2026-2027 BENEFITS SUMMARIES BOOK

PMS
PRESBYTERIAN MEDICAL SERVICES

Our purpose is you.

HUMAN RESOURCES
1422 Paseo de Peralta
Santa Fe, NM 87501
505-443-1125
benefits@pmsnm.org

WHAT'S INSIDE

This Benefits Plan Summaries book contains the summaries of the medical, dental, vision, and supplemental benefits plans.

The benefits summaries give you a brief overview of the benefits available under the different plans that PMS offers to benefits-eligible employees

Please read these summaries prior to enrolling in coverage.

Visit the benefits website at mybensite.com/pmsnm for additional information regarding these benefits.

HUMAN RESOURCES BENEFITS ADMINISTRATION

1422 Paseo de Peralta · Santa Fe, NM · 87501 · 505-443-1125 · benefits@pmsnm.org

Presbyterian Medical Services

(PMS) Plan Highlights – CDHP + HRA Plan
Effective 04/01/26 – 03/31/27

Administered by:
BlueCross BlueShield of New Mexico

Highlights the deductible, health reimbursement account limit amounts, out-of-pocket limit amounts, member coinsurance percentages and prescription drug copayment amounts of the PMS CDHP + HRA Plan.

PMS CDHP + HRA Plan Benefits – There is no lifetime maximum benefit. However, certain services have maximum annual limits. See below.	**Member's Share of Covered Charges**		
	PMS[1]	**Preferred Provider[1]**	**Nonpreferred Provider[1]**
Calendar Year Deductible (per individual)[1] (Family deductible may be met by two or more family members.)	$1,000 Individual $2,000 Family	$2,000 Individual $4,000 Family	
Health Reimbursement Account (HRA) – Used to offset the deductible, the HRA covers a portion of the deductible. Once the HRA is exhausted, the remainder of the deductible and coinsurance will apply. Limited to a 2-year cap.	$500 Individual $1,000 Family		
Calendar Year Out-of-Pocket Limit: (Includes deductible, coinsurance, and prescription drug copayments only; Not penalty amounts, or non-covered charges.) Family limit may be met by two or more family members.[2]	$7,350 Individual $14,700 Family		$14,700 Individual $29,400 Family
Primary Preferred Provider* Office Visit and initial office visit to diagnose pregnancy	10%	20%	40%
Virtual Visit (MDLIVE)	N/A	No Charge	No Benefit
Mental Health and Chemical Dependency (outpatient/office visit)	No Charge	No Charge	40%
Specialist Office Visit and initial office visit to diagnose pregnancy	10%	20%	40%
Office Surgery (including casts, splints, and dressings)	10%	20%	40%
Allergy Injections, Tests, Serum	10%	20%	40%
Preventive Services Routine Adult Physicals and Gynecological Exams, Well-Child Care; Routine Vision or Hearing Screenings, Related Testing (includes routine Pap tests, cholesterol tests, urinalysis, etc.), Routine Colonoscopies (outpatient/office), Smoking/Tobacco Cessation Counseling, and Immunizations	No Charge		No Benefit
Acupuncture Treatment (max. **20 visits**/calendar year)	N/A	20%	40%
Ambulance Services: Ground and Emergency Air Transport	N/A	20%	
Ambulance Services: Nonemergency Air Transfer	N/A	20%[4]	40%[4]
Autism Spectrum Disorders Applied Behavior Analysis	10%[4]	20%[4]	40%[4]
Cardiac and Pulmonary Rehabilitation	N/A	20%	No Benefit
Dental/Facial Accident, Oral Surgery, and TMJ/CMJ Services	N/A	20%	40%
Emergency Room/Observation Room Treatment	N/A	20%[3]	
Hearing Aids and Related Services: Hearing aids for members under age 21 are paid at 100% of covered charges up to a maximum of **1 hearing aid per hearing-impaired ear every 3 years**; exams and testing are subject to usual cost-sharing provisions. These services are not covered for members age 21 and older.			
Home Health Care/Home I.V. Services (max. **100 visits**/year)	N/A	20%	40%
Hospice Services	N/A	20%[4,5]	40%[4,5]
Lab, X-Ray, and Other Basic Diagnostic Tests (non-routine)	10%	20%	40%
MRI, CT Scans, PET Scans	N/A	20%[4]	40%[4]

*A Primary Preferred Provider is a physician or other professional provider in one of the following categories of practice: Family or General Practice, Internal Medicine, Pediatrics, Obstetrics and Gynecology, and Gynecology Only. A "PPP" is a Primary Preferred Provider in the Preferred Provider network.

PMS CDHP + HRA Plan Benefits – There is no lifetime maximum benefit. However, certain services have maximum annual limits. See below.	**Member's Share of Covered Charges**		
	PMS[1]	**Preferred Provider[1]**	**Nonpreferred Provider[1]**
Inpatient Hospital/Facility Services (See "Short-Term Rehabilitation" for physical rehabilitation and skilled nursing facility admissions and "Transplant Services," if applicable.)			
Medical/Surgical, Maternity-Related Room and Board, and Covered Ancillaries	N/A	20%[5]	40%[5]
Mental Health/Chemical Dependency, (including Partial Hospitalization), Residential Treatment Facility (RTC)		No Charge[5]	
Maternity Services (also see "Inpatient Hospital/Facility Services") Routine Nursery/Pediatrician Care for Covered Newborns	N/A	20%[5]	40%[5]
Outpatient Facility/Physician (including surgical procedures related to pregnancy and family planning; and non-routine colonoscopies)	N/A	20%	40%
Short-Term Rehabilitation: Occupational, Physical, and Speech Therapy	N/A	20%	No Benefit
Skilled Nursing Facility and Inpatient Rehabilitation	N/A	20%[5]	No Benefit
Spinal Manipulation (max. **25 visits**/calendar year)	N/A	20%	40%
Supplies, Durable Medical Equipment, Prosthetics and Orthotics	N/A	20%[6]	40%[6]
Therapy: Chemotherapy, Dialysis, and Radiation	N/A	20%	40%
Transplant Services (Must be received at a facility that contracts with BCBSNM or with the national BCBS transplant network.)			
Cornea, Kidney, and Bone Marrow	N/A	Based on place of treatment and type of service[4,5]	
Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney (**$10,000** max for travel and lodging per diem)		20%[4,5]	Not Covered
Urgent Care Facility	N/A	20%	40%

Prescription Drugs, Insulin, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods

Your copayment for prescription drugs is based on whether the drug you receive is a generic or a brand-name drug AND whether the drug is on the Performance Select Drug List. If your drug is not on the Performance Select drug list it is not a covered drug. You pay additional costs if you receive a brand-name drug when a generic equivalent is available (even if your doctor requests the brand-name drug). The Performance Select Drug List is available on the BCBSNM web site at www.bcbsnm.com.

Note: Deductible does not apply; but Prescription Drug Copayments apply to the out-of-pocket limit. Certain drugs and enteral nutritional products require preauthorization or benefits will be denied. Prescription drugs must be purchased at a pharmacy that participates in the Retail Pharmacy or Mail Order Service programs. (BCBSNM has contracted for administration of the outpatient prescription drug benefits.)

Retail Pharmacy (up to a 30-day supply). **Mail-Order Pharmacy** (up to a 90-day supply)	**Tier 1 Preferred Pharmacies** (Including PMS Pharmacies)[7]			**Tier 2 Non- Preferred Pharmacies**		
Retail Pharmacy (up to a 30-day supply). You can fill up to a 90-day supply at a Retail Pharmacy at 2.5 times retail copay.	**Generic Drug:**	**Brand-Name Drug:**		**Generic Drug:**	**Brand-Name Drug:**	
	$15	**If a generic equivalent is available & you or your doctor order the brand-name drug, you pay:**	**If there is no generic equivalent available:**	$20	**If a generic equivalent is available & you or your doctor order the brand-name drug, you pay:**	**If there is no generic equivalent available:**
		$15 plus difference in cost between brand and generic	**On Drug List:** $40 / **Not on Drug List:** $75		$20 plus difference in cost between brand and generic	**On Drug List:** $50 / **Not on Drug List:** $80
Mail-Order Service	**Two** copayments for up to a 90-day supply					
Specialty Pharmacy (up to a 30-day supply)	**15%** up to $350 copay per script (Specialty Drug are not available through Mail-Order)					
Nonprescription Enteral Nutritional Products and Special Medical Foods	**50%** (up to a 30-day supply per 30-day period; preauthorization required)					

FOOTNOTES:

[1] The initial covered charges that are incurred in a calendar year are applied to the calendar year deductible. The deductible must be met before benefit payments are made (excluding routine/preventive services and items covered under the drug plan). Deductible amounts do not cross-apply within the PMS/Preferred Provider and Nonpreferred Provider benefit levels.

[2] After a member reaches the out-of-pocket limit, BCBSNM pays 100 percent of most of that member's covered PMS, Preferred or Nonpreferred Provider charges, whichever is applicable. Out-of-pocket amounts do not cross-apply within the PMS/Preferred Provider and Nonpreferred Provider benefit levels.

[3] Initial treatment of a medical emergency is paid at the Preferred Provider level. Follow-up treatment and treatment that is not for an emergency is paid at Nonpreferred Provider level.

[4] Certain services are not covered if preauthorization is not obtained from BCBSNM. See a Benefit Booklet for a list of services requiring preauthorization.

[5] Preauthorization is required for inpatient admissions. Some services, such as transplants, require additional preauthorization. If you do not receive preauthorization for these individually identified procedures and services, benefits for any related admissions will be denied. See a Benefit Booklet for details.

[6] Rental benefits for medical equipment and other items will not exceed the purchase price of a new unit.

[7] The following Presbyterian Medical Pharmacies are covered under Tier 1 Preferred Pharmacies: Farmington Community Health Center, Carlsbad Family Health Center, Cuba Health Center Pharmacy, PMS Pecos Valley Medical Center, PMS Central Pharmacy.

IMPORTANT: Deductible amounts and coinsurance percentages are applied to BCBSNM's covered charges, which may be less than the provider's billed charges. Preferred Providers will not charge you the difference between the covered charge and the billed charge for covered services; Nonpreferred Providers may.

NOTE: BCBSNM provides administrative claims payment services and does not assume any financial risk or obligation with respect to claims, except as specified in the Administrative Services Agreement.

This is a summary only – please refer to the Summary of Benefits and Coverage (SBC) document and Benefit Booklet for more details.

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?	PMS provider: $1,000 Individual / $2,000 Family Preferred & Non-preferred provider: $2,000 Individual / $4,000 Family Health Reimbursement Accou t (HRA): $500 Individual / $1,000 Family (limited to a 2-year cap)	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. Prescriptio drugs, and preferred preve tive 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?	PMS provider & preferred provider: $7,350 Individual / $14,700 Family Non-preferred provider: $14,700 Individual / $29,400 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?	Premiums, bala ce-billing charges, a d 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 Preferred Provider Orga ization (PPO) Network at www.bcbsnm.com or call 1-800-432-0750 for a list of preferred providers.	You pay the least if you use a provider in PMS provider. You pay more if you use a provider in-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
		PMS Provider (You will pay the Least)	referred rovider (You will pay more)	Non-Preferred rovider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary ca e visit to treat an injury or illness	10% coinsu ance	20% coinsu ance	40% c insurance	Vi tual visits are available, please refer to your plan policy for more details.
	Specialist visit	10% coinsurance	20% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunizati n	No Charge; deductible does not apply	No Charge; deductible does not apply	Not Covered	Includes preventive lab work / screenings. 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 ork)	10% coinsurance	20% coinsurance	40% coinsurance	Does not include preventive lab work / screenings.
	Imaging (CT/PET scans, MRIs)	Not Covered	20% coinsurance	40% coinsurance	Requires preauthorization. Gynecological or obstetrical ultrasounds do not require preauthorization.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		PMS Provider (You will pay the Least)	Preferred Provider (You will pay more)	Non-Preferred Provider (You will pay the most)	
If you need drugs to treat your illness or condition Mo e information about **prescription drug coverage** is available at w .bcbsnm.c m/member/p esc ipti n-d ug-plan-inf rmation/drug-lists.	Generic drugs	$15 preferred retail $30 mail order; deductible does not apply	$15 preferred retail $30 mail order; deductible does not apply	$20 preferred retail $40 mail order; deductible does not apply	Retail copay covers a 30-day supply: 90-day supply available for 2.5 times retail copay. Mail-order copay covers a 90-day supply for 2 times retail copay. Copay is based on the drug being generic or brand-name. Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available. Specialty drugs are not available through mail-order.
	Preferred brand drugs	$40 preferred retail $80 mail order; deductible does not apply	$40 preferred retail $80 mail order; deductible does not apply	$50 preferred retail $100 mail order; deductible does not apply	
	Non-prefer ed brand drugs	$75 preferred retail $150 mail order; deductible does not apply	$75 preferred retail $150 mail order; deductible does not apply	$80 preferred retail $160 mail order; deductible does not apply	
	Specialty d ugs	15% up to $350 copay/prescription; deductible does not apply	15% up to $350 copay/prescription; deductible does not apply	15% up to $350 copay/prescription; deductible does not apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	Not Covered	20% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		PMS Provider (You will pay the Least)	Preferred Provider (You will pay more)	Non-Preferred Provider (You will pay the most)	
If you need immediate medical attention	Eme gency room ca e	Not Covered	Facility Charges: 20% coinsurance ER Physician Cha ges: 20% coinsurance	Facility Charges: 20% c insurance ER Physician Charges: 20% c insurance	None
	Eme gency medical t ansportation	Not Covered	20% coinsurance	20% coinsurance	Nonemergency air transfer is 40% coinsurance Out-of-Network and requires preauthorization.
	Urgent care	Not Covered	20% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital om)	Not Covered	20% coinsurance	40% coinsurance	Requires preauthorization.
	Physician/surgeon fees	Not Covered	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge; deductible does not apply	No Charge; deductible does not apply	40% coinsurance	Preauthorization may be required; see your benefit booklet* for details.
	Inpatient services	Not Covered	No Charge; deductible does not apply	40% coinsurance	
If you are pregnant	Office visits	10% coinsurance	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professi nal services	Not Covered	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	Not Covered	20% coinsurance	40% coinsurance	Requires preauthorization.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		PMS Provider (You will pay the Least)	Preferred Provider (You will pay more)	Non-Preferred Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	Not Covered	20% coinsurance	40% coinsurance	Limited to 100 visits per year.
	Rehabilitation se vices	Not Covered	20% coinsurance	N t Covered	Includes physical, occupational, and speech therapies (office/outpatient). Autism Spectrum Disorders Applied Behavioral Analysis Tier 1 - 10% coinsurance Tier 2 - 20% coinsurance Tier 3 – 40% coinsurance
	Habilitation services	Not Covered	20% coinsurance	N t Covered	
	Skilled nursing care	Not Covered	20% coinsurance	Not Covered	Includes inpatient physical rehabilitation. Requires preauthorization.
	Durable medical equipment	Not Covered	20% coinsurance	40% coinsurance	None
	Hospice services	Not Covered	20% coinsurance	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	If vision coverage purchased, see your vision plan information.
	Children's glasses	Not Covered	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult, routine dental)
- Long term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (unless you are diabetic)
- Weight loss programs

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)
- Chiropractic care (25 visits per year)
- Hearing aids (only up to age 21; max 1 aid per hearing impaired ear every 3 years)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.

For more information about limitations and exceptions, see the plan or policy document at w .bcbsnm.c m.

our ights to Continue Cove age: There are agencies that can help if you want o con inue your coverage af er it ends. The con act informa ion for hose 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, Cen er for Consumer Information and Insurance Oversight, a 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 he Health Insurance Marketplace or the New Mexico State-Based Exchange BeWellnm at www.BeWellnm.com. For more information about the Marketplace, visi 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, his 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 assis ance 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 he 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. Tr atments shown ar just examples of how this plan mig t cover m dical care. Your actual costs will b differ nt dep nding on the actual care you rec ive, t e prices your providers charg , and many oth r factors. Focus on the cost s aring amounts (deductibles, copayments and coinsurance) and excluded services under t e plan. Use this information to compare the portion of costs you mig t pay und r differ nt health plans. Please not th se coverage examples are based on s lf-only coverage.

Peg is Having a Baby
(9 mont s of in-n twork pr -natal car and a ospital d liv ry)

The plan's overall deductible	$2,000
Specialist coinsurance	20%
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	$2,000
Copayments	$10
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,170**

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

The plan's overall deductible	$2,000
Specialist coinsurance	20%
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	$1,900
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,720**

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

The plan's overall deductible	$2,000
Specialist coinsurance	20%
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	$2,000
Copayments	$10
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,210**

The plan would be responsible for th other costs of th se EXAMPLE cov red services.

BlueCross BlueShield of New Mexico

Non-Discrimination Notice

Health Care Coverage Is Important For Everyone

We do not discriminate on the basis of race, religion, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

To receive reasonable modifications, communication aids or language assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, you can file a grievance with:

Office of Civil Rights Coordinator
Attn: Office of Civil Rights Coordinator
300 E. Randolph St., 3 th Floor
Chicago, IL 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: civilrightscoordinator@bcbsil.com

You can file a grievance by mail, fax or email. If you need help filing a grievance, please call the toll-free phone number listed on the back of your ID card (TTY: 711).

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

U Dept of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-769
Complaint Portal:
ocrportal.hhs.gov/ocr/smartscreen/main.jsf Complaint Forms:
hhs.gov/civil-rights/filing-a-complaint/index.html

This notice is available on our website at bcbsnm.com/legal-and-privacy/non-discrimination-notice

ATTENTION: If you speak another language, 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 855-710-6984 (TTY: 711) or speak to your provider.

Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 855-710-6984 (TTY: 711) o hable con su proveedor.
العربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 855-710-6984 (TTY: 711) أو تحدث إلى مقدم الخدمة.

BlueCross BlueShield of New Mexico

中文 Chinese	注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 855-710-6984（文本电话：711）或咨询您的服务提供商。
Français French	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 855-710-6984 (TTY : 711) ou parlez à votre fournisseur.
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 855-710-6984 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
ગુજરાતી Gujarati	ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
हिंदी Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 855-710-6984 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Italiano Italian	ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'855-710-6984 (tty: 711) o parla con il tuo fornitore.
한국어 Korean	주의: 한국어 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 855-710-6984(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.
Diné Navajo	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' 855-710-6984 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih.
فارسي Farsi	توجه: اگر فارسي صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 855-710-6984 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.
Polski Polish	UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 855-710-6984 (TTY: 711) lub porozmawiaj ze swoim dostawcą.
РУССКИЙ Russian	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 855-710-6984 (TTY: 711) или обратитесь к своему поставщику услуг.
Tagalog Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 855-710-6984 (TTY: 711) o makipag-usap sa iyong provider.
اردو Urdu	توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔855-710-6984 (711:TTY) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 855-710-6984 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

Presbyterian Medical Services

(PMS) Plan Highlights – EPO Plan
Effective 04/01/26 – 03/31/27

Administered by:
BlueCross BlueShield of New Mexico

Highlights the deductible, out-of-pocket limits, member copayments and coinsurance percentage amounts, and provides a brief description of PMS EPO health care plan benefits.

PMS EPO Plan Benefits – There is no lifetime maximum benefit. However, certain services have maximum annual limits. See below.	**Member's Share of Covered Charges**	
	PMS[1]	**Preferred Provider[1]**
Calendar Year Deductible (per individual)[1] (Family deductible may be met by two or more family members.)	$750 Individual $1,500 Family	$1,500 Individual $3,000 Family
Calendar Year Out-of-Pocket Limit (Includes deductible, coinsurance, copayments, and prescription drug copayments only; NOT penalty amounts, or non-covered charges.) Family limit may be met by two or more family members.[2]	$7,000 Individual $14,000 Family	
Office Services: If listed on this summary, other services received during the office visit to the Primary Preferred Provider (PPP*) or to the PPO Specialist, such as physical therapy, acupuncture, etc., are subject to deductible and coinsurance as listed below.		
Primary Preferred Provider* Office Visit and initial office visit to diagnose pregnancy	$15 copay/visit	$35 copay/visit
Virtual Visit (MDLIVE)	Not Covered	No Charge
Mental Health and Chemical Dependency Outpatient/office	No Charge	No Charge
Specialist Office Visit and initial office visit to diagnose pregnancy	$15 copay/visit	$45 copay/visit
Office Surgery (including casts, splints, and dressings)	15%	25%
Allergy Injections, Tests, Serum	15%	25%
Preventive Services Routine Adult Physicals and Gynecological Exams, Well-Child Care; Routine Vision or Hearing Screenings; Related Testing (includes routine Pap tests, mammograms, cholesterol tests, urinalysis, etc.), Routine Colonoscopies (outpatient/office), Smoking/Tobacco Cessation Counseling, and Immunizations	No Charge	
Acupuncture Treatment (max. **20 visits**/calendar year)	Not Covered	25%
Ambulance Services: Ground and Emergency Air Transport	Not Covered	25%
Ambulance Services: Nonemergency Air Transfer	Not Covered	25%[4]
Autism Spectrum Disorders Applied Behavior Analysis[4]	$15 copay/visit	$35 copay/visit
Cardiac and Pulmonary Rehabilitation, Outpatient	Not Covered	25%
Dental/Facial Accident, Oral Surgery and TMJ/CMJ Services	Not Covered	25%
Emergency Room/Observation Room Treatment (copayment waived if admitted to the hospital)	Not Covered	$250 copay/visit (deductible waived)[3]
Hearing Aids and Related Services: Hearing aids for members under age 21 are paid at 100% of covered charges up to a maximum of **1 hearing aid per hearing-impaired ear every 3 years**; exams and testing are subject to usual cost-sharing provisions. These services are not covered for members age 21 and older.		
Home Health Care/Home I.V. Services (max. **100 visits**/year)	Not Covered	25%
Hospice Services	Not Covered	25%[4,5]
Lab, X-Ray, EKG, and Other Basic Diagnostic Tests (Non-routine)	15% (deductible waived)	25% (deductible waived)
MRI, CT Scans, PET Scans	Not Covered	25%[4]
Inpatient Hospital/Facility Services: (See "Short-Term Rehabilitation" for physical rehabilitation/skilled nursing facility admissions and "Transplant Services," if applicable.)		
Medical/Surgical, Maternity-Related Room and Board, and Covered Ancillaries	Not Covered	25%[5]
Mental Health/Chemical Dependency, (including Partial Hospitalization), Residential Treatment Facility (RTC)		No Charge[5]
Maternity Services (also see "Inpatient Hospital/Facility Services") Routine Nursery/Pediatrician Care for Covered Newborns	Not Covered	25%[5]

*A Primary Preferred Provider (PPP) is a preferred physician or other professional provider in one of the following categories of practice: Family or General Practice, Internal Medicine, Pediatrics, Obstetrics and Gynecology, and Gynecology Only.

PMS EPO Plan Benefits – There is no lifetime maximum benefit. However, certain services have maximum annual limits. See below.	**Member's Share of Covered Charges**	
	PMS[1]	**Preferred Provider[1]**
Outpatient Facility/Physician (includes surgical procedures related to pregnancy/family planning; and non-routine colonoscopies)	Not Covered	25%[4]
Short-Term Rehabilitation, Physical, Occupational, and Speech Therapy	Not Covered	25%
Skilled Nursing Facility and Inpatient Rehabilitation	Not Covered	25%[5]
Spinal Manipulation Services (max. **25 visits**/calendar year)	Not Covered	25%
Supplies, Durable Medical Equipment, Prosthetics and Orthotics	Not Covered	25%[6]
Therapy: Chemotherapy, Dialysis, and Radiation	Not Covered	25%
Transplant Services (Must be received at a facility that contracts with BCBSNM or with the national BCBS transplant network.)		
Cornea, Kidney, and Bone Marrow	Not Covered	Based on place of treatment and type of service[4,5]
Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney: (**$10,000** maximum for travel and lodging per diem)	Not Covered	25%[4,5]
Urgent Care Facility	Not Covered	$50 copay/visit

Prescription Drugs, Insulin, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods

Your copayment for prescription drugs is based on whether the drug you receive is a generic or a brand-name drug AND whether the drug is on the Performance Select Drug List. If your drug is not on the Performance Select drug list it is not a covered drug. You pay additional costs if you receive a brand-name drug when a generic equivalent is available (even if your doctor requests the brand-name drug). The Performance Select Drug List is available on the BCBSNM web site at www.bcbsnm.com.

NOTE: Deductible does not apply; but Prescription Drug Copayments apply to the out-of-pocket limit. Certain drugs and enteral nutritional products require preauthorization or benefits will be denied. Prescription drugs must be purchased at a pharmacy that participates in the Retail Pharmacy or Mail Order Service programs. (BCBSNM has contracted for administration of the outpatient prescription drug benefits.)	**Generic Drug**	**Brand-Name Drug**		
		If a generic equivalent is available and you or your doctor order the brand- name drug, you pay:	**If no generic equivalent is available:**	
			On Drug List	**Not on Drug List**
Retail Pharmacy Program (up to a 30-day supply) You can fill up to a 90-day supply at a Retail Pharmacy at 2.5 times retail copay.	$15	$15 plus difference in cost between brand and generic	$30	$60
Mail-Order Service	Two copayments for up to a 90-day supply.			
Specialty Pharmacy (up to a 30-day supply)	**15%** up to $250 copay per script (Specialty Drugs are not available through Mail-Order)			
Nonprescription Enteral Nutritional Products and Special Medical Foods	**50%** (up to a 30-day supply per 30-day period; preauthorization required)			

Retail Pharmacy (up to a 30-day supply). **Mail-Order Pharmacy** (up to a 90-day supply)	**Tier 1 Preferred Pharmacies** (Including PMS Pharmacies)[7]				**Tier 2 Non- Preferred Pharmacies**			
Retail Pharmacy (up to a 30-day supply). You can fill up to a 90-day supply at a Retail Pharmacy at 2.5 times retail copay.	**Generic Drug:**	**Brand-Name Drug:**			**Generic Drug:**	**Brand-Name Drug:**		
	$15	**If a generic equivalent is available & you or your doctor order the brand-name drug, you pay:**	**If there is no generic equivalent available:**		$20	**If a generic equivalent is available & you or your doctor order the brand-name drug, you pay:**	**If there is no generic equivalent available:**	
		$15 plus difference in cost between brand and generic	**On Drug List**	**Not on Drug List**		$20 plus difference in cost between brand and generic	**On Drug List**	**Not on Drug List**
			$30	$60			$40	$70
Mail-Order Service	**Two** copayments for up to a 90-day supply							
Specialty Pharmacy (up to a 30-day supply)	**15%** up to $250 copay per script (Specialty Drug are not available through Mail-Order)							
Nonprescription Enteral Nutritional Products and Special Medical Foods	**50%** (up to a 30-day supply per 30-day period; preauthorization required)							

FOOTNOTES:

[1] Except in an emergency, there are NO benefits for services of a non-PPO provider. The deductible must be met before benefit payments are made (excluding charges for which you pay a fixed dollar copayment, lab/X-ray/diagnostic services; but including all other services billed during a non-preventive office visit). Deductible amounts cross-apply between PMS and Preferred Provider benefit levels.

[2] After a member reaches the applicable out-of-pocket limit, BCBSNM pays 100 percent of most of that member's covered charges for the rest of the calendar year. Out-of-pocket amounts cross-apply between PMS and Preferred Provider benefit levels.

[3] Initial treatment of a medical emergency from a non-preferred provider is covered. Follow-up treatment and treatment that is not for an emergency is not covered if received from a non-preferred provider.

[4] Services are not covered if preauthorization is not obtained from BCBSNM. See a Benefit Booklet for a list of services requiring preauthorization.

[5] Preauthorization is required for inpatient admissions. Some services, such as transplants and physical rehabilitation, require additional preauthorization. If you do not receive preauthorization for these individually identified procedures and services, benefits for any related admissions will be denied. See a Member's Benefit Booklet for details.

[6] Rental benefits for medical equipment and other items will not exceed the purchase price of a new unit.

[7] The following Presbyterian Medical Pharmacies are covered under Tier 1 Preferred Pharmacies: Farmington Community Health Center, Carlsbad Family Health Center, Cuba Health Center Pharmacy, PMS Pecos Valley Medical Center, PMS Central Pharmacy.

Important Note: You must use a PMS or BCBSNM Preferred Provider, unless in an emergency. Deductibles, copayments, and coinsurance percentages are applied to BCBSNM's covered charges, which may be less than billed charges. Covered services received from Preferred Providers that contract with their local BCBS Plan are also eligible for coverage under this plan.

NOTE: BCBSNM provides administrative claims payment services and does not assume any financial risk or obligation with respect to claims, except as specified in the Administrative Services Agreement.

This is a summary only – please refer to the Summary of Benefits and Coverage (SBC) document and Benefit Booklet for more details.

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?	PMS provider: $750 Individual / $1,500 Family Preferred provider: $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, 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, emergency room services, a d preferred preve tive 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?	$7,000 Individual / $14,000 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 limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, bala ce-billing charges, a d 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 Preferred Provider Orga ization (PPO) Network at www.bcbsnm.com or call 1-800-432-0750 for a list of preferred providers.	You pay the least if you use a provider in PMS provider. You pay more if you use a provider in-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
		MS Provider (You will pay the Least)	Preferred rovider (You will pay more)	Non-Preferred Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary ca e visit to treat an injury or illness	$15 c pay/visit; deductible d es not apply	$35 c pay/visit; deductible d es not apply	N t Cove ed	Virtual visits are available, please refer to y ur plan p licy for more details.
	Specialist visit	$15 copay/visit; deductible does not apply	$45 copay/visit; deductible does not apply	Not Covered	None
	Preventive care/screening/ immunization	No Charge; deductible does not apply	No Charge; deductible does not apply	Not Covered	Includes preventive lab work / screenings. 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)	15% coinsurance; deductible does not apply	25% coinsurance; deductible does not apply	Not Covered	Does not include preventive lab work / screening.
	Imaging (CT/PET scans, MRIs)	Not Covered	25% coinsurance	Not Covered	Requires preauthorization. Gynecological or obstetrical ultrasounds do not require preauthorization.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		PMS Provider (You will pay the Least)	Preferred Provider (You will pay more)	Non-Preferred Provider (You will pay the most)	
If you need drugs to treat your illness or condition Mo e information about **prescription drug coverage** is available at w .bcbsnm.c m/member/p esc ipti n-d ug-plan-inf rmation/drug-lists.	Generic drugs	$15 preferred retail $30 mail order; deductible does not apply	$15 preferred retail $30 mail order; deductible does not apply	$20 preferred retail $40 mail order; deductible does not apply	Retail copay covers a 30-day supply, 90-day supply available for 2.5 times retail copay. Mail-order copay covers a 90-day supply for 2 times retail copay. Copay is based on the drug being generic or brand-name. Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available. Specialty drugs are not available through mail-order.
	Preferred brand drugs	$30 preferred retail $60 mail order; deductible does not apply	$30 preferred retail $60 mail order; deductible does not apply	$40 preferred retail $80 mail order; deductible does not apply	
	Non-preferred brand drugs	$60 preferred retail $120 mail order; deductible does not apply	$60 preferred retail $120 mail order; deductible does not apply	$70 preferred retail $140 mail order; deductible does not apply	
	Specialty drugs	15% up to $250 copay/prescription; deductible does not apply	15% up to $250 copay/prescription; deductible does not apply	15% up to $250 copay/prescription; deductible does not apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered	25% coinsurance	Not Covered	None
	Physician/surgeon fees	Not Covered	25% coinsurance	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		PMS Provider (You will pay the Least)	Preferred Provider (You will pay more)	Non-Preferred Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	Not Covered	Facility Charges: $250 copay/visit; deductible does not apply ER Physician Charges: No Charge; deductible does not apply	Facility Charges: $250 copay/visit; deductible does not apply ER Physician Charges: No Charge; deductible does not apply	Copay waived if admitted.
	Emergency medical transportation	Not Covered	25% coinsurance	25% coinsurance	Requires preauthorization unless during a medical emergency.
	Urgent care	Not Covered	$50 copay/visit; deductible does not apply	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital om)	Not Covered	25% coinsurance	Not Covered	Requires preauthorization.
	Physician/surgeon fees	Not Covered	25% coinsurance	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge; deductible does not apply	No Charge; deductible does not apply	Not Covered	Preauthorization may be required; see your benefit booklet* for details.
	Inpatient services	Not Covered	No Charge; deductible does not apply	Not Covered	
If you are pregnant	Office visits	$15 copay/visit; deductible does not apply	$35 copay/visit; deductible does not apply	Not Covered	PPP office visit copay for initial visit to confirm pregnancy. 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	Not Covered	25% coinsurance	Not Covered	
	Childbirth/delivery facility services	Not Covered	25% coinsurance	Not Covered	Requires preauthorization.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		PMS Provider (You will pay the Least)	Preferred Provider (You will pay more)	Non-Preferred Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	Not Covered	25% coinsurance	Not Covered	Limited to 100 visits per year.
	Rehabilitation services	Not Covered	25% coinsurance	Not Covered	Includes physical, occupational, and speech therapies (office/outpatient). Autism Spectrum Disorders Applied Behavioral Analysis Tier 1 - $15 copay/visit Tier 2 - $35 copay/visit
	Habilitation services	Not Covered	25% coinsurance	Not Covered	
	Skilled nursing care	Not Covered	25% coinsurance	Not Covered	Includes inpatient physical rehabilitation. Requires preauthorization.
	Durable medical equipment	Not Covered	25% coinsurance	Not Covered	None
	Hospice services	Not Covered	25% coinsurance	Not Covered	None
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	If vision coverage purchased, see your vision plan information.
	Children's glasses	Not Covered	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult, routine dental)
- Long term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (unless you are diabetic)
- Weight loss programs

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)
- Chiropractic care (25 visits per year)
- Hearing aids (only up to age 21; max 1 aid per hearing impaired ear every 3 years)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.

our ights to Continue Cove age: There are agencies that can help if you want to continue your coverage after it ends. The con act informa ion 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. Tr atments shown ar just examples of how this plan mig t cover m dical care. Your actual costs will b differ nt dep nding on the actual care you rec ive, t e prices your providers charg , and many oth r factors. Focus on the cost s aring amounts (deductibles, copayments and coinsurance) and excluded services under t e plan. Use this information to compare the portion of costs you mig t pay und r differ nt health plans. Please not th se coverage examples are based on s lf-only coverage.

Peg is Having a Baby
(9 mont s of in-n twork pr -natal car and a ospital d liv ry)

The plan's overall deductible	$1,500
Specialist copayment	$45
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	$1,500
Copayments	$50
Coinsurance	$2,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,410**

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

The plan's overall deductible	$1,500
Specialist copayment	$45
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	$800
Copayments	$1,000
Coinsurance	$30
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,850**

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

The plan's overall deductible	$1,500
Specialist copayment	$45
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	$1,500
Copayments	$400
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,950**

The plan would be responsible for th other costs of th se EXAMPLE cov red services.

BlueCross BlueShield of New Mexico

Non-Discrimination Notice

Health Care Coverage Is Important For Everyone

We do not discriminate on the basis of race, religion, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

To receive reasonable modifications, communication aids or language assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, you can file a grievance with:

Office of Civil Rights Coordinator
Attn: Office of Civil Rights Coordinator
300 E. Randolph St., 3 th Floor
Chicago, IL 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: civilrightscoordinator@bcbsil.com

You can file a grievance by mail, fax or email. If you need help filing a grievance, please call the toll-free phone number listed on the back of your ID card (TTY: 711).

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

U Dept of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-769
Complaint Portal:
ocrportal.hhs.gov/ocr/smartscreen/main.jsf Complaint Forms:
hhs.gov/civil-rights/filing-a-complaint/index.html

This notice is available on our website at bcbsnm.com/legal-and-privacy/non-discrimination-notice

ATTENTION: If you speak another language, 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 855-710-6984 (TTY: 711) or speak to your provider.

Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 855-710-6984 (TTY: 711) o hable con su proveedor.
العربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 855-710-6984 (TTY: 711) أو تحدث إلى مقدم الخدمة.

BlueCross BlueShield of New Mexico

中文 Chinese	注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 855-710-6984（文本电话：711）或咨询您的服务提供商。
Français French	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 855-710-6984 (TTY : 711) ou parlez à votre fournisseur.
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 855-710-6984 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
ગુજરાતી Gujarati	ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
हिंदी Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 855-710-6984 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Italiano Italian	ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'855-710-6984 (tty: 711) o parla con il tuo fornitore.
한국어 Korean	주의: 한국어 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 855-710-6984(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.
Diné Navajo	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' 855-710-6984 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih.
فارسي Farsi	توجه: اگر فارسي صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 855-710-6984 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.
Polski Polish	UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 855-710-6984 (TTY: 711) lub porozmawiaj ze swoim dostawcą.
РУССКИЙ Russian	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 855-710-6984 (TTY: 711) или обратитесь к своему поставщику услуг.
Tagalog Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 855-710-6984 (TTY: 711) o makipag-usap sa iyong provider.
اردو Urdu	توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔855-710-6984 (711:TTY) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 855-710-6984 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

Presbyterian Medical Services

(PMS) Plan Highlights – PPO Plan
Effective 04/01/26 – 03/31/27

Administered by:
BlueCross BlueShield of New Mexico

Highlights the deductible, out-of-pocket limits, member copayments and coinsurance percentage amounts, and provides a brief description of PMS PPO Plan benefits.

PMS PPO Benefits – There is no lifetime maximum benefit. However, certain services have maximum annual limits. See below.	**Member's Share of Covered Charges**		
	PMS[1]	**Preferred Provider[1]**	**Nonpreferred Provider[1]**
Calendar Year Deductible (per individual)[1] (Family deductible may be met by two or more family members.)	$500 Individual $1,000 Family	$1,000 Individual $2,000 Family	$2,000 Individual $4,000 Family
Calendar Year Out-of-Pocket Limit – (Includes deductible, coinsurance, copayments, and prescription drug copayments only; NOT penalty amounts, or noncovered charges.)[2]	$5,500 Individual $11,000 Family		$11,000 Individual $22,000 Family
Office Services: If listed on this summary, other services received during the office visit to the Primary Preferred Provider (PPP*) or to the PPO Specialist, such as physical therapy, acupuncture, etc., are subject to deductible and coinsurance as listed below.			
Primary Preferred Provider* Office Visit and initial office visit to diagnose pregnancy	$10 copay/visit	$25 copay/visit	40%
Virtual Visit (MDLIVE)	Not Covered	No Charge	No Benefit
Mental Health and Chemical Dependency (outpatient/office visit)	No Charge	No Charge	40%
Specialist Office Visit and initial office visit to diagnose pregnancy	$10 copay/visit	$35 copay/visit	40%
Office Surgery (including casts, splints, and dressings)	10%	20%	40%
Allergy Injections, Tests, Serum	10%	20%	40%
Preventive Services Routine Adult Physicals and Gynecological Exams, Well-Child Care; Routine Vision or Hearing Screenings, Related Testing (includes routine Pap tests, cholesterol tests, urinalysis, etc.), Routine Colonoscopies (outpatient/office), Smoking/Tobacco Cessation Counseling, and Immunizations	No Charge		No Benefit
Acupuncture Treatment (max. **20 visits**/year)	Not Covered	20%	40%
Ambulance Services: Ground and Emergency Air Transport	Not Covered	20%	
Ambulance Services: Nonemergency Air Transfer	Not Covered	20%[4]	40%[4]
Autism Spectrum Disorders Applied Behavior Analysis[4]	$10 copay/visit	$25 copay/visit	40%
Cardiac and Pulmonary Rehabilitation	Not Covered	20%	No Benefit
Dental/Facial Accident, Oral Surgery, and TMJ/CMJ Services	Not Covered	20%	40%
Emergency Room/Observation Room Treatment (copayment waived if admitted to the hospital)	Not Covered	$250 copay/visit (deductible waived)[3]	
Hearing Aids and Related Services: Hearing aids for members under age 21 are paid at 100% of covered charges up to a maximum of **1 hearing aid per hearing-impaired ear every 3 years**; exams and testing are subject to usual cost-sharing provisions. These services are not covered for members age 21 and older.			
Home Health Care/Home I.V. Services (max. **100 visits**/year)	Not Covered	20%	40%
Hospice Services	Not Covered	20%[4,5]	40%[4,5]
Lab, X-Ray, and Other Basic Diagnostic Tests (non-routine)	10%	20%	40%
MRI, CT Scans, PET Scans	Not Covered	20%[4]	40%[4]

*A Primary Preferred Provider is a physician or other professional provider in one of the following categories of practice: Family or General Practice, Internal Medicine, Pediatrics, Obstetrics and Gynecology, and Gynecology Only. A "PPP" is a Primary Preferred Provider in the Preferred Provider network.

PMS PPO Benefits – There is no lifetime maximum benefit. However, certain services have maximum annual limits. See below.	**Member's Share of Covered Charges**		
	PMS[1]	**Preferred Provider[1]**	**Nonpreferred Provider[1]**
Inpatient Hospital/Facility Services (See "Short-Term Rehabilitation" for physical rehabilitation and skilled nursing facility admissions and "Transplant Services," if applicable.)			
Medical/Surgical, Maternity-Related Room and Board, and Covered Ancillaries	Not Covered	20%[5]	40%[5]
Mental Health/Chemical Dependency, (including Partial Hospitalization), Residential Treatment Facility (RTC)		No Charge[5]	
Maternity Services (also see "Inpatient Hospital/Facility Services") Routine Nursery/Pediatrician Care for Covered Newborns	Not Covered	20%[5]	40%[5]
Outpatient Facility/Physician (including surgical procedures related to pregnancy and family planning; and nonroutine colonoscopies)	Not Covered	20%	40%
Short-Term Rehabilitation: Occupational, Physical, and Speech Therapy	Not Covered	20%	No Benefit
Skilled Nursing Facility and Inpatient Rehabilitation	Not Covered	20%[5]	No Benefit
Spinal Manipulation (max. **25 visits**/calendar year)	Not Covered	20%	40%
Supplies, Durable Medical Equipment, Prosthetics and Orthotics	Not Covered	20%[6]	40%[6]
Therapy: Chemotherapy, Dialysis, and Radiation	Not Covered	20%	40%
Transplant Services (Must be received at a facility that contracts with BCBSNM or with the national BCBS transplant network.)			
Cornea, Kidney, and Bone Marrow	Not Covered	Based on place of treatment and type of service[4,5]	
Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney (**$10,000** max for travel and lodging per diem)		20%[4,5]	Not Covered
Urgent Care Facility	Not Covered	$50 copay/visit	40%

Prescription Drugs, Insulin, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods

Your copayment for prescription drugs is based on whether the drug you receive is a generic or a brand-name drug AND whether the drug is on the Performance Select Drug List. If your drug is not on the Performance Select drug list it is not a covered drug. You pay additional costs if you receive a brand-name drug when a generic equivalent is available (even if your doctor requests the brand-name drug). The Performance Select Drug List is available on the BCBSNM web site at www.bcbsnm.com.

Note: Deductible does not apply; but Prescription Drug Copayments apply to the out-of-pocket limit. Certain drugs and enteral nutritional products require preauthorization or benefits will be denied. Prescription drugs must be purchased at a pharmacy that participates in the Retail Pharmacy or Mail Order Service programs. (BCBSNM has contracted for administration of the outpatient prescription drug benefits.)

Retail Pharmacy (up to a 30-day supply). **Mail-Order Pharmacy** (up to a 90-day supply)	**Tier 1 Preferred Pharmacies** (Including PMS Pharmacies)[7]				**Tier 2 Non- Preferred Pharmacies**			
Retail Pharmacy (up to a 30-day supply). You can fill up to a 90-day supply at a Retail Pharmacy at 2.5 times retail copay.	**Generic Drug:**	**Brand-Name Drug:**			**Generic Drug:**	**Brand-Name Drug:**		
	$15	**If a generic equivalent is available & you or your doctor order the brand-name drug, you pay:**	**If there is no generic equivalent available:**		$20	**If a generic equivalent is available & you or your doctor order the brand-name drug, you pay:**	**If there is no generic equivalent available:**	
		$15 plus difference in cost between brand and generic	**On Drug List:**	**Not on Drug List:**		$20 plus difference in cost between brand and generic	**On Drug List:**	**Not on Drug List:**
			$30	$60			$40	$70
Mail-Order Service	**Two** copayments for up to a 90-day supply							
Specialty Pharmacy (up to a 30-day supply)	**15%** up to $250 copay per script (Specialty Drug are not available through Mail-Order)							
Nonprescription Enteral Nutritional Products and Special Medical Foods	**50%** (up to a 30-day supply per 30-day period; preauthorization required)							

FOOTNOTES:

[1] The deductible must be met before benefit payments are made (excluding charges for which you pay a fixed-dollar copayment and specified transplant services, but including all other services billed during a non-preventive office visit). Deductible amounts do not cross-apply within the PMS/Preferred Provider and Nonpreferred Provider benefit levels.

[2] After a member reaches the applicable out-of-pocket limit, BCBSNM pays 100 percent of most of that member's covered PMS, Preferred or Nonpreferred provider charges, whichever is applicable. Out-of-pocket amounts do not cross-apply within the PMS/Preferred Provider and Nonpreferred Provider benefit levels.

[3] Initial treatment of a medical emergency is paid at the Preferred Provider level. Follow-up treatment and treatment that is not for an emergency is paid at the Nonpreferred Provider level.

[4] Certain services are not covered if preauthorization is not obtained from BCBSNM. See a Benefit Booklet for a list of services requiring preauthorization.

[5] Preauthorization is required for inpatient admissions. Some services, such as transplants and physical rehabilitation, require additional preauthorization. If you do not receive preauthorization for these individually identified procedures and services, benefits for any related admissions will be denied. See a Benefit Booklet for details.

[6] Rental benefits for medical equipment and other items will not exceed the purchase price of a new unit.

[7] The following Presbyterian Medical Pharmacies are covered under Tier 1 Preferred Pharmacies: Farmington Community Health Center, Carlsbad Family Health Center, Cuba Health Center Pharmacy, PMS Pecos Valley Medical Center, PMS Central Pharmacy.

IMPORTANT: Deductible amounts and coinsurance percentages are applied to BCBSNM's covered charges, which may be less than the provider's billed charges. Preferred Providers will not charge you the difference between the covered charge and the billed charge for covered services; Nonpreferred Providers may.

NOTE: BCBSNM provides administrative claims payment services and does not assume any financial risk or obligation with respect to claims, except as specified in the Administrative Services Agreement.

This is a summary only – please refer to the Summary of Benefits and Coverage (SBC) document and Benefit Booklet for more details.

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?	PMS provider: $500 Individual / $1,000 Family Preferred provider: $1,000 Individual / $2,000 Family Non-preferred provider: $2,000 Individual / $4,000 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, 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, emergency room services, and preferred 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?	PMS provider & preferred provider: $5,500 Individual / $11,000 Family Non-preferred provider: $11,000 Individual / $22,000 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 limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, bala ce-billing charges, a d 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 Preferred Provider Orga ization (PPO) Network at www.bcbsnm.com or call 1-800-432-0750 for a list of preferred providers.	You pay the least if you use a provider in PMS provider. You pay more if you use a provider in-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
		PMS Provider (You will pay the Least)	Preferred Provider (You will pay more)	Non-Preferred Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary ca e visit to treat an injury or illness	$10 copay/visit; deductible does not apply	$25 copay/visit; deductible does not apply	40% coinsurance	Virtual visits are available, please refer to your plan policy for more details.
	Specialist visit	$10 copay/visit; deductible does not apply	$35 copay/visit; deductible does not apply	40% coinsurance	None
	Preventive care/screening/ immunizati n	No Charge; deductible does not apply	No Charge; deductible does not apply	Not Covered	Includes preventive lab work / screening. 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 ork)	10% coinsurance	20% coinsurance	40% coinsurance	Does not include preventive lab work / screening.
	Imaging (CT/PET scans, MRIs)	Not Covered	20% coinsurance	40% coinsurance	Requires preauthorization. Gynecological or obstetrical ultrasounds do not require preauthorization.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		PMS Provider (You will pay the Least)	Preferred Provider (You will pay more)	Non-Preferred Provider (You will pay the most)	
If you need drugs to treat your illness or condition Mo e information about **prescription drug coverage** is available at w .bcbsnm.c m/member/p esc ipti n-d ug-plan-inf rmation/drug-lists.	Generic drugs	$15 preferred retail $30 mail order; deductible does not apply	$15 preferred retail $30 mail order; deductible does not apply	$20 preferred retail $40 mail order; deductible does not apply	Retail copay covers a 30-day supply, 90-day supply available for 2.5 times retail copay. Mail-order copay covers a 90-day supply for 2 times retail copay. Copay is based on the drug being generic or brand-name. Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available. Specialty drugs are not available through mail-order.
	Preferred brand drugs	$30 preferred retail $60 mail order; deductible does not apply	$30 preferred retail $60 mail order; deductible does not apply	$40 preferred retail $80 mail order; deductible does not apply	
	Non-prefer ed brand drugs	$60 preferred retail $120 mail order; deductible does not apply	$60 preferred retail $120 mail order; deductible does not apply	$70 preferred retail $140 mail order; deductible does not apply	
	Specialty d ugs	15% up to $250 copay/prescription; deductible does not apply	15% up to $250 copay/prescription; deductible does not apply	15% up to $250 copay/prescription; deductible does not apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	Not Covered	20% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		PMS Provider (You will pay the Least)	Preferred Provider (You will pay more)	Non-Preferred Provider (You will pay the most)	
If you need immediate medical attention	Eme gency room ca e	Not Covered	Facility Charges: $250 copay/visit; deductible does not apply ER Physician Charges: No Charge; deductible does not apply	Facility Charges: $250 copay/visit; deductible does not apply ER Physician Charges: No Charge; deductible does not apply	Copay waived if admitted.
	Eme gency medical t ansportation	Not Covered	20% coinsurance	20% coinsurance	Non-emergency air transfer is 40% coinsurance Out-of-Network and requires preauthorization.
	Urgent care	Not Covered	$50 copay/visit; deductible does not apply	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital om)	Not Covered	20% coinsurance	40% coinsurance	Requires preauthorization.
	Physician/surgeon fees	Not Covered	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Covered	No Charge; deductible does not apply	40% coinsurance	Preauthorization may be required; see your benefit booklet* for details.
	Inpatient services	Not Covered	No Charge; deductible does not apply	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		PMS Provider (You will pay the Least)	Preferred Provider (You will pay more)	Non-Preferred Provider (You will pay the most)	
If you are pregnant	Office visits	$10 copay/visit; deductible does not apply	$25 copay/visit; deductible does not apply	40% coinsurance	PPP office visit copay for initial visit to confirm pregnancy. 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 professi nal services	Not Covered	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	Not Covered	20% coinsurance	40% coinsurance	Requires preauthorization.
If you need help recovering or have other special health needs	Home health care	Not Covered	20% coinsurance	40% coinsurance	Limited to 100 visits per year.
	Rehabilitation se vices	Not Covered	20% coinsurance	Not Covered	Includes physical, occupational, and speech therapies (office/outpatient). Autism Spectrum Disorders Applied Behavioral Analysis Tier 1 - $10 copay/visit Tier 2 - $25 copay/visit Tier 3 – 40% coinsurance
	Habilitation services	Not Covered	20% coinsurance	Not Covered	
	Skilled nursing care	Not Covered	20% coinsurance	Not Covered	Includes inpatient physical rehabilitation. Requires preauthorization.
	Durable medical equipment	Not Covered	20% coinsurance	40% coinsurance	None
	Hospice services	Not Covered	20% coinsurance	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	If vision coverage purchased, see your vision plan information.
	Children's glasses	Not Covered	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	Not Covered	If dental coverage purchased, see your dental plan information.

xcluded 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.)		
• Bariatric surgery • Cosmetic surgery • Dental Care (Adult, routine dental)	• Long-term care • Private duty nursing • Routine eye care (Adult)	• Routine foot care (unless you are diabetic) • Weight loss programs

Other Covered Servi es (Limitations may apply to these services. This isn't a complete list. Please see your plan do ument.)		
• Acupuncture (20 visits per year) • Chiropractic care (25 visits per year)	• Hearing aids (only up to age 21; max 1 aid per hearing impaired ear every 3 years) • Infertility treatment	• Non-emergency care when traveling outside the U.S.

our ights to Continue Cove age: There are agencies that can help if you want to continue your coverage after it ends. The con act informa ion for hose 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. Tr atments shown are just examples of how this plan mig t cover m dical care. Your actual costs will b different d pending on the actual care you rec iv , the prices your providers charg , and many oth r factors. Focus on the cost s aring amounts (deductibles, copayments and coinsurance) and excluded services under t e plan. Use this information to compare the portion of costs you mig t pay und r differ nt health plans. Please not th se coverage examples are based on s lf-only coverage.

Peg is Having a Baby
(9 mont s of in-n twork pr -natal car and a ospital d liv ry)

- **The plan's overall deductible** **$1,000**
- **Specialist copayment** **$35**
- **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	$1,000
Copayments	$40
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,400**

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

- **The plan's overall deductible** **$1,000**
- **Specialist copayment** **$35**
- **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	$900
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,720**

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

- **The plan's overall deductible** **$1,000**
- **Specialist copayment** **$35**
- **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	$1,000
Copayments	$400
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,500**

The plan would be responsible for th other costs of th se EXAMPLE cov red services.

BlueCross BlueShield of New Mexico

Non-Discrimination Notice

Health Care Coverage Is Important For Everyone

We do not discriminate on the basis of race, religion, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

To receive reasonable modifications, communication aids or language assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, you can file a grievance with:

Office of Civil Rights Coordinator
Attn: Office of Civil Rights Coordinator
300 E. Randolph St., 3 th Floor
Chicago, IL 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: civilrightscoordinator@bcbsil.com

You can file a grievance by mail, fax or email. If you need help filing a grievance, please call the toll-free phone number listed on the back of your ID card (TTY: 711).

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

U Dept of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-769
Complaint Portal:
ocrportal.hhs.gov/ocr/smartscreen/main.jsf Complaint Forms:
hhs.gov/civil-rights/filing-a-complaint/index.html

This notice is available on our website at bcbsnm.com/legal-and-privacy/non-discrimination-notice

ATTENTION: If you speak another language, 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 855-710-6984 (TTY: 711) or speak to your provider.

Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 855-710-6984 (TTY: 711) o hable con su proveedor.
العربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 855-710-6984 (TTY: 711) أو تحدث إلى مقدم الخدمة.

BlueCross BlueShield of New Mexico

中文 Chinese	注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 855-710-6984（文本电话：711）或咨询您的服务提供商。
Français French	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 855-710-6984 (TTY : 711) ou parlez à votre fournisseur.
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 855-710-6984 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
ગુજરાતી Gujarati	ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
हिंदी Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 855-710-6984 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Italiano Italian	ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'855-710-6984 (tty: 711) o parla con il tuo fornitore.
한국어 Korean	주의: 한국어 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 855-710-6984(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.
Diné Navajo	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' 855-710-6984 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih.
فارسي Farsi	توجه: اگر فارسي صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 855-710-6984 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.
Polski Polish	UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 855-710-6984 (TTY: 711) lub porozmawiaj ze swoim dostawcą.
РУССКИЙ Russian	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 855-710-6984 (TTY: 711) или обратитесь к своему поставщику услуг.
Tagalog Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 855-710-6984 (TTY: 711) o makipag-usap sa iyong provider.
اردو Urdu	توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔855-710-6984 (711:TTY) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 855-710-6984 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

Delta Dental PPO™ Point of Service
Summary of Dental Plan Benefits
For Group #9766-1000,9999
Presbyterian Medical Services

Benefit Period: January 1 through December 31

Deductible: $50 Deductible per person total per Calendar Year limited to a maximum Deductible of $150 per family per Calendar Year. Deductible does not apply to all covered services; see page 2.

Maximum Benefit Amount: $1,500 per person total per Calendar Year

Orthodontic Lifetime Maximum: $1,000 per person total per lifetime

Covered Services	Delta Dental PPO™ Provider	Delta Dental Premier® Provider	Non-Participating Provider
	You Pay	You Pay	You Pay*
Diagnostic and Preventive Services			
Diagnostic and Preventive Services – exams, cleanings, topical fluoride, and space maintainers	No Charge	20%	20%
Emergency Palliative Treatment – to temporarily relieve pain	No Charge	20%	20%
Sealants – to prevent decay of permanent teeth	No Charge	20%	20%
Brush Biopsy – to detect oral cancer	No Charge	20%	20%
Radiographs – images	No Charge	20%	20%
Periodontal Maintenance – cleanings following periodontal therapy	No Charge	20%	20%
Basic Services			
Minor Restorative Services – fillings	20%	20%	20%
Endodontic Services – root canals	20%	20%	20%
Periodontic Services – to treat gum disease	20%	20%	20%
Oral Surgery Services – extractions and dental surgery	20%	20%	20%
Other Basic Services – misc. services	20%	20%	20%
Major Services			
Crown Repair – to individual crowns	50%	50%	50%
Major Restorative Services – crowns	50%	50%	50%
Relines and Repairs – to bridges, dentures, and implants	50%	50%	50%
Prosthodontic Services – bridges, dentures, and implants	50%	50%	50%
Orthodontic Services			
Orthodontic Services – braces (lifetime max.)	50%	50%	50%
Orthodontic Age Limit – child only	**Dependent Children:** To the end of the month of age 19	**Dependent Children:** To the end of the month of age 19	**Dependent Children:** To the end of the month of age 19

1) Schedule of higher fees applies. Delta Dental Premier Providers are subject to a schedule of higher Maximum Approved Fees than Delta Dental PPO Providers. You may have higher out-of-pocket costs when you visit a Delta Dental Premier Provider than if you visited a Delta Dental PPO Provider. This may be true even if the Coinsurance percentages are the same for these two types of Providers. You may have the lowest out-of-pocket costs when you select a Delta Dental PPO Provider. See the Summary of Dental Plan Benefits for more information on networks and cost sharing.

***2) Balance billing applies.** Non-Participating Providers may bill you above the Non-Participating Maximum Approved Fees they receive from Delta Dental. You will have the highest out-of-pocket costs when you visit a Non-Participating Provider. This will be true even if the Coinsurance percentages in this column match the percentages for other types of Providers. In addition, Non-Participating Providers have not agreed to Delta Dental's in-network protections for Enrollees. See the Summary of Dental Plan Benefits for more information on networks and cost sharing.*

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Routine prophylaxes (cleanings), periodontal maintenance, and scaling in the presence of generalized moderate or severe gingival inflammation are payable twice per calendar year.
- Topical fluoride treatments are payable twice per calendar.
- Fixed bilateral space maintainers are payable once per arch per lifetime for people up to age 14.
- Fixed unilateral, removable unilateral, and removable bilateral space maintainers are payable once per quadrant per lifetime for people up to age 14.
- Bitewing images are payable once per calendar year and a complete series of radiographic images (which include bitewing images) or panoramic radiographic image is payable once in any five-year period.
- Sealants are payable once per tooth per three-year period for the occlusal surface of permanent molars up to age 16.
- Composite resin (white) restorations are Covered Services on all teeth.
- Implants and implant-related services are payable once per tooth in any five-year period.
- Occlusal guards are payable once per lifetime.

Additional Plan Information

Deductible: Does not apply to Diagnostic and Preventive Services, radiographic images, sealants, full mouth debridement, periodontal maintenance, emergency palliative treatment, consultations, cephalometric radiographic images, photos, diagnostic casts, and orthodontics (including fiberotomy, surgical repositioning, and devices to facilitate tooth eruption).

Maximum Benefit Amount: The Maximum Benefit Amount applies to all services except cephalometric radiographic images, photos, diagnostic casts, and orthodontics (including fiberotomy, surgical repositioning, and devices to facilitate tooth eruption).

Orthodontic Lifetime Maximum: Applies to cephalometric radiographic images, photos, diagnostic casts, and orthodontics (including fiberotomy, surgical repositioning, and devices to facilitate tooth eruption).

Pre-Treatment Estimates: Delta Dental recommends that you ask your Provider for a Pre-Treatment Estimate when more-costly procedures are anticipated. This free report estimates your applicable dental Benefits and out-of-pocket expenses for proposed dental services. Please see the Dental Benefit Handbook for more information. Pre-Treatment Estimates are optional unless specified otherwise in this Summary of Dental Plan Benefits.

Eligibility Provisions

An Eligible Employee is an Employee who satisfies the following: the eligibility definition(s) specified by the Group and accepted by Delta Dental; and the Eligibility Waiting Period specified by the Group and agreed to by Delta Dental. The Eligibility Waiting Period shall not exceed twelve (12) months.

Eligible Employees may enroll on the first day of the month concurrent with their date of hire for Executive Class employees. The first day of the month following sixty (60) days of continuous employment for all other employees, subject to any additional requirements which may apply.

Benefits will cease on the last day of the month in which the employee is terminated, subject to any additional requirements which may apply.

Domestic Partners are not eligible to enroll in this Plan.

Special Benefit Provisions

None.

Your Network: Delta Dental PPO Point of Service

This section describes the types of Providers you may visit under your Plan and how fees and payments will work for different Providers.

Delta Dental PPO Provider	
Participates with Delta Dental?	Yes
Out-of-Pocket Costs for This Plan:	Lowest
Delta Dental Pays Up To:	Delta Dental PPO Maximum Approved Fees
Provider May Balance Bill You?	No
Description:	You will be responsible for any Coinsurance and Deductible (if applicable) for Covered Services up to the Delta Dental PPO Maximum Approved Fees. You are also responsible for the full payment for any non-covered services.

Delta Dental Premier Provider	
Participates with Delta Dental?	Yes
Out-of-Pocket Costs for This Plan:	Higher than Delta Dental PPO
Delta Dental Pays Up To:	Delta Dental Premier Maximum Approved Fees
Provider May Balance Bill You?	No
Description:	You will be responsible for any Coinsurance and Deductible (if applicable) for Covered Services up to the Delta Dental Premier Maximum Approved Fees. You are also responsible for the full payment for any non-covered services. Coinsurance amounts may be higher when selecting a Delta Dental Premier Provider.

Non-Participating Provider	
Participates with Delta Dental?	No
Out-of-Pocket Costs for This Plan:	Highest
Delta Dental Pays Up To:	Delta Dental's Non-Participating Maximum Approved Fees
Provider May Balance Bill You?	Yes, up to the Provider's Submitted Amount
Description:	In addition to any Coinsurance, Deductible (if applicable), and fees for non-covered services, you will be responsible for any difference between Delta Dental's Non-Participating Maximum Approved Fees and the Provider's Submitted Amount. Subscribers are responsible for full payment to a Non-Participating Provider. Any payment made by Delta Dental for services received from a Non-Participating Provider may be paid to the Provider or directly to the Subscriber.

Understanding Your Benefits

This Summary of Dental Plan Benefits only highlights Benefit levels; it does not provide complete coverage information. Refer to your Dental Benefit Handbook for other important eligibility and Plan provisions. This Summary of Dental Plan Benefits is attached to and is a component of the Dental Benefit Handbook. To the extent that the rules in the Dental Benefit Handbook conflict with the ones stated in this Summary of Dental Plan Benefits, the rules in this Summary of Dental Plan Benefits control.

Call Delta Dental's Customer Service Department at (877) 395-9420, or log into the Consumer Toolkit via www.deltadentalnm.com, for answers to questions about Benefits and claims.

vsp vision care

Make Eye Health a Priority with VSP!

Your health comes first with VSP and PRESBYTERIAN MEDICAL SERVICES. Take a look at your VSP vision care coverage.

VSP members save an annual average of

$489*

More Ways to Save

Extra $20 to spend on Featured Frame Brands†

bebe · Calvin Klein · COLE HAAN · DRAGON · FLEXON · LONGCHAMP PARIS · and more

Up to 40% Savings on lens enhancements‡

See all brands and offers at **vsp.com/offers**.

Enroll through your employer today.
Questions?
vsp.com
800.877.7195 (TTY: 711)

Scan QR code or visit **vsp.com** to learn more.

Routine eye exams have saved lives.

Did you know an eye exam is the only non-invasive way to view blood vessels in your body? Your VSP® network doctor can detect signs of more than 270 health conditions during your annual eye exam—including diabetes and high blood pressure, as well as eye conditions such as glaucoma and diabetic eye disease.**

Savings you'll love.

See and look your best without breaking the bank. VSP members get exclusive savings on popular frame brands and contact lenses, and they get additional discounts on things like LASIK, and more.

The choice is yours!

vsp PREMIER edge

With thousands of choices, getting the most out of your benefits is easy at a VSP Premier Edge™ location.

Shop online and connect your benefits.

eyeconic a vsp vision company

Save on Featured Frame Brands when you shop on Eyeconic®, the VSP in-network online eyewear store.

Getting started is easy!

Let your plan do the most it can. When you create an account on **vsp.com**, you can view your in-network coverage details, find a VSP network doctor that is right for you, and discover extra savings to maximize your benefits.

†Frame brands and promotion subject to change. Only available to VSP members with applicable plan benefits. Only available at in-network locations. Members who participate in a Medicaid/state-funded plan are not eligible.
‡Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.
*Based on state and national averages for eye exams and most commonly purchased brands. This represents the average savings for a VSP member with a full-service plan at an in-network provider. Your actual savings will depend on the eyewear you choose, the plan available to you, the eye doctor you visit, your copays, your premium, and whether it is deducted from your paycheck pre-tax. Source: VSP book-of-business paid claims data for Aug-Jan of each prior year. **Full Picture of Eye Health, American Optometric Association, 2020. +Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington. VSP Premier Edge™ is not available in all states.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**. Visionworks, Eyeconic, and Eyemart Express family of stores are VSP-affiliated companies.

Classification: Restricted

Your VSP Vision Benefits Summary

Prioritize your health and your budget with a VSP plan through PRESBYTERIAN MEDICAL SERVICES.

Provider Network:
VSP Signature
Effective Date:
04/01/2026

vsp vision care

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
YOUR COVERAGE WITH A VSP DOCTOR			
WELLVISION EXAM	• Focuses on your eyes and overall wellness • Routine retinal screening	$10 Up to $39	Every 12 months
ESSENTIAL MEDICAL EYE CARE	• Retinal imaging for members with diabetes covered-in-full • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP network doctor for details.	$20 per exam	Available as needed
PRESCRIPTION GLASSES		**$10**	See frame and lenses
FRAME[+]	• $240 Featured Frame Brands allowance • $220 frame allowance • 20% savings on the amount over your allowance • $220 Walmart/Sam's Club frame allowance • $120 Costco frame allowance	Included in Prescription Glasses	Every 24 months
LENSES	• Single vision, lined bifocal, and lined trifocal lenses	Included in Prescription Glasses	Every 12 months
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Impact-resistant lenses • Average savings of 40% on other lens enhancements	$0 $80 - $90 $120 - $160 $0	Every 12 months
CONTACTS (INSTEAD OF GLASSES)	• $220 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
VSP LIGHTCARE™[+]	• $220 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts	$10	Every 24 months
ADDITIONAL SAVINGS	**Glasses and Sunglasses** • Discover all current eyewear offers and savings at **vsp.com/offers**. • 30% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% savings from a VSP provider within 12 months of your last WellVision Exam.		
	Laser Vision Correction • Average of 15% off the regular price; discounts available at contracted facilities.		
	Exclusive Member Extras for VSP Members • Contact lens rebates, lens satisfaction guarantees, and more offers at **vsp.com/offers**. • Save up to 60% on digital hearing aids with TruHearing®. Visit **vsp.com/offers/special-offers/hearing-aids** for details. • Enjoy everyday savings on health, wellness, and more with VSP Simple Values.		

COVERAGE WITH AN OUT-OF-NETWORK DOCTOR

With so many in-network choices, VSP makes it easy to maximize your benefits. Choose from our large doctor network including private practice and retail locations. Plus, you can shop eyewear online at Eyeconic®. Log in to **vsp.com** to find an in-network doctor. Your plan provides the following out-of-network reimbursements:

Exam ..... up to $50	Lined Bifocal Lenses ..... up to $75	Progressive Lenses ..... up to $75
Frame ..... up to $70	Lined Trifocal Lenses ..... up to $100	Contacts ..... up to $105
Single Vision Lenses ..... up to $50		

UNITED OF OMAHA LIFE INSURANCE COMPANY
A MUTUAL of OMAHA COMPANY

Voluntary Accident Insurance

If you broke a leg, would it break your bank account too?

Don't let an accident catch you off guard. Protect your family's finances with Accident Insurance from United of Omaha Life Insurance Company.

An accident insurance policy supplements your medical coverage and provides a cash benefit for injuries you or an insured family member sustain from an accident. This benefit can be used to pay out-of-pocket medical expenses, help supplement your daily living expenses and cover unpaid time off work.

As an active employee of Presbyterian Medical Services, Inc., you may purchase this coverage for yourself and your family members, and premiums can be deducted from your paycheck. It's a simple and affordable way for your family to receive added financial protection.

Coverage guidelines and benefits are outlined below.

This insurance offers financial protection by paying a cash benefit if you or an insured dependent are injured as a result of a covered accident. Unless otherwise stated, the benefit amount payable is the same for you and your insured dependent(s).

Two accident plans are available to you, **Option 1: Full Plan 1H (NM-NC-CAT-NABM)** and **Option 2: Full Plan 1M (NM-NC-CAT-NABM)**. You have the flexibility to enroll for the plan that best meets your (and your family's) supplemental insurance needs.

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES		
Eligibility Requirement	You must be actively working a minimum of 20 hours per week to be eligible for coverage.	
Dependent Eligibility Requirement	To be eligible for coverage, your dependents must be able to perform normal activities, and not be confined (at home, in a hospital, or in any other care facility), and any child(ren) must be under age 26. In order for your spouse and/or children to be eligible for coverage, you must elect coverage for yourself.	
Premium Payment	The premiums for this insurance are paid in full by you.	
PLAN INFORMATION	**OPTION 1**	**OPTION 2**
Plan Type	Full Plan 1H (NM-NC-CAT-NABM)	Full Plan 1M (NM-NC-CAT-NABM)
Coverage Type	24-hour (On and off-job)	24-hour (On and off-job)
Express Benefit	$100	$75
Portability	Included	Included

BENEFITS	OPTION 1	OPTION 2
Initial Care & Emergency[1] – Most treatment / service required within 72 hours of accident; Once per accident per insured person		
Emergency Room	$200	$150
Urgent Care Center	$125	$100
Initial Physician Office Visit	$100	$75
Ambulance	Up to $1,500	Up to $1,000
Specified Injuries[1,2]		
Fractures (Surgical / Non-surgical)	Up to $6,000 / Up to $3,000	Up to $5,000 / Up to $2,500
Dislocations (Surgical / Non-surgical)	Up to $9,000 / Up to $4,500	Up to $6,000 / Up to $3,000
Lacerations	Up to $800	Up to $600
Burns	Up to $15,000	Up to $10,000
Dental	Up to $300	Up to $200
Hospital, Surgical & Diagnostic[1,3]		
Admission	$1,500	$1,000
Daily Confinement (Up to 365 days per accident)	$300 per day	$200 per day
ICU Confinement (Up to 15 days per accident)	$600 per day	$400 per day
Rehab. Facility Confinement (Up to 30 days per accident)	$150 per day	$100 per day
Surgical	Up to $2,000	Up to $1,500
Diagnostic	Up to $300	Up to $200
Follow-Up Care[1] – Treatment / service required within 365 days of accident; Medical device is once per accident per insured person		
Physician Follow-Up Office Visit	$100; Up to 2 per accident	$75; Up to 2 per accident
Therapy Services	$50; Up to 6 per accident	$25; Up to 6 per accident
Medical Device	$200	$100
Prosthetic Device(s)	$1,000; Up to 2 per accident	$750; Up to 2 per accident
Additional Benefits[1] – Benefits are payable within 365 days of accident		
Transportation (Up to 3 trips per accident)	$450 per trip	$300 per trip
Lodging (Up to 30 nights per accident)	$150 per night	$125 per night
Childcare (Up to 30 days per accident)	$30 per day	$20 per day
Catastrophic Benefits[1,4] – Benefits are payable within 365 days of accident; Once per accident per insured person		
Principal Sum (PS)	You: $60,000 Spouse: $30,000 Child(ren): $15,000	You: $40,000 Spouse: $20,000 Child(ren): $10,000
Common Carrier Accidental Death	300% of PS	300% of PS
Transportation of Remains	Up to $5,000	Up to $5,000
Dismemberment & Paralysis	Up to 100% of PS	Up to 100% of PS
Reasonable Modifications	Up to 10% of PS	Up to 10% of PS
Coma	25% of PS	50% of PS
SERVICES		
Hearing Discount Program	The Hearing Discount program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.	

[1]Additional limitations apply as described in the certificate. [2]Fractures and dislocations require treatment within 90 days of accident, burns and lacerations within 72 hours of an accident, and dental care within 30 days. If an insured person sustains both a fracture and dislocation as the result of the same accident, the maximum amount payable is up to 200% of the amount payable for the injury with the highest applicable benefit amount. [3]Daily confinement must begin with 90 days of accident and ICU confinement within 30 days. Surgical treatment timeframes vary. If applicable, diagnostic services must be received within 90 days of accident. Except for admission and confinement benefits, most benefits are payable once per accident per insured person. If any surgery occurs concurrently with an open reduction for a fracture or dislocation of the same bone or joint as a result of the same accident, only the highest applicable benefit is payable. 4.The principal sum for you & your spouse reduces by 50% when you reach the age of 70.

How Accident Insurance Works

(For Illustration Purposes Only)

Accident Coverage

This insurance pays a benefit for each injury, treatment or service included in the policy that occurs as the result of a covered accident.

For example, Jeff's son, Jake, was playing soccer during recess at school. He was tripped and falls hard, injures his shoulder, and is transported by ambulance to the ER due to concerns of head trauma. The ER doctor orders a CT scan to check for any facial or head injuries and a shoulder X-ray.

Jake was diagnosed with a concussion and a broken collarbone. His arm was set in a sling, and he was released to his pediatrician for follow-up care. Jake visits his pediatrician at two weeks and one month after the accident to make sure he's healing well.

In the meantime, Jeff starts receiving bills for the care Jake received. The ambulance bill alone was $556. He's a pretty healthy kid, so a health insurance deductible of $1,500 had to be met before Jeff's health insurance would begin covering Jake's care, and after that, there's a 20% copay.

Accident benefits pay in addition to other insurance, and can be used to help cover gaps in health insurance or other expenses if the unexpected happens.

BENEFITS	AMOUNT
Ambulance	$200
ER Visit	$150
CT Scan	$200
X-ray	$50
Concussion	$150
Broken Collarbone	$300
Follow-Up Visit 1	$75
Follow-Up Visit 2	$75
Total Benefit	$1,200

Note: The benefits shown in this example are for a sample design and may vary from the benefits that are available to you.

Voluntary Accident Premium Rates

The amounts shown below are **SEMI-MONTHLY** amounts (24 payments / deductions per year). You may elect insurance for you only, or for your family. You have a choice of plan options. Premiums will be automatically deducted from your paychecks as authorized by you during the enrollment process.

COVERAGE TIER	OPTION 1	OPTION 2
Employee/Member	$11.54 ($0.76 per day)	$8.18 ($0.54 per day)
Employee/Member + Spouse	$18.07 ($1.19 per day)	$12.83 ($0.84 per day)
Employee/Member + Child(ren)	$20.52 ($1.35 per day)	$14.55 ($0.96 per day)
Employee/Member + Family	$27.93 ($1.84 per day)	$19.84 ($1.30 per day)

Note: The amount(s) above may vary due to rounding and are subject to change based on the final terms of the policy.

Frequently Asked Questions

Who is eligible for this insurance?

- You must be actively working (performing all normal duties of your job) at least 20 hours per week and be under age 80
- Your dependent(s) must be performing normal activities and not be confined (at home or in a hospital / care facility) and any child(ren) must be under age 26

What is the “Express Benefit”?

This benefit is payable upon notification of an accident in which an insured person is injured. It can be paid in a short time frame with minimal information (compared to a typical claim).

Can I take this insurance with me if I change jobs / am no longer a member of this group?

In the event this insurance ends due to a change in your employment / membership status with the group, or for certain other reasons, you or your insured spouse have the right to continue this insurance under the Portability provision, subject to certain conditions.

When does this insurance end?

Insurance will end on the last day of the month in which an insured person no longer satisfies the applicable eligibility conditions, or when you reach the age of 80. Additional circumstances under which insurance will end are described in the certificate.

Are there any exclusions or limitations?

The benefits payable are based on the insurance in effect on the date of the covered accident, subject to the definitions, limitations, exclusions and other provisions of the policy. The exclusions and limitations are summarized in the outline of coverage and detailed in the certificate. Please contact your benefits administrator for a copy of the outline of coverage or if you have questions prior to enrolling.

Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

Voluntary Critical Illness Insurance

An unexpected critical illness can have a lasting impact on you and your family – physically, emotionally and financially.

As an active employee of Presbyterian Medical Services, you can give your family the extra security they need to lessen the financial impact of a serious illness by purchasing Critical Illness insurance through United of Omaha Life Insurance Company.

A critical illness insurance policy provides a lump-sum cash benefit upon diagnosis of a critical illness like a heart attack, stroke or cancer. The benefit can be used to pay out-of-pocket expenses or to supplement your daily cost of living.

How much insurance is enough?

Even if you have the best health insurance plan, it will not cover 100 percent of medical expenses. You also need to consider other expenses associated with the recovery process – time off work, travel to treatment centers, home modifications – that may quickly deplete your savings.

Coverage guidelines and benefits are outlined in the chart below.

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES		
Eligibility Requirement	You must be actively working a minimum of 20 hours per week to be eligible for coverage.	
Dependent Eligibility Requirement	To be eligible for coverage, your dependents must be able to perform normal activities, and not be confined (at home, in a hospital, or in any other care facility), and any child(ren) must be under age 26. In order for your spouse and/or children to be eligible for coverage, you must elect coverage for yourself.	
Premium Payment	The premiums for this insurance are paid in full by you. Child insurance is automatic. A separate premium is not required.	
BENEFIT CATEGORY[1]	**CONDITION**	**% OF CI PRINCIPAL SUM**
Heart/Circulatory/Motor Function	Heart Attack, Heart Transplant, Stroke, ALS (Lou Gehrig's), Advanced Alzheimer's, Advanced Parkinson's	100%
	Heart Valve Surgery, Coronary Artery Bypass, Aortic Surgery	25%

Organ	Major Organ Transplant/Placement on UNOS List, End-Stage Renal Failure	100%
	Acute Respiratory Distress Syndrome (ARDS)	25%
Childhood/Developmental *benefits only available to children	Cerebral Palsy, Structural Congenital Defects, Genetic Disorders, Congenital Metabolic Disorders, Type 1 Diabetes	100%
Cancer	Cancer (Invasive)	100%
	Bone Marrow Transplant	50%
	Carcinoma in Situ, Benign Brain Tumor	25%

COVERAGE GUIDELINES[2]			
	MINIMUM	**MAXIMUM**	**GUARANTEE ISSUE**[3]
For You Elect in $5,000 increments	$5,000	$50,000	$50,000
Spouse Elect in $5,000 increments	$5,000	100% of employee's CI Principal Sum, up to $50,000	$50,000
Child(ren) *benefit for each child	25% of employee's CI Principal Sum, up to $10,000		$5,000

ADDITIONAL BENEFITS	
Policy Benefit Maximum	The maximum payout amount is 400% of the CI Principal Sum amount for each insured person. If the policy benefit maximum is reached for an insured person, the coverage will terminate. Dependents will remain insured if you continue to satisfy the eligibility requirements of the policy.
Health Screening Benefit	Pays a flat, annual benefit of $100 for a health screening test.
Additional Occurrence Benefit	Once benefits have been paid for a Critical Illness, no additional benefits are payable for that same Critical Illness for each insured person. Benefits are still payable for any other Critical Illness in the same benefit category, for each insured person.
Reoccurrence Benefit	The reoccurrence benefit is equal to 100% of the Critical Illness principal sum.
Portability	When insurance ends, you have the right to continue group Critical Illness insurance for yourself and your dependents.

CONDITIONS & LIMITATIONS	
Age Reductions	When you turn age 70, the original amount of insurance will reduce to 50% for both you and your spouse.
Benefit Waiting Period	There is no benefit waiting period.

SERVICES	
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.
Advocacy	Advocacy services give an employee who has been diagnosed with a medical condition access to skilled clinicians and nurses for personalized, problem-solving assistance in a one-on-one setting. Call 1-866-372-5577 Monday – Friday 7 A.M. to 7 P.M. CST or email customerserve@personifyhealth.com for assistance.

[1]Payment of a partial benefit reduces the remaining amount payable in a category.

[2]The amount of insurance for your spouse and child(ren) will be rounded to the next higher multiple of $1,000, if not already an even multiple of $1,000.

[3]Subject to any reductions, Guarantee Issue is available to new hires. Amounts over the Guarantee Issue will require a health application/evidence of insurability. For late entrants, all amounts will require a health application/evidence of insurability. Amounts over the Guarantee Issue and/or not meeting minimum participation levels will require a health application/evidence of insurability.

Voluntary Critical Illness Coverage Selection and Premium Calculation

Please note that the premium amounts presented below may vary slightly from the amounts provided on your enrollment form, due to rounding.

The premium rates for employees under this plan are contingent upon tobacco use. If you have used tobacco in any form (cigarettes, chewing tobacco, forms of nicotine replacement, etc.) during the last 12 months, you must refer to the tobacco premium table. If not, refer to the non-tobacco premium table.

To select your benefit amount and calculate your premium, do the following:

1) Locate the benefit amount you want from the top row of the employee premium table (tobacco or non-tobacco). Your benefit amount must be in an increment of $5,000. Refer to the Coverage Guidelines section for minimums and maximums, if needed.
2) Find your age bracket in the far left column.
3) Your premium amount is found in the box where the row (your age) and the column (benefit amount) intersect.
4) Enter the benefit and premium amounts into their respective areas in the Voluntary Critical Illness section of your enrollment form.

If the benefit amount you want to select is greater than any amount in the table below, select the benefit amount from the top row that when multiplied by another number results in the benefit amount you want to select. For example, if you want $20,000 in coverage, you obtain your premium amount by multiplying the rate for $10,000 times 2.

VOLUNTARY CRITICAL ILLNESS EMPLOYEE OR SPOUSE PREMIUM RATES FOR NON-TOBACCO USERS (24 PAYROLL DEDUCTIONS PER YEAR)

Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
0 - 24	$0.85	$1.70	$2.55	$3.40	$4.25	$5.10	$5.95	$6.80	$7.65	$8.50
25 - 29	$1.03	$2.05	$3.08	$4.10	$5.13	$6.15	$7.18	$8.20	$9.23	$10.25
30 - 34	$1.35	$2.70	$4.05	$5.40	$6.75	$8.10	$9.45	$10.80	$12.15	$13.50
35 - 39	$1.80	$3.60	$5.40	$7.20	$9.00	$10.80	$12.60	$14.40	$16.20	$18.00
40 - 44	$2.60	$5.20	$7.80	$10.40	$13.00	$15.60	$18.20	$20.80	$23.40	$26.00
45 - 49	$3.55	$7.10	$10.65	$14.20	$17.75	$21.30	$24.85	$28.40	$31.95	$35.50
50 - 54	$4.65	$9.30	$13.95	$18.60	$23.25	$27.90	$32.55	$37.20	$41.85	$46.50
55 - 59	$6.10	$12.20	$18.30	$24.40	$30.50	$36.60	$42.70	$48.80	$54.90	$61.00
60 - 64	$8.50	$17.00	$25.50	$34.00	$42.50	$51.00	$59.50	$68.00	$76.50	$85.00
65 - 69	$11.33	$22.65	$33.98	$45.30	$56.63	$67.95	$79.28	$90.60	$101.93	$113.25
70 - 74	$15.90	$31.80	$47.70	$63.60	$79.50	$95.40	$111.30	$127.20	$143.10	$159.00
75+	$21.88	$43.75	$65.63	$87.50	$109.38	$131.25	$153.13	$175.00	$196.88	$218.75

VOLUNTARY CRITICAL ILLNESS EMPLOYEE OR SPOUSE PREMIUM RATES FOR TOBACCO USERS (24 PAYROLL DEDUCTIONS PER YEAR)

Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
0 - 24	$0.88	$1.75	$2.63	$3.50	$4.38	$5.25	$6.13	$7.00	$7.88	$8.75
25 - 29	$1.08	$2.15	$3.23	$4.30	$5.38	$6.45	$7.53	$8.60	$9.68	$10.75
30 - 34	$1.45	$2.90	$4.35	$5.80	$7.25	$8.70	$10.15	$11.60	$13.05	$14.50
35 - 39	$2.05	$4.10	$6.15	$8.20	$10.25	$12.30	$14.35	$16.40	$18.45	$20.50
40 - 44	$3.10	$6.20	$9.30	$12.40	$15.50	$18.60	$21.70	$24.80	$27.90	$31.00
45 - 49	$4.68	$9.35	$14.03	$18.70	$23.38	$28.05	$32.73	$37.40	$42.08	$46.75
50 - 54	$6.93	$13.85	$20.78	$27.70	$34.63	$41.55	$48.48	$55.40	$62.33	$69.25
55 - 59	$10.00	$20.00	$30.00	$40.00	$50.00	$60.00	$70.00	$80.00	$90.00	$100.00
60 - 64	$15.15	$30.30	$45.45	$60.60	$75.75	$90.90	$106.05	$121.20	$136.35	$151.50
65 - 69	$21.75	$43.50	$65.25	$87.00	$108.75	$130.50	$152.25	$174.00	$195.75	$217.50
70+	$29.15	$58.30	$87.45	$116.60	$145.75	$174.90	$204.05	$233.20	$262.35	$291.50

Child dependent coverage is offered at no additional cost.

Follow the method described above to select a benefit amount and calculate premiums for optional dependent spouse coverage. **Your spouse's rate is based on your age,** so find your age bracket in the far left column of the Spouse Premium Table. Your spouse's premium amount is found in the box where the row (the age) and the column (benefit amount) intersect. Your spouse's benefit amount must be in an increment of $5,000. Refer to the Coverage Guidelines section for minimums and maximums, if needed.

SPOUSE PREMIUM RATES FOR NON-TOBACCO USERS (24 PAYROLL DEDUCTIONS PER YEAR)										
Age	**$5,000**	**$10,000**	**$15,000**	**$20,000**	**$25,000**	**$30,000**	**$35,000**	**$40,000**	**$45,000**	**$50,000**
0 - 24	$0.85	$1.70	$2.55	$3.40	$4.25	$5.10	$5.95	$6.80	$7.65	$8.50
25 - 29	$1.03	$2.05	$3.08	$4.10	$5.13	$6.15	$7.18	$8.20	$9.23	$10.25
30 - 34	$1.35	$2.70	$4.05	$5.40	$6.75	$8.10	$9.45	$10.80	$12.15	$13.50
35 - 39	$1.80	$3.60	$5.40	$7.20	$9.00	$10.80	$12.60	$14.40	$16.20	$18.00
40 - 44	$2.60	$5.20	$7.80	$10.40	$13.00	$15.60	$18.20	$20.80	$23.40	$26.00
45 - 49	$3.55	$7.10	$10.65	$14.20	$17.75	$21.30	$24.85	$28.40	$31.95	$35.50
50 - 54	$4.65	$9.30	$13.95	$18.60	$23.25	$27.90	$32.55	$37.20	$41.85	$46.50
55 - 59	$6.10	$12.20	$18.30	$24.40	$30.50	$36.60	$42.70	$48.80	$54.90	$61.00
60 - 64	$8.50	$17.00	$25.50	$34.00	$42.50	$51.00	$59.50	$68.00	$76.50	$85.00
65 - 69	$11.33	$22.65	$33.98	$45.30	$56.63	$67.95	$79.28	$90.60	$101.93	$113.25
70 - 74	$15.90	$31.80	$47.70	$63.60	$79.50	$95.40	$111.30	$127.20	$143.10	$159.00
75+	$21.88	$43.75	$65.63	$87.50	$109.38	$131.25	$153.13	$175.00	$196.88	$218.75

SPOUSE PREMIUM RATE FOR TOBACCO USERS (24 PAYROLL DEDUCTIONS PER YEAR)										
Age	**$5,000**	**$10,000**	**$15,000**	**$20,000**	**$25,000**	**$30,000**	**$35,000**	**$40,000**	**$45,000**	**$50,000**
0 - 24	$0.88	$1.75	$2.63	$3.50	$4.38	$5.25	$6.13	$7.00	$7.88	$8.75
25 - 29	$1.08	$2.15	$3.23	$4.30	$5.38	$6.45	$7.53	$8.60	$9.68	$10.75
30 - 34	$1.45	$2.90	$4.35	$5.80	$7.25	$8.70	$10.15	$11.60	$13.05	$14.50
35 - 39	$2.05	$4.10	$6.15	$8.20	$10.25	$12.30	$14.35	$16.40	$18.45	$20.50
40 - 44	$3.10	$6.20	$9.30	$12.40	$15.50	$18.60	$21.70	$24.80	$27.90	$31.00
45 - 49	$4.68	$9.35	$14.03	$18.70	$23.38	$28.05	$32.73	$37.40	$42.08	$46.75
50 - 54	$6.93	$13.85	$20.78	$27.70	$34.63	$41.55	$48.48	$55.40	$62.33	$69.25
55 - 59	$10.00	$20.00	$30.00	$40.00	$50.00	$60.00	$70.00	$80.00	$90.00	$100.00
60 - 64	$15.15	$30.30	$45.45	$60.60	$75.75	$90.90	$106.05	$121.20	$136.35	$151.50
65 - 69	$21.75	$43.50	$65.25	$87.00	$108.75	$130.50	$152.25	$174.00	$195.75	$217.50
70+	$29.15	$58.30	$87.45	$116.60	$145.75	$174.90	$204.05	$233.20	$262.35	$291.50

Frequently Asked Questions

Who is eligible for this insurance?

- You must be actively working (performing all normal duties of your job) at least 20 hours per week
- Your dependent(s) must be performing normal activities and not be confined (at home or in a hospital / care facility) and any child(ren) must be under age 26

What is the additional occurrence benefit?

Once benefits have been paid for a Critical Illness, no additional benefits are payable for that same Critical Illness for each insured person. Benefits are still payable for any other Critical Illness in the same benefit category, for each insured person.

What is the reoccurrence benefit?

Once benefits have been paid for a Critical Illness, a reoccurrence benefit is payable one time for a subsequent diagnosis of the same Critical Illness, subject to certain conditions. The reoccurrence benefit is equal to 100% of the Critical Illness principal sum.

Can I take this insurance with me if I change jobs / am no longer a member of this group?

In the event this insurance ends due to a change in your employment / membership status with the group, or for certain other reasons, you or your insured spouse have the right to continue this insurance under the Portability provision, subject to certain conditions.

Are there any limitations or exclusions?

The benefits payable are subject to the following:

- Your plan is subject to a pre-existing condition limitation. A pre-existing condition is one for which you have received medical treatment, consultation, care or services including diagnostic measures, or if you were prescribed or took prescription medications in the predetermined time frame prior to your effective date of coverage. The pre-existing condition under this plan is 12/12 which means any condition that you receive medical attention for in the 12 months prior to your effective date of coverage that results in a disability during the first 12 months of coverage, would not be covered.
- Benefits are not payable for any Critical Illness that:
  - Is diagnosed prior to the effective date of insurance under the Policy for the Insured Person
  - Results, whether the insured person is sane or insane, from an intentionally self-inflicted injury or illness, suicide, or attempted suicide
  - Results from an act of declared or undeclared war or armed aggression
  - Is incurred while the insured person is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country and for which any governmental body or its agencies are liable
  - Results from illegal activities, including participation in an illegal occupation
  - Is the result of the voluntary use of illegal drugs by an insured person; the intentional misuse of over the counter medication or prescription drugs by an insured person that is not in accordance with recommended dosage and/or warning instruction(s); or the excessive or harmful use of alcohol and/or alcoholic drinks by an insured person
  - Is diagnosed outside of the United States

All exclusions may not be applicable, or may be adjusted, as required by state regulations.

Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

Voluntary Short-Term Disability Insurance

How Would You Pay Your Bills if You Were Sick or Injured Temporarily?

Even a short illness or injury could seriously impact your paycheck. Sick time will get you by while it lasts, but what happens when your sick days run out? A short-term disability policy provides you with cash benefits when you need it.

We've Got You Covered

As an active employee of Presbyterian Medical Services, you have access to a disability income insurance policy from United of Omaha Life Insurance Company.

A disability income insurance policy can help provide security when you need it, plus give you peace of mind so you can recover faster and get back on the job sooner.

Coverage guidelines and benefits are outlined below.

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES	
Eligibility Requirement	You must be actively working a minimum of 20 hours per week to be eligible for coverage.
Premium Payment	The premiums for this insurance are paid in full by you.
BENEFITS	
Elimination Period	If you become disabled, there is an elimination period before benefits are payable. Your benefits begin: • On the 15th day of your disabling injury. • On the 15th day of your disabling illness.
Weekly Benefit	Your benefit is equivalent to 60% of your before-tax weekly earnings, not to exceed the plan's maximum weekly benefit amount less other income sources. The premium for your short-term disability coverage is waived while you are receiving benefits.
Maximum Benefit Period	Up to 24 weeks
Maximum Weekly Benefit	$1,500
Minimum Weekly Benefit	$25

Partial Disability Benefits	If you become disabled and can work part-time (but not full-time), you may be eligible for partial disability benefits, which will help supplement your income until you are able to return to work full-time.
DEFINITIONS	
Definition of Disability	Disability and disabled mean that because of an injury or illness, a significant change in your mental or functional abilities has occurred, for which you are prevented from performing at least one of the material duties of your regular job and are unable to generate current earnings which exceed 99% of your weekly earnings from your regular job. You can be totally or partially disabled during the elimination period.
Definition of Weekly Earnings	Weekly earnings for salaried employees is the gross annual salary in effect immediately prior to the date disability begins, divided by 52. Weekly earnings for hourly employees is the hourly rate of pay multiplied by the average number of hours worked per week during the 12 month period immediately prior to the date disability begins. If employed for part of the prior 12 month period, weekly earnings is the hourly rate of pay multiplied by the average number of hours worked.
FEATURES	
Voluntary Vocational Rehabilitation Benefit	If you become disabled and choose to participate in the vocational rehabilitation program, you will be eligible for a weekly benefit increase of 10%.
Portability	The portability feature allows you to apply for disability insurance through a trust policy should your employment end, without having to provide evidence of insurability. You will be responsible for paying the premium for coverage.
SERVICES	
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.

VOLUNTARY SHORT-TERM DISABILITY PREMIUM CALCULATION

Use the rates in the Age/Premium Factor Table to calculate your premium for voluntary short-term disability coverage in the worksheet below, using the example as a guide.

BI-WEEKLY PREMIUM CALCULATION		EXAMPLE *(42-year-old employee earning $40,000 a year)*
List your weekly earnings (Maximum is $2,500)	$ _____	$ *769.23*
Multiply by the premium factor	_____	*0.0426000*
Your Estimated Bi-Weekly Premium**	$ _____	$ *32.77*

AGE	PREMIUM FACTOR
< 50	0.0426000
50 - 59	0.0564000
60+	0.0756000

**This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

Frequently Asked Questions

Who is eligible for this insurance?

You must be actively working (performing all normal duties of your job) at least 20 hours per week.

How long will my benefits be paid?

Benefits begin after the end of the elimination period and can be payable up to the maximum benefit period as long as you remain disabled.

Will my benefits be reduced by other sources of income?

Yes, depending on the type of income you receive. Your benefit amount may be reduced by other sources of income such as retirement/government plans, other group disability plans, salary continuance/sick leave, settlements on payments received and no-fault benefits.

Does this plan cover me if I become disabled due to an injury at work?

No, your STD insurance only provides benefits for off-the-job coverage for disabilities due to injury or sickness.

Are there any limitations or exclusions?

The benefits payable are subject to the following:

- Your plan is subject to a pre-existing condition limitation. A pre-existing condition is one for which you have received medical treatment, consultation, care or services including diagnostic measures, or if you were prescribed or took prescription medications in the predetermined time frame prior to your effective date of coverage. The pre-existing condition under this plan is 3/6 which means any condition that you receive medical attention for in the 3 months prior to your effective date of coverage that results in a disability during the first 6 months of coverage, would not be covered.

Benefits are not payable for any disability or loss that:

- Results from an act of declared or undeclared war
- Results from participation in a riot or commission of or attempt to commit a felony
- Arises out of or in the course of employment with the policyholder for benefits under any workers' compensation or occupational disease law, or receives any settlement from the workers' compensation carrier
- Results, whether the insured person is sane or insane, from an intentionally self-inflicted injury, or attempted suicide
- Occurs while incarcerated or imprisoned in a penal or correctional facility for any period exceeding 31 days

All exclusions may not be applicable, or may be adjusted, as required by Interstate Insurance Product Regulation Commission standards.

Can I take this insurance with me if I change jobs/am no longer a member of this group?

In the event this insurance ends due to a change in your employment/membership status with the group, or for certain other reasons, you have the right to port your coverage to a group trust plan, subject to certain conditions.

United of Omaha Life Insurance Company
A Mutual of Omaha Company

Voluntary Term Life Insurance

Help Protect What Matters – You, Your Family & Your Future

We understand you've worked hard to get where you are today. Ensuring your loved ones can maintain financial stability if an unexpected death should occur is something to consider when planning for the future.

We've Got You Covered

As an active employee of Presbyterian Medical Services, you have access to a life insurance policy from United of Omaha Life Insurance Company.

It replaces the income you would have provided, and helps pay funeral costs, manage debt and cover ongoing expenses.

How much insurance is enough?

When determining how much life insurance you need, think about the expenses you may encounter now and through every stage of your life.

Coverage guidelines and benefits are outlined in the chart below.

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES	
Eligibility Requirement	You must be actively working a minimum of 20 hours per week to be eligible for coverage.
Dependent Eligibility Requirement	To be eligible for coverage, your dependents must be able to perform normal activities, and not be confined (at home, in a hospital, or in any other care facility), and any child(ren) must be under age 26. In order for your spouse and/or children to be eligible for coverage, you must elect coverage for yourself.
Premium Payment	The premiums for this insurance are paid in full by you.

COVERAGE GUIDELINES			
	Minimum	**Guarantee Issue**	**Maximum**
For You	$10,000	5 times annual salary, up to $250,000	$500,000, in increments of $10,000, but no more than 5 times annual salary
Spouse	$5,000	100% of employee's benefit,	100% of employee's benefit, up to $100,000

		up to $50,000	
Children	$2,000	100% of employee's benefit	100% of employee's benefit, up to $10,000

Subject to any reductions shown below. Guarantee Issue is available to new hires. Amounts over the Guarantee Issue will require a health application/evidence of insurability. For late entrants, all amounts will require a health application/evidence of insurability.

BENEFITS	
Life Insurance Benefit Amount	Within the coverage guidelines defined above, you select the amount of life insurance coverage you want. This plan includes the option to select coverage for your spouse and dependent children. Children include those, up to age 26. In the event of death, the benefit paid will be equal to the benefit amount after any age reductions less any living care/accelerated death benefits previously paid under this plan.
FEATURES	
Living Care/ Accelerated Death Benefit	75% of the amount of the life insurance benefit is available to you and your spouse if terminally ill, not to exceed $250,000.
Waiver of Premium	If it is determined that you are totally disabled, your life insurance benefit will continue without payment of premium, subject to certain conditions.
Annual Benefit Amount Increase	If you enroll for even the minimum amount of coverage during your initial enrollment, you have the ability to enroll for additional coverage at your next enrollment by up to $10,000, provided the total amount of insurance does not exceed your maximum benefit amount. This feature allows you to secure additional life insurance protection in the event your needs change (ex. you get married or have a child). Amounts over the Guarantee Issue will require evidence of insurability (proof of good health).
Portability	Allows you to continue this insurance program for yourself and your dependents should you leave your employer for any reason, without having to provide evidence of insurability (information about your health). You will be responsible for the premium for the coverage.
Conversion	If your employment ends, you may apply for an individual life insurance policy from Mutual of Omaha without having to provide evidence of insurability (information about your health). You will be responsible for the premium for the coverage.
SERVICES	
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.
Will Prep Services	We work with Epoq, Inc. to offer employees online will prep tools. In just a few clicks you can complete a basic will or other documents to protect your family and property. To get started visit www.willprepservices.com.

AGE REDUCTIONS AND EXCLUSIONS

Insurance benefits and guarantee issue amounts are subject to age reductions:

- At age 70, amounts reduce to 50%

Spouse coverage terminates when you reach age 70.

Life insurance benefits will not be paid if the insured's death is the result of suicide within two years from the date coverage begins. If this occurs, the sum of the premiums paid will be returned to the beneficiary. The same applies for any future increases in coverage under this plan.

Please contact your employer if you have questions prior to enrolling.

Voluntary Term Life Coverage Selection and Premium Calculation

Please note that the premium amounts presented below may vary slightly from the amounts provided on your enrollment form, due to rounding.

To select your benefit amount and calculate your premium, do the following:

1) Locate the benefit amount you want from the top row of the employee premium table. Your benefit amount must be in an increment of $10,000. Refer to the Coverage Guidelines section for minimums and maximums, if needed.
2) Find your age bracket in the far left column.
3) Your premium amount is found in the box where the row (your age) and the column (benefit amount) intersect.
4) Enter the benefit and premium amounts into their respective areas in the Voluntary Life section of your enrollment form.

If the benefit amount you want to select is greater than any amount in the table below, select the benefit amount from the top row that when multiplied by another number results in the benefit amount you want. For example, if you want $150,000 in coverage, you obtain your premium amount by multiplying the rate for $50,000 times 3.

EMPLOYEE PREMIUM TABLE (24 PAYROLL DEDUCTIONS PER YEAR)										
Age	**$10,000**	**$20,000**	**$30,000**	**$40,000**	**$50,000**	**$60,000**	**$70,000**	**$80,000**	**$90,000**	**$100,000**
0 - 29	$0.46	$0.92	$1.38	$1.84	$2.30	$2.76	$3.22	$3.68	$4.14	$4.60
30 - 34	$0.55	$1.10	$1.65	$2.20	$2.75	$3.30	$3.85	$4.40	$4.95	$5.50
35 - 39	$0.63	$1.25	$1.88	$2.50	$3.13	$3.75	$4.38	$5.00	$5.63	$6.25
40 - 44	$0.83	$1.66	$2.49	$3.32	$4.15	$4.98	$5.81	$6.64	$7.47	$8.30
45 - 49	$1.29	$2.57	$3.86	$5.14	$6.43	$7.71	$9.00	$10.28	$11.57	$12.85
50 - 54	$1.74	$3.48	$5.22	$6.96	$8.70	$10.44	$12.18	$13.92	$15.66	$17.40
55 - 59	$2.90	$5.79	$8.69	$11.58	$14.48	$17.37	$20.27	$23.16	$26.06	$28.95
60 - 64	$4.01	$8.01	$12.02	$16.02	$20.03	$24.03	$28.04	$32.04	$36.05	$40.05
65 - 69	$6.94	$13.87	$20.81	$27.74	$34.68	$41.61	$48.55	$55.48	$62.42	$69.35
70 - 74	$10.36	$20.72	$31.08	$41.44	$51.80	$62.16	$72.52	$82.88	$93.24	$103.60
75 - 79	$18.24	$36.48	$54.72	$72.96	$91.20	$109.44	$127.68	$145.92	$164.16	$182.40
80+	$30.70	$61.39	$92.09	$122.78	$153.48	$184.17	$214.87	$245.56	$276.26	$306.95

Follow the method described above to select a benefit amount and calculate premiums for optional dependent spouse and/or child(ren) coverage. **Your spouse's rate is based on your age,** so find your age bracket in the far left column of the Spouse Premium Table. Your spouse's premium amount is found in the box where the row (the age) and the column (benefit amount) intersect. Your spouse's benefit amount must be in an increment of $5,000. Refer to the Coverage Guidelines section for minimums and maximums, if needed.

SPOUSE PREMIUM TABLE (24 PAYROLL DEDUCTIONS PER YEAR)										
Age	**$5,000**	**$10,000**	**$15,000**	**$20,000**	**$25,000**	**$30,000**	**$35,000**	**$40,000**	**$45,000**	**$50,000**
0 - 29	$0.23	$0.46	$0.69	$0.92	$1.15	$1.38	$1.61	$1.84	$2.07	$2.30
30 - 34	$0.28	$0.55	$0.83	$1.10	$1.38	$1.65	$1.93	$2.20	$2.48	$2.75
35 - 39	$0.32	$0.63	$0.94	$1.25	$1.57	$1.88	$2.19	$2.50	$2.82	$3.13
40 - 44	$0.42	$0.83	$1.25	$1.66	$2.08	$2.49	$2.91	$3.32	$3.74	$4.15
45 - 49	$0.65	$1.29	$1.93	$2.57	$3.22	$3.86	$4.50	$5.14	$5.79	$6.43
50 - 54	$0.87	$1.74	$2.61	$3.48	$4.35	$5.22	$6.09	$6.96	$7.83	$8.70
55 - 59	$1.45	$2.90	$4.35	$5.79	$7.24	$8.69	$10.14	$11.58	$13.03	$14.48
60 - 64	$2.01	$4.01	$6.01	$8.01	$10.02	$12.02	$14.02	$16.02	$18.03	$20.03
65 - 69	$3.47	$6.94	$10.41	$13.87	$17.34	$20.81	$24.28	$27.74	$31.21	$34.68

ALL CHILDREN PREMIUM TABLE (24 PAYROLL DEDUCTIONS PER YEAR)*								
$2,000	**$3,000**	**$4,000**	**$5,000**	**$6,000**	**$7,000**	**$8,000**	**$9,000**	**$10,000**
$0.17	$0.26	$0.34	$0.43	$0.51	$0.60	$0.68	$0.77	$0.85

*Regardless of how many children you have, they are included in the "All Children" premium amounts listed in the table above.

Frequently Asked Questions

Who is eligible for this insurance?

- You must be actively working (performing all normal duties of your job) at least 20 hours per week.
- Your dependent(s) must be performing normal activities and not be confined (at home or in a hospital/care facility) and any child(ren) must be under age 26.

What is Guarantee Issue?

The amount of insurance applied for without answering any health questions (or which does not require evidence of insurability). Coverage amounts over the Guarantee Issue Amount will require evidence of insurability.

What is Evidence of Insurability?

Evidence of Insurability or proof of good health – may be required if you are a late entrant and/or you request any additional coverage above your guarantee issue amount.

Can I take this insurance with me if I change jobs/am no longer a member of this group?

In the event this insurance ends due to a change in your employment/membership status with the group, or for certain other reasons, you or your insured spouse may have the right to continue this insurance under the Portability or Conversion provision, subject to certain conditions.

Are there any limitations, reductions or exclusions?

The benefits payable are based on the following:

- Insurance benefits and guarantee issue amounts are subject to age reductions:

  - At age 70, amounts reduce to 50%
- Spouse coverage terminates when you reach age 70.
- Life insurance benefits will not be paid if the insured's death is the result of suicide within two years from the date coverage begins. If this occurs, the sum of the premiums paid will be returned to the beneficiary. The same applies for any future increases in coverage under this plan.

All exclusions may not be applicable, or may be adjusted, as required by state regulations.

NortonLifeLock™

In a digital world, it's reassuring to have real, dedicated people behind your employee benefit.

Employee Benefits Member Support:

800-607-9174

Specialty Trained Agents

Dedicated agents available to answer questions Monday through Friday, from 9am to 7pm EST

Identity Restoration Specialists

If an employee has an identity theft issue, a dedicated U.S.-based specialist will work from start to finish to fix it.

We have our members' backs. And we back it up with our Million Dollar Protection™ Package.†††

Up to $1 million for Coverage for Lawyers & Experts

If an employee becomes a victim of identity theft while a LifeLock member, we will provide the necessary lawyers and experts, if needed, to help resolve the case. We rely on a specialized network of attorneys and experts to aid in resolution.

Up to $1 million for Reimbursement of Stolen Funds

If an employee has money stolen due to identity theft, we will reimburse up to $1 million. Plus, there's no limit on the number of claims your employee can file.

Up to $1 Million for Personal Expense Compensation

We will cover personal expenses incurred as a result of identity theft, up to $1 million.

††† Reimbursement and Expense Compensation, each with limits of up to $1 million for LifeLock with Norton Benefit Essential and LifeLock with Norton Benefit Premier. And up to $1 million for coverage for lawyers and experts if needed, for all plans. Benefits under the Master Policy are issued and covered by United Specialty Insurance Company (State National Insurance Company, Inc. for NY State members). Policy terms, conditions and exclusions at: LifeLock.com/legal.

norton™
LifeLock Benefit Solutions

Benefit Plans

PRICING: Monthly Rates	BENEFIT ESSENTIAL	BENEFIT PREMIER
Employee Only (18+ Years Old)	$7.49	$9.99
Employee + Family[Δ]	$14.98	$18.98

[Δ] The Norton Benefit Junior plan is for minors under the age of 18. LifeLock enrollment is limited to employees and their eligible dependents. Eligible dependents must live within the employee's household, or be financially dependent on employee. LifeLock services will only be provided after receipt and applicable verification of certain information about you and each family member. Please refer to employer group for the required information under your plan. In the event you do not complete the enrollment process for any family member, those individuals will not receive LifeLock services, but you will continue to be charged the full amount of the monthly membership selected until you cancel or modify your plan at your employer's next open enrollment period, which may be annually. Please note that we will NOT refund or credit you for any period of time during which we are unable to provide LifeLock services to any family member on your plan after your benefit effective date due to your failure to submit the information necessary to complete enrollment. If you do not complete the enrollment process for each family member, you may continue to pay more for LifeLock services than you otherwise would if you had selected a lower tier plan.

		BENEFIT ESSENTIAL	BENEFIT PREMIER
LIFELOCK IDENTITY THEFT PROTECTION	Identity Lock[1,5]	●	●
	Home Title Monitoring[¶]		●
	Social Media Monitoring[*]	●	●
	Credit, Bank & Utility Account Freezes[**]	●	●
	LifeLock Identity Alert™ System[†]	●	●
	• Identity Verification Monitoring[†,**]	●	●
	• Telecom & Cable Applications for New Service	●	●
	• Payday - Online Lending Alerts[†]	●	●
	• Credit Alerts & Social Security Alerts[†]	●	●
	Mobile app (Android™ & iOS)[**] Downloading the app does not provide protection until enrollment has been completed.	●	●
	Dark Web Monitoring[**]	●	●
	• Dark Web Monitoring – Gamer Tags[**]	●	●
	• Dark Web Monitoring – Password Combo List	●	●
	Court Records Scanning		●
	USPS Address Change Verification	●	●
	Stolen Wallet Protection	●	●
	Reduced Pre-Approved Credit Card Offers	●	●
	Fictitious Identity Monitoring	●	●
	Phone Takeover Monitoring	●	●
	Data Breach Notifications	●	●
	Bank & Credit Card Activity Alerts[†,**]	●	●
	• Unusual Charge Alerts[†]	●	●
	• Recurring Charge Alert[†]	●	●
	Checking & Savings Account Application Alerts[†,**]		●
	Bank Account Takeover Alerts[†,**]		●
	401k & Investment Account Activity Alerts[†,**]	●	●
	File Sharing Network Searches	●	●
	Sex Offender Registry Reports	●	●
	Prior Identity Theft Remediation[ª] This feature is separate from our Million Dollar Protection™ Package and does not provide coverage for lawyers and experts, reimbursement of stolen funds or compensation for personal expenses for events occurring during the 12 months prior to enrollment. See disclaimer for details.	●	●
	U.S.-based Identity Restoration Specialists	●	●
	24/7 Live Member Support	●	●
	Million Dollar Protection™ Package[†††] • Stolen Funds Reimbursement • Personal Expense Compensation • Coverage for Lawyers and Experts	*Up to $1 Million each*	*Up to $1 Million each*
	Credit Application Alerts[2,**]	*One-Bureau[1]*	*One-Bureau[1]*
	Credit Monitoring[1,**]	*One-Bureau[1]*	*Three-Bureau[1]*
	Credit Reports & Credit Scores[1,**] The credit scores provided are VantageScore 3.0 credit scores based on data from Equifax, Experian and TransUnion respectively. Third parties use many different types of credit scores and are likely to use a different type of credit score to assess your creditworthiness.	*One-Bureau[1] Monthly*	***On Demand –*** *One Bureau Daily/ Three-Bureau[1] Annual*
	Monthly Credit Score Tracking[1,**] The credit score provided is a VantageScore 3.0 credit score based on Equifax data. Third parties use many different types of credit scores and are likely to use a different type of credit score to assess your creditworthiness.		*One-Bureau[1]*
NORTON DEVICE SECURITY	Secures PCs, Mac & mobile devices[**]	*Up to 3 devices (Family gets 6 devices)*	*Up to 5 devices (Family gets 10 devices)*
	Online Threat Protection[**]	●	●
	Password Manager[**]	●	●
	Parental Control[4,**]	●	●
	Smart Firewall[**]	●	●
	Cloud Backup[3,**]	*10 GB*	*50 GB*
ONLINE PRIVACY	Secure VPN[**]	●	●
	Privacy Monitor	●	●
	SafeCam[3,**]	●	●

No one can prevent all identity theft or all cybercrime.

[1] If your plan includes credit reports, scores, and/or credit monitoring features ("Credit Features"), two requirements must be met to receive said features: (i) your identity must be successfully verified with Equifax; and (ii) Equifax must be able to locate your credit file and it must contain sufficient credit history information. IF EITHER OF THE FOREGOING REQUIREMENTS ARE NOT MET YOU WILL NOT RECEIVE CREDIT FEATURES FROM ANY BUREAU. If your plan also includes Credit Features from Experian and/or TransUnion, the above verification process must also be successfully completed with Experian and/or TransUnion, as applicable. If verification is successfully completed with Equifax, but not with Experian and/or TransUnion, as applicable, you will not receive Credit Features from such bureau(s) until the verification process is successfully completed and until then you will only receive Credit Features from Equifax. Any credit monitoring from Experian and TransUnion will take several days to begin after your successful plan enrollment. Please note that in order to enjoy all features in your chosen plan, such as bank account alerts, credit monitoring, and credit reports, it may require additional action from you and may not be available until completion.

[2] If your plan includes One Bureau Credit Application Alerts, two requirements must be met to receive said features: (i) your identity must be successfully verified with TransUnion; and (ii) TransUnion must be able to locate your credit file and it must contain sufficient credit history information. IF EITHER OF THE FOREGOING REQUIREMENTS ARE NOT MET YOU WILL NOT RECEIVE ONE BUREAU CREDIT APPLICATION ALERTS. One Bureau Credit Application Alerts will take several days to begin after your successful LifeLock plan enrollment.

[3] Norton Cloud Backup, Norton SafeCam, Norton Family, and Norton Parental Control features are not supported on Mac, Windows 10 in S mode, and Windows running on ARM processor).

[4] Norton Family and Norton Parental Control can only be installed and used on a child's Windows PC, iOS and Android devices but not all features are available on all platforms. Parents can monitor and manage their child's activities from any device – Windows PC, Mac, iOS and Android -- via our mobile apps, or by signing into their account at my.Norton.com and selecting Parental Control via any browser.

[5] Locking or unlocking your credit file does not affect your credit score and does not stop all companies and agencies from pulling your credit file. The credit lock on your Transunion Credit File will be unlocked if your subscription is downgraded or canceled.

[¶] Home Title Monitoring feature includes your home, second home, rental home, or other properties where you have an ownership interest.

[†] The LifeLock alert network includes a variety of product features and data sources. Although it is very extensive, our network does not cover all transactions at all businesses, so you might not receive a LifeLock alert in every single case.

[†††] Reimbursement and Expense Compensation, each with limits of up to $1 million for Norton LifeLock Benefit Essential, Norton LifeLock Benefit Premier, Benefit Elite, and Ultimate Plus, up to $100,000 for Advantage and Ultimate, and up to $25,000 for Standard, Command Center, Basic, and Benefit Junior and up to $1 million for coverage for lawyers and experts if needed, for all plans. Benefits under the Master Policy are issued and covered by United Specialty Insurance Company (State National Insurance Company, Inc. for NY State members). Policy terms, conditions and exclusions at: NortonLifeLock.com/legal.

[*] Does not include monitoring of chats or direct messages.

[**] These features are not enabled upon enrollment. Member must take action to activate this protection.

[ª] Subject to eligibility requirements defined in Terms & Conditions. Norton reserves the right to change and/or cease services at any time.

Not all products, services and features are available on all devices or operating systems. System requirement information on Norton.com.

OnePack Plan™ by petpartners

PetPartners Group Pet Insurance

Help take the stress out of unexpected vet bills. Pet insurance reimburses you for the eligible costs of accidents and illnesses. Coverage Includes: emergency treatments, surgeries, medications, laboratory services, and more. Plus, you can visit any licensed veterinarian or specialist. **Available only during Open Enrollment or Qualifying Life Events.**

Base Plan	
Annual Deductible	$250
Coinsurance	70%
Annual Limit	$7,000
Age (Min/Max)*	8 Weeks / No Age Max
Benefit Waiting Periods:	
Injuries	Waived
Illnesses	Waived
Orthopedics	6 Months
Pre-Existing Conditions	Covered after 12 months
Prior Coverage Credits+	Included

Optional Wellness	Annual Reimbursement
Rabies Vaccine	$30
Flea & Tick Prevention	$50
Heartworm Prevention	$50
Blood, Fecal, Parasite Test	$30
Preventative Vaccines	$45
Urinalysis or ERD	$30
Heartworm or Feline Leukemia Test (FeLV)	$30
Spay/Neuter	$50
Microchip	$50
Office Visit/Exam	$35

Additional Benefits		
Office Exams and Telehealth Consult	Covers cost of physical exam and fees for telephone consult	Subject to Deductible and Coinsurance
Rehabilitation and Physical Therapy	Covers physical therapy, hydrotherapy, thermotherapy and therapeutic massage	Subject to Deductible and Coinsurance
Inherited and Congenital Care	Covers diabetes, IVDD, luxating patella, osteoarthritis, spondylosis, hip dysplasia and birth defects (Not available for Accident Only)	Subject to Deductible and Coinsurance and 30-day Benefit Waiting Period
Alternative and Behavioral Care	Covers acupuncture, chiropractic, homeopathy, herbal therapy, naturopathy, and vitamins/ supplements (Behavioral Care not available for Accident Only)	Subject to Deductible and Coinsurance Behavioral Care subject to $1,000 Annual Limit and 14-day Benefit Waiting Period
Final Respects	Covers cremation and burial expenses	$300 Limit Paid in excess of Annual Limit (Not subject to Deductible and Coinsurance)

Accident and Illness (per covered pet)

Per Pay Rate	Cat:	$13.30	Dog:	$23.71

Accident and Illness Plan With Wellness (per covered pet)

Per Pay Rate	Cat:	$20.68	Dog:	$33.20

Contact PetPartners Customer Care:
800-956-2495
mypolicy@petpartners.com

*Does not apply to the Accident Only plan. Pets enrolled before the age of 11 years old can remain on the Accident & Illness plan. Mention the age they are at the time of enrollment.
+If you currently have coverage with another pet insurance carrier, we may be able to apply that coverage towards our benefit waiting periods. Call our Customer Care team for more details.
All pet insurance plans have limitations and exclusions. Specific products, features, rates, and discounts may vary by state, eligibility, and are subject to change. For all terms and conditions visit: https://www.petpartners.com/sample-policies.
Insurance products are underwritten by Independence American Insurance Company (NAIC #26581), 11333 N. Scottsdale Rd. Suite 160, Scottsdale, AZ 85254, and produced by PetPartners Inc. (NPN #7612549; CA license #0F27261 PPI Pet Insurance Agency, Inc.), 8051 Arco Corporate Drive, Suite 350, Raleigh, NC 27617.

PMS Discretionary Contribution Plan

Employees who are age 18 and above are eligible to participate after they have completed one year of service and have worked at least 1,000 hours during their first twelve consecutive months of employment. Employees are entered into the Plan on either January 1st or July 1st (whichever occurs first) after meeting the eligibility requirements.

This Plan is a type of qualified retirement plan in which PMS makes contributions to the plan on behalf of eligible employees. Eligible employees must be actively employed on the last day of the Plan Year (December 31st) in order to receive an employer contribution. This plan is 100% funded by PMS.

Employees are fully vested in the plan after 6 "Years of Service." To earn a "Year of Service," employees must be credited with at least 1,000 hours of service during any plan year.

Vesting Schedule
Profit Sharing Contributions

Years of Service 1,000 hours worked in a calendar year	Percentage
1 year	15%
2 years	29%
3 years	43%
4 years	60%
5 years	80%
6 years	100%

Once you enter the plan, you are eligible for that year's contribution if you are paid for 1,000 hours during that year and are an active employee on December 31st of that year. The contribution amount is determined in March of the following year and is contributed to employee accounts at that time. The contribution by PMS is a percentage of your compensation.

403(b) Retirement Savings Plan

All employees, excluding temporary employees, are eligible to participate upon employment.

Very similar to a 401(k), the PMS 403(b) plan is a retirement savings plan that allows you to defer a portion of your salary into an individual retirement plan account. When you enroll, PMS will make payroll deductions to **Vanguard** on your behalf. You can choose among various investment options that meet your tolerance level for risk and return. Investments include both **Pre-Tax** (Traditional) and **Post-Tax** (Roth) options.

During 2026, employee deferrals are limited by IRS rules to a maximum of $**24,500** per year. Employees aged 50 or older can make catch-up contributions up to $**8,000** higher than the standard limit, and employees aged 60-63 can make catch-up contributions up to $**11,250** higher than the standard limit.

Contact Vanguard for additional information regarding how these accounts work, fees, and to review the account agreement.

- **Vanguard** **800-569-4903, opt. 5** **ownyourfuture.vanguard.com**

Navigate to the PMS benefits website at mybensite.com/pmsnm for information on how to enroll in the 403(b) Retirement Savings Plan.

Medicare Part D Creditable Coverage Notice

Important Notice from Presbyterian Medical Services About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Presbyterian Medical Services (the "Plan Sponsor") and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

(1) Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

(2) The Plan Sponsor has determined that the prescription drug coverage offered by the Presbyterian Medical Services Group Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current Plan Sponsor coverage may be affected. Moreover, if you do decide to join a Medicare drug plan and drop your current Plan Sponsor coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact the person listed at the end of this notice for more information about what happens to your coverage if you enroll in a Medicare Part D prescription Drug Plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with the Plan Sponsor and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage
Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the Plan Sponsor changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov or call them at 1-800-772-1213 (TTY 1-800-325-0778).
Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	April 1, 2026
Name of Entity/Sender:	Presbyterian Medical Services
Contact-Position/Office:	Senior Benefits Administrator
Address:	1422 Paseo de Peralta, Santa Fe, NM 87501
Phone Number:	505-443-2596

CHIPRA/CHIP Notice

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility.

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Annual Notice of Women's Health and Cancer Rights Act

Do you know that your plan, as required by the Women's Health and Cancer Right Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses and treatment for complications resulting from a mastectomy, including lymphedema? Call your plan administrator at 505-443-**1125** for more information.

Notice of Availability of HIPAA Notice of Privacy Practices

Presbyterian Medical Services
1422 Paseo de Peralta Santa Fe, NM 87501
April 1, 2025

To: Participants in the Blue Cross Blue Shield EPO, Blue Cross Blue Shield PPO, Blue Cross Blue Shield HSA, Delta Dental PPO, VSP Vision

From: Kevin Meyers, Senior Benefits Administrator

Re: Availability of Notice of Privacy Practices
The Blue Cross Blue Shield EPO, Blue Cross Blue Shield PPO, Blue Cross Blue Shield HSA, Delta Dental PPO, VSP Vision (each a "Plan") maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Kevin Meyers, Senior Benefits Administrator at 1422 Paseo de Peralta Santa Fe, NM 87501, 505-443-2596, kevin.meyers@pmsnm.org.

State of New Mexico Contractor Health Coverage Requirement

Pursuant to Executive Order 2007-049, PMS is required to advise employees of the availability of State publicly financed health care coverage programs. To obtain additional information about these plans please visit: www.insurenewmexico.state.nm.us/.

Notice of Marketplace Coverage Options

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins November 1, 2023 for coverage starting January 1, 2024.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% (as adjusted annually) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact. Kevin Meyers, Senior Benefits Administrator at 1422 Paseo de Peralta Santa Fe, NM 87501, 505-443-2596, kevin.meyers@pmsnm.org.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Part B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

Here is some basic information about health coverage offered by this employer:

3. Employer name Presbyterian Medical Services	4. Employer Identification Number (EIN) 85-0206810
5. Employer address, 7. City, 8. State, 9. Zip Code 1422 Paseo de Peralta Santa Fe, NM 87501	6. Employer phone number 505-443-2596
10. Who can we contact about employee health coverage at this job? Kevin Meyers, Senior Benefits Administrator	
11. Phone number (if different from above) 505-443-2596	12. Email address kevin.meyers@pmsnm.org

- As your employer, we offer a health plan to:
  - ☒ All employees. Eligible employees are those who work 20+ hours per week.
  - ☐ Some employees. Eligible employees are:
- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are spouse, and dependents up to age 26.
  - ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment no later than **30 days** after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment no later than **30 days** after the marriage, birth, adoption, or placement for adoption.

Effective April 1, 2009, if either of the following two events occur, you will have **60 days** after the date of the event to request enrollment in your employer's plan:

- Your dependents lose Medicaid or CHIP coverage because they are no longer eligible.
- Your dependents become eligible for a state's premium assistance program.

To take advantage of special enrollment rights, you must experience a qualifying event *and* provide the employer plan with timely notice of the event and your enrollment request.

To request special enrollment or obtain more information, contact **Presbyterian Medical Services**, Human Resource Dept. at **505-443-2596**.

General COBRA Notice

General Notice of COBRA Continuation Coverage Rights

Continuation Coverage Rights Under COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage **must pay** for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Kevin Meyers.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of

COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit **https://www.medicare.gov/medicare-and-you**.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Kevin Meyers, Senior Benefits Administrator at 1422 Paseo de Peralta Santa Fe, NM 87501, 505-443-2596, kevin.meyers@pmsnm.org.

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[1] **https://www.medicare.gov/basics/get-started-with-medicare/sign-up/how-do-i-sign-up-for-medicare.**

PMS
PRESBYTERIAN MEDICAL SERVICES

Our purpose is you.

HUMAN RESOURCES DEPARTMENT
1422 Paseo de Peralta
Santa Fe, NM 87501
505-443-1125
benefits@pmsnm.org