar Year. Not subject to deductible.
	Preventive care/screening/immunization	No charge	Not covered	Not subject to deductible.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered	----------None----------
	Imaging (CT/PET scans, MRIs)	20% coinsurance up to a max of $200 per test/per day	Not covered	Prior Authorization may be required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.phs.org/tools-resources/member/Pages/forms-and-documents.aspx.	Generic Drugs	$5 copay (retail) / $15 copay (mail order)	Not Covered	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription)
	Preferred brand drugs	30% coinsurance ($30 minimum up to $90) (retail) / $95 copay (mail order)	Not Covered	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription)
	Non-preferred drugs	40% coinsurance ($55 minimum up to $125) (retail) / $125 copay (mail order)	Not Covered	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription)
	Specialty drugs	$60 Generic $85 Preferred Brand $125 Non-Preferred	Not covered	----------None----------

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	----------None----------
	Physician/surgeon fees	20% coinsurance	Not covered	Facility claim only
If you need immediate medical attention	Emergency room services	$175 copay/visit	$175 copay/visit	Waived if admitted into a hospital, then hospital copay applies.
	Emergency medical transportation	$30 copay/trip ground; $100 copay/trip air	$30 copay/trip ground; $100 copay/trip air	----------None----------
	Urgent care	$50 copay/visit	$50 copay/visit	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/admission	Not covered	Prior authorization may be required.
	Physician/surgeon fee	No change	Not covered	Prior authorization may be required.
If you have mental health, behavioral health, or substance abuse needs	Mental Behavioral Health Outpatient Services	$25 copay/visit	Not covered	----------None----------
	Mental Behavioral Health Inpatient Services	$500 copay/admission	Not covered	Prior authorization may be required.
	Substance use disorder outpatient services	$25 copay/visit	Not covered	----------None----------
	Substance use disorder inpatient services	$500 copay/admission	Not covered	Prior authorization may be required.
If you are pregnant	Prenatal and postnatal care	$25 copay initial visit	Not covered	No Charge for all other visits after the initial copay.
	Delivery and all inpatient services	$500 copay/pregnancy	Not covered	Prior authorization may be required.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	$40 copay/physician services	Not covered	No charge for nursing services. Not subject to deductible. Prior authorization may be required.
	Rehabilitation services	Inpatient: $500 copay/admission; Outpatient: $40 copay/visit	Not covered	Office visit Not subject to deductible. Prior authorization may be required.
	Habilitation services	$40 copay/visit	Not covered	Prior authorization may be required.
	Skilled nursing care	$500 copay/admission	Not covered	Admission copay waived if readmitted within 15 days. Prior authorization may be required.
	Durable medical equipment	20% coinsurance	Not covered	Hearing Aids- plan pays 100% up to a max of $2,500 per hearing impaired ear every 36 months. Prior authorization may be required.
	Hospice service	No charge	Not covered	Not subject to deductible. Prior authorization may be required.
If your child needs dental or eye care	Eye exam	20% Coinsurance	Not covered	Coverage is limited to refraction eye exam associated with post cataract surgery or Keratoconus correction.
	Glasses	20% Coinsurance	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.
	Dental check up	Not covered	Not covered	----------None----------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic Surgery
- Dental Care (Adult)
- Dental check-up (Child)
- Eye exam (Child)
- Glasses (Child)
- Infertility Treatment (Only limited services covered)
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Private-Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs (Morbid obesity treatment only)

Excluded Services & Other Covered Services:

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-275-7737. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: 1-855-593-7737.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

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, kwiijigo holne' 1-888-275-7737.

----------To see examples of how this plan might cover costs for a sample medical situation, see the next page.----------

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $6390**
- **Patient pays $1150**

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	$7,540

Patient pays:

Deductibles	$330
Co-pays	$530
Coinsurance	$120
Limits or exclusions	$170
Total	$1150

Managing type 2 diabetes
(routine maintenance of (a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan pays $1680**
- **Patient pays $3720**

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	$5,400

Patient pays:

Deductibles	$320
Co-pays	$250
Coinsurance	$220
Limits or exclusions	$2930
Total	$3720

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Questions and answers about the Coverage Examples:

- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Notice of Nondiscrimination and Accessibility

Discrimination is Against the Law

Presbyterian Healthcare Services complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Presbyterian Healthcare Services does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Presbyterian Healthcare Services:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Presbyterian Customer Service Center at 505- 923-5420, 1-855-592-7737, TTY 711.

If you believe that Presbyterian Healthcare Services has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance. You can file a grievance in person, or by mail, fax, or email. If you need help filing a grievance, the Privacy Officer and Civil Rights Coordinator is available to help you.

Presbyterian Privacy Officer and Civil Rights Coordinator
P.O. Box 27489
Albuquerque, NM 87125

Phone: 866-977-3021, TTY 711
Fax: 505-923-5124
Email: info@phs.org

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal. hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201

Phone: 1-800-868-1019, 800-537-7697 (TDD)
Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

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Multi-Language Interpreter Services

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 505-923-5420, 1-855-592-7737 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 505-923-5420, 1-855-592-7737 (TTY: 711).
Navajo	Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 505-923-5420, 1-855-592-7737 (TTY: 711).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 505-923-5420, 1-855-592-7737 (TTY: 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 505-923-5420, 1-855-592-7737 (TTY: 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 505-923-5420, 1-855-592-7737 (TTY: 711)。
Arabic	اذكر لل غة، فإن خدمات لل مس اعدة لل لغوية تتوافر لك بل مجان. اتصل برقم (TTY:711), 505-923-5420 1-855-592-7737 رقم هاتف لل صم ول بكم. ملحوظة: إذا كنت تتحدث
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 505-923-5420, 1-855-592-7737 (TTY: 711)번으로 전화해 주십시오.
Tagalog-Filipino	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 505-923-5420, 1-855-592-7737 (TTY: 711).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 505-923-5420, 1-855-592-7737 (TTY: 711) まで、お電話にてご連絡ください。
French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 505-923-5420, 1-855-592-7737 (ATS : 711).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 505-923-5420, 1-855-592-7737 (TTY: 711).
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 505-923-5420, 1-855-592-7737 (телетайп: 711).
Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 505-923-5420, 1-855-592-7737 (TTY: 711) पर कॉल करें।
Farsi	**توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 505-923-5420 1-855-592-7737 (TTY:711) تماس بگیرید.
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 505-923-5420, 1-855-592-7737 (TTY: 711).

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