Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
City of Rio Rancho: Copay Plan

Coverage Period: 07/01/2025 – 06/30/2026
Coverage for: Individual/Family | Plan Type: PPO

⚠️ **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 1-800-432-0750 or at www.bcbsnm.com. 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 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Preferred provider: $0 Individual / $0 Two-Person / $0 Family Non-preferred provider: $300 Individual / $600 Two-Person / $900 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. Services that charge a copay, prescription drugs, diagnostic tests, and certain preventive care 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 www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Preferred provider: $1,000 Individual / $2,000 Two-Person / $3,000 Family Non-preferred provider: $3,500 Individual / $7,000 Two-Person / $10,500 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 limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Prescription drug copayments, premiums, penalty amounts, balance-billing charges, and health care this plan doesn't cover.	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 www.bcbsnm.com or call 1-800-432-0750 for a list of preferred 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). 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
		Preferred Provider (You will pay the least)	**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	$20 copay/visit adult $10 copay/visit child	30% coinsurance	Virtual visits are available, please refer to your plan policy for more details.
	Specialist visit	$40 copay/visit	30% coinsurance	None
	Preventive care/screening/immunization	No Charge	30% coinsurance	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	Diagnostic test (x-ray, blood work)	No Charge	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	$100 copay/test	30% coinsurance	Preauthorization may be required; see your benefit booklet* for details.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 1-800-232-6549	Generic drugs	$5 copay (30 day retail)/ $10 copay (90 day mail order)	$5 copay (30 day retail / Not Covered (90 day mail order)	Generic, Preferred, and Nonpreferred: Covers up to a 30 day supply (retail) or 90 day supply (mail order). Not all drugs are covered or have quantity limits. For more information, go to www.expresscripts.com or call 1-800-232-6549. Please see the "Important Questions" section (Page 1sss) of this document regarding the plan's out of pocket limit.
	Preferred brand drugs	$35 copay (30 day retail)/ $87.50 copay (90 day mail order)	$35 copay (30 day retail / Not Covered (90 day mail order)	
	Non-preferred brand drugs	$55 copay (30 day retail) / $137.50 copay (90 day mail order)	$55 copay (30 day retail / Not Covered (90 day mail order)	
	Specialty drugs	Same cost as other generic, preferred brand, and non-preferred bran drugs.	Not Covered	

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsnm.com.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-preferred Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay/admit	30% coinsurance	None
	Physician/surgeon fees	No Charge	30% coinsurance	None
If you need immediate medical attention	Emergency room care	Facility Charges: $100 copay/visit ER Physician Charges: No Charge	Facility Charges: $100 copay/visit ER Physician Charges: No Charge	Copay waived if admitted.
	Emergency medical transportation	$50 copay/trip ground $100 copay/trip air	$50 copay/trip ground $100 copay/trip air	Non-emergency transportation 30% coinsurance.
	Urgent care	$40 copay/visit	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/admit	30% coinsurance	Requires preauthorization.
	Physician/surgeon fees	No Charge	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay adult/$10 copay children office visit only 20% coinsurance for other outpatient services	30% coinsurance	Preauthorization may be required; see your benefit booklet* for details.
	Inpatient services	$500 copay/admit	30% coinsurance	
If you are pregnant	Office visits	$20 adult/$10 children/ $40 copay/visit	30% coinsurance	Copay charged for initial visit only. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No Charge	30% coinsurance	
	Childbirth/delivery facility services	$500 copay/admit	30% coinsurance	Requires preauthorization.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsnm.com.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-preferred Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	$40 copay/visit	30% coinsurance	None
	Rehabilitation services	$40 copay/visit	30% coinsurance	Includes physical, occupational, and speech therapies (office/outpatient). Limited to 80 visits per year. $20 copay applies to cardiac and pulmonary rehabilitation.
	Habilitation services	$40 copay/visit	30% coinsurance	
	Skilled nursing care	$500 copay/admit	30% coinsurance	Limited to 60 days per year. Requires preauthorization.
	Durable medical equipment	30% coinsurance	50% coinsurance	None
	Hospice services	$500 copay/admit	30% coinsurance	No Charge for home hospice.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	If vision coverage purchased, see your vision plan information.
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	If dental coverage purchased, see your dental plan information.

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	• Long term care	• Routine eye care (Adult)
• Dental care (Adult)	• Private-duty nursing	• Routine foot care (unless you are diabetic)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (20 visits per year)	• Hearing aids (1 hearing aid per hearing impaired ear every 3 years)	• Non-emergency care when traveling outside the U.S.
• Bariatric surgery		• Weight loss programs
• Chiropractic care (20 visits per year)	• Infertility treatment (unless for medical condition causing the infertility)	

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsnm.com.

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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 plan at 1-800-432-0750, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or 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 or the New Mexico State-Based Exchange BeWellnm at www.BeWellnm.com. 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 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: Blue Cross and Blue Shield of New Mexico (BCBSNM) Appeals Unit at 1-800-205-9926 or visit www.bcbsnm.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the New Mexico Superintendent of Insurance toll-free at 1-855-427-5674 or www.osi.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 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 1-800-432-0750.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-432-0750.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-432-0750.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-432-0750.

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 $0 ◼ Specialist copayment $40 ◼ Hospital (facility) copayment $500 ◼ Other coinsurance 30%	◼ The plan's overall deductible $0 ◼ Specialist copayment $40 ◼ Hospital (facility) copayment $500 ◼ Other coinsurance 30%	◼ The plan's overall deductible $0 ◼ Specialist copayment $40 ◼ Hospital (facility) copayment $500 ◼ Other coinsurance 30%
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*)	**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*)	**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	$12,700

Total Example Cost	$5,600

Total Example Cost	$2,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$760**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,020**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$600
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$670**

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

Health care coverage is important for everyone.

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984. We provide free communication aids and services for anyone with a disability or who needs language assistance.

We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability. If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator	Phone:	855-664-7270 (voicemail)
300 E. Randolph St., 35th Floor	TTY/TDD:	855-661-6965
Chicago, IL 60601	Fax:	855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building 1019	Complaint Portal:	https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Washington, DC 20201	Complaint Forms:	https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

	To receive language or communication assistance free of charge, please call us at 855-710-6984.
Español	Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo.
العربية	لتلقي المساعدة اللغوية أو التواصل مجانًا، يرجى الاتصال بنا على الرقم 855-710-6984.
繁體中文	如欲獲得免費語言或溝通協助，請撥打855-710-6984與我們聯絡。
Français	Pour bénéficier gratuitement d'une assistance linguistique ou d'une aide à la communication, veuillez nous appeler au 855-710-6984.
Deutsch	Um kostenlose Sprach- oder Kommunikationshilfe zu erhalten, rufen Sie uns bitte unter 855-710-6984 an.
ગુજરાતી	ભાષા અથવા સંચાર સહાય મફતમાં મેળવવા માટે, કૃપા કરીને અમને 855-710-6984 પર કૉલ કરો.
हिंदी	निःशुल्क भाषा या संचार सहायता प्राप्त करने के लिए, कृपया हमें 855-710-6984 पर कॉल करें।
Italiano	Per assistenza gratuita alla lingua o alla comunicazione, chiami il numero 855-710-6984.
한국어	언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요.
Navajo	Niná: Doo bilagáana bizaad dinits'á'góó, shá ata' hodooni nínízingo, t'áájíík'eh bee náhaz'á. 1-866-560-4042 jį' hodíilni.
فارسی	برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید.
Polski	Aby uzyskać bezpłatną pomoc językową lub komunikacyjną, prosimy o kontakt pod numerem 855-710-6984.
Русский	Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984.
Tagalog	Para makatanggap ng tulong sa wika o komunikasyon nang walang bayad, pakitawagan kami sa 855-710-6984.
اردو	مفت میں زبان یا مواصلت کی مدد موصول کرنے کے لیے، براو کرم ہمیں 855-710-6984 پر کال کریں۔
Tiếng Việt	Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984.

PRESBYTERIAN **City of Rio Rancho Copay Plan**

Coverage for: Individual or Family | **Plan Type:** POS

⚠️ **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 for Medical and 1-800-232-6549 or visit 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 deductible?	In-network **$0** Out-of-network **$300** Individual **$600** Double **$900** Family	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. preventive care is covered before you meet your deductible.	This plan covers some items and 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network **$1,000** Individual **$2,000** Double **$3,000** Family. Out-of-network **$3,500** Individual **$7,000** Double **$10,500** 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_directory?insurance_plans=AHPH or call 1-877-752-4164** 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.

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⚠	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 provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment/visit - adult /$10 copayment/visit -child	30% coinsurance after deductible is met. Video visits-deductible may apply and coinsurance	$0 copayment for virtual visits apply only to Online Visits and TalkSpace Behavioral Health.
	Specialist visit	$40 copayment/visit	30% coinsurance after deductible is met	--------------None---------------
	Preventive care/screening/immunization	No charge	30% coinsurance after deductible 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	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance after deductible is met	Prior authorization may be required.
	Imaging (CT/PET scans, MRIs)	$100 copayment/test per day	30% coinsurance after deductible is met	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scrpits.com	Generic drugs (Tier 1)	$5 copayment (30-day retail)/ $10 copayment (90-day mail order)	$5 copayment (30-day retail)/ Not Covered (90-day 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 www.express-scripts.com or call 1-866-217- 3774.
	Preferred brand drugs (Tier 2)	$35 copayment (30-day retail) /$87.50 copayment (90-day mail order)	$35 copayment (30-day retail)/ Not Covered (90-day mail order)	
	Non-preferred drugs (Tier 3)	$55 copayment (30-day retail) /$137.50 copayment (90-day mail order)	$55 copayment (30-day retail)/ Not Covered (90-day mail order)	
	Self-Administered Specialty (Tier 4)	Same cost as other generic, preferred brand, and non-preferred brand drugs Visit www.express-scripts.com	Not Covered	Please see the "Important Questions" section (page 1) of this document regarding the plan's out-of-pocket limit.

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)	$250 copayment	30% coinsurance after deductible is met	Prior authorization may be required.
	Physician/surgeon fees	No charge	30% coinsurance after deductible is met	Prior authorization may be required.
If you need immediate medical attention	Emergency room care	$100 copayment/visit	$100 copayment initial visit	Out-of-network follow-up Deductible does apply and 30% coinsurance.
	Emergency medical transportation	$50 copayment/occurrence ground; $100 copayment/occurrence air	$50 copayment/occurrence ground; $100 copayment/occurrence air	The member will be responsible for any balance due above Reasonable and Customary Charges for out-of-network air ambulance service.
	Urgent care	$40 copayment/visit	$40 copayment/visit	--------------None---------------
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copayment/admission	30% coinsurance after deductible is met	Prior authorization may be required.
	Physician/surgeon fees	No charge	30% coinsurance after deductible is met	Prior authorization may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copayment/visit - adult /$10 copayment/visit -child	30% coinsurance after deductible is met	--------------None---------------
	Inpatient services	$500 copayment/admission	30% coinsurance after deductible is met	Prior authorization may be required.
If you are pregnant	Office visits	$20 copayment/visit up to a maximum of $200/pregnancy	30% coinsurance after deductible is met	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	All delivery services are included	30% coinsurance after deductible is met	All services included.
	Childbirth/delivery facility services	$500 copayment/admission	30% coinsurance after deductible 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 you need help recovering or have other special health needs	Home health care	$40 copayment	30% coinsurance after deductible is met; 20% penalty applies if prior authorization not obtained.	Prior authorization may be required.
	Rehabilitation services	Inpatient: $500 copayment/admission; Outpatient: $40 copayment/visit	30% coinsurance after deductible is met; 20% penalty applies if prior authorization not obtained.	Coverage is limited to 80 visits/calendar year combined in- and out-of-network. Prior authorization may be required.
	Habilitation services	Inpatient: $500 copayment/admission; Outpatient: $40 copayment/visit	30% coinsurance after deductible is met; 20% penalty applies if prior authorization not obtained.	--------------None---------------
	Skilled nursing care	$500 copayment/admission	30% coinsurance after deductible is met; 20% penalty applies if prior authorization not obtained.	Coverage is limited to 60 days/calendar year combined in- and out-of-network. Prior authorization may be required.
	Durable medical equipment	30% coinsurance	50% coinsurance after deductible is met; 20% penalty applies if prior authorization not obtained.	Prior authorization may be required.
	Hospice services	No Charge	30% coinsurance after deductible is met	Waived if transferred directly from an inpatient hospital, rehabilitation, or skilled nursing facility. Prior authorization may be required
If your child needs dental check-up or eye care	Children's eye exam	Included in office visit copayment	Not covered	Coverage is limited to refraction eye exam associated with post cataract surgery or Keratoconus correction
	Children's glasses	50% coinsurance after deductible is met	Not covered	Coverage is limited to eyeglasses/contact lenses within 12 months following cataract surgery, correction of Keratoconus or when related to Genetic Inborn Errors of Metabolism. Prior authorization may be required.
	Children's dental check-up	Included in office visit copayment	Not covered	--------------None---------------

Excluded Services and 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	• Non-Emergency Care When Traveling Outside the U.S.	• Routine Foot Care * Only covered when medically necessary for diabetes. See SPD for details.
• Dental Care (Adult)	• Private-Duty Nursing	• Weight Loss Programs
• Long-Term Care	• Routine Eye Care (Adult)	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Chiropractic Care	• Infertility Treatment
• Bariatric Surgery	• Hearing Aids for school aged children	

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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. 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.

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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** $0	■ **The plan's overall deductible** $0	■ **The plan's overall deductible** $0
■ **Specialist** $40	■ **Specialist** $40	■ **Specialist** $40
■ **Hospital (Facility)** $500	■ **Hospital (Facility)** $500	■ **Hospital (Facility)** $500
■ **Other** No Charge	■ **Other** No Charge	■ **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*)	**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*)	**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 $12,700	**Total Example Cost** $5,600	**Total Example Cost** $2,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$760**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$900
Coinsurance	$90
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$570**

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

⚠ PRESBYTERIAN   City of Rio Rancho HDHP FAM

Coverage for: Individual or Family | **Plan Type:** PPO

⚠ 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 for medical and call 1-800-232-6549 or visit 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 deductible?	In-Network: **$2,500**/Individual / **$5,000**/Family Out-of-Network: **$5,000**/Individual / **$10,000**/Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. preventive care is covered before you meet your deductible.	This plan covers some items and 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In Network: **$2,500**/ Individual / **$5,000**/ Family Out of Network: **$10,000** /Individual / **$20,000**/ 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_directory?insurance_plans=AHPH or call 1-877-752-4164** 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.

HWP20010_PNO10061

> ⚠️ 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 provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance after deductible is met	30% coinsurance after deductible is met. Video visits: Deductible may apply and coinsurance	--------------None--------------
	Specialist visit	0% coinsurance after deductible is met	30% coinsurance after deductible is met	--------------None--------------
	Preventive care/screening/immunization	No charge	30% coinsurance after deductible 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	Diagnostic test (x-ray, blood work)	0% coinsurance after deductible is met	30% coinsurance after deductible is met	Prior authorization may be required.
	Imaging (CT/PET scans, MRIs)	0% coinsurance after deductible is met	30% coinsurance after deductible 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)	
If you need drugs to treat your illness or condition More information about [prescription drug coverage](#) is available at [www.express-scripts.com](#)	Generic drugs (Tier 1)	0% [coinsurance](#) after [deductible](#) (30-day retail)/0% [coinsurance](#) after [deductible](#) (90-day mail order)	30% [coinsurance](#) after [deductible](#) (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 [www.express-scripts.com](#) or call 1-866-217-3774.
	Preferred brand drugs (Tier 2)	0% [coinsurance](#) after [deductible](#) (30-day retail)/0% [coinsurance](#) after [deductible](#) (90-day mail order)	30% [coinsurance](#) after [deductible](#) (30-day retail)/ Not Covered (90- day mail order)	
	Non-preferred drugs (Tier 3)	0% [coinsurance](#) after [deductible](#) (30-day retail)/0% [coinsurance](#) after [deductible](#) (90-day mail order)	30% [coinsurance](#) after [deductible](#) (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 www.express-scripts.com	Not Covered	Please see the "Important Questions" section (page 1) of this document regarding the plan's out-of-pocket limit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% [coinsurance](#) after [deductible](#) is met	30% [coinsurance](#) after [deductible](#) is met	Prior authorization may be required.
	Physician/surgeon fees	0% [coinsurance](#) after [deductible](#) is met	30% [coinsurance](#) after [deductible](#) is met	Prior authorization may be required.
If you need immediate medical attention	[Emergency room care](#)	0% [coinsurance](#) after [deductible](#) is met	0% [coinsurance](#) after [deductible](#) is met	--------------None---------------
	[Emergency medical transportation](#)	0% [coinsurance](#) after [deductible](#) is met	0% [coinsurance](#) after [deductible](#) is met	The member will be responsible for any balance due above Reasonable and Customary Charges for out-of- network air ambulance service.
	[Urgent care](#)	0% [coinsurance](#) after [deductible](#) is met	0% [coinsurance](#) after [deductible](#) 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% coinsurance after deductible is met	30% coinsurance after deductible is met	Prior authorization may be required.
	Physician/surgeon fees	0% coinsurance after deductible is met	30% coinsurance after deductible is met	Prior authorization may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance after deductible is met	30% coinsurance after deductible is met	--------------None---------------
	Inpatient services	0% coinsurance after deductible is met	30% coinsurance after deductible is met	Prior authorization may be required.
If you are pregnant	Office visits	0% coinsurance after deductible is met	30% coinsurance after deductible is met	--------------None---------------
	Childbirth/delivery professional services	0% coinsurance after deductible is met	30% coinsurance after deductible is met	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery facility services	0% coinsurance after deductible is met	30% coinsurance after deductible is met	Prior authorization may be required.
If you need help recovering or have other special health needs	Home health care	0% coinsurance after deductible is met	30% coinsurance after deductible is met	Prior authorization may be required.
	Rehabilitation services	0% coinsurance after deductible is met	30% coinsurance after deductible is met	Coverage is limited up to 80 visits combined/calendar year; combined in- and out-if-network. Prior authorization may be required.
	Habilitation services	0% coinsurance after deductible is met	30% coinsurance after deductible is met	Prior authorization may be required.
	Skilled nursing care	0% coinsurance after deductible is met	30% coinsurance after deductible is met	Coverage is limited up to 60 days/calendar year. Prior authorization may be required.
	Durable medical equipment	0% coinsurance after deductible is met	30% coinsurance after deductible is met	Prior authorization may be required.
	Hospice services	0% coinsurance after deductible is met	30% coinsurance after deductible 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% coinsurance after deductible is met	Not Covered	Coverage is limited to refraction eye exam associated with post cataract surgery or Keratoconus correction.
	Children's glasses	0% coinsurance after deductible 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 **Plan** Generally Does NOT Cover (Check your policy or **plan** document for more information and a list of any other **excluded services**.)		
• Cosmetic Surgery	• Long-Term Care	• Routine Eye Care (Adult)
• Dental Care (Adult)	• Non-Emergency Care When Traveling Outside the U.S.	• Routine Foot Care
• Dental check-up (Child)	• Private-Duty Nursing	• Weight Loss Programs
• Infertility Treatment		

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 for school aged children
• Bariatric Surgery		

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■ 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%

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*)

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*)

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	**$12,700**	**Total Example Cost**	**$5,600**	**Total Example Cost**	**$2,800**

In this example, Peg would pay:

In this example, Joe would pay:

In this example, Mia would pay:

Cost Sharing		*Cost Sharing*		*Cost Sharing*	
Deductibles	$2,500	Deductibles	$2,500	Deductibles	$2,500
Copayments	$0	Copayments	$0	Copayments	$0
Coinsurance	$0	Coinsurance	$0	Coinsurance	$0
What isn't covered		*What isn't covered*		*What isn't covered*	
Limits or exclusions	$60	Limits or exclusions	$20	Limits or exclusions	$0
The total Peg would pay is	**$2,560**	**The total Joe would pay is**	**$2,520**	**The total Mia would pay is**	**$2,500**

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