



Presbyterian Health Plan Benefit Guide for the City of Albuquerque and Participating Entities



Welcome to Presbyterian Health Plan! We are glad to have you as a member, and we look forward to being your partner in good health. In this booklet you will find essential information about your health plan benefits, plus tools and resources to help you manage your healthcare.

The benefit information provided in this guide is a brief summary, not a comprehensive description of benefits, limitations and/or exclusions. For complete information, please refer to your Group Subscriber Agreement.

Where to find your Group Subscriber Agreement

You can find your Group Subscriber Agreement in three locations:

1. At the City of Albuquerque website, www.cabq.gov/humanresources/employee-benefits/insurance-benefits.
2. At the Presbyterian Health Plan City of Albuquerque website, www.phs.org/cabq.
3. In your myPRES account. Log in to myPRES at www.phs.org.

My Care Plan: The Independent Option



Thank you for choosing the Independent option!

With the Independent option, you can receive services from providers who are either in the Presbyterian Health Plan network (in-network providers) or who are not in the network (out-of-network providers).

Unique Services Reimbursement Program

You'll also receive up to a \$250 reimbursement per family per calendar year under the **Unique Services Reimbursement Program** for the following:

- Alternative therapies
- Hearing aids
- Routine vision care
- Prescription drug costs
- Dental treatments*
- Diagnostic devices*
- Disease management classes*

**You must submit a note or prescription from the doctor with your Unique Services Reimbursement Form.*

To receive your unique services reimbursement, fill out the reimbursement form on our website: www.phs.org/cabq. Here are some tips to help your reimbursement go smoothly:

- Be sure to save all relevant receipts.
- Submit original, itemized receipts with your reimbursement form.
- Complete one form each time you submit eligible expenses for reimbursement. Return the original, signed form to Presbyterian Health Plan, and keep a copy for your records.
- The program is based on the calendar year. You must submit all your receipts within one year from the date of service.

Staying in-network saves you money!

With the **Independent** option, you spend less by choosing providers within the Presbyterian Health Plan network for your healthcare services.

- If you stay in-network for all of your care, the maximum you will spend out-of-pocket in a year is \$6,350 for individual coverage and \$12,700 for family coverage.
- To find providers in our network, visit our online Provider Directory at www.phs.org/directory.
- If you go out-of-network, you could spend up to \$12,700 for individuals and \$25,400 for families (in addition to the costs you have accrued by seeing in-network providers). In addition, you could be liable for any charges above the standard Presbyterian Health Plan payment to out-of-network providers (these are called reasonable and customary amounts). Your provider(s) may send you a bill for these extra amounts (this is called balance-billing). We usually cannot protect you from out-of-network balance billing because we do not have contracts with those providers.

Coordination of benefits: When you have more than one insurance plan

You must tell us if you or your covered dependents have medical coverage under any other health benefits plan. Presbyterian Health Plan will work with that other plan to determine which plan should pay your claims first. The second plan may pay the remaining costs, or, in the case of your spouse, domestic partner and/or children, Presbyterian Health Plan may be the secondary payor.

Contact your dedicated customer service team to verify if we have a record of your other insurance plan.

Transition of care: If you are undergoing certain treatments with an out-of-network provider

New Presbyterian Health Plan members may be eligible to continue an ongoing course of treatment for a transitional period of time with a provider who is not in our network. This period of time will not be less than 30 days, and may be longer depending on your medical needs. In-network benefits will apply *only during this approved transitional period*. The same is true if you are receiving care from an in-network provider who leaves our network.

Call Presbyterian Health Plan's Health Services Department at 1-888-923-5757 to learn more about transition of care.



Need healthcare while outside of New Mexico?

Our national healthcare provider network is a nationwide network of more than 900,000 providers that you can access if you need to receive care while outside of the state of New Mexico. Using national healthcare provider network participating providers has several advantages:

- Your services will be covered at the in-network benefit level.
- The provider will file your claim with Presbyterian Health Plan.
- The provider will accept Presbyterian Health Plans' allowed amounts and will not bill you for additional amounts for covered services, except for your deductible, copay or coinsurance.
- National healthcare provider network providers will contact Presbyterian Health Plan for any needed prior authorization (see page 11 for more about prior authorization).

What is my coverage for urgent care or emergency care?

Presbyterian Health Plan covers urgent care and emergency care services wherever you need them, regardless if you are in New Mexico or outside of the state of New Mexico. In these circumstances, you may seek services from the nearest appropriate facility. You can help reduce the cost of such services by seeking care from a provider in our national network.

For more information on our national healthcare provider network, please call customer service or visit www.multiplan.com/Presbyterian.

Your Independent Option Benefit Summary (effective July 1, 2014)

The benefit information provided below is a brief summary, not a comprehensive description of benefits, limitations and/or exclusions. For complete information, please refer to your Group Subscriber Agreement, which can be found online at www.phs.org/cabq. You also may call us at (505) 923-7787.

Plan Benefits/Coverage		In-Network Member Costs	Out-of-Network Member Costs ¹	Prior Authorization Required	Subject to Deductible	Important Details/Limitations
Individual Deductible July 2014 – June 2015		\$100 Individual \$200 Family	\$500 Individual \$1,000 Family			Learn more about deductibles and out-of-pocket maximums on page 8.
Annual Out-of-Pocket Maximum July 2014 – June 2015		\$6,350 Individual \$12,700 Family	\$12,700 Individual \$25,400 Family			
Preventive Care		\$0	40%	No	No	For a complete list of preventive services, visit www.healthcare.gov/what-are-my-preventive-care-benefits . Exams, immunizations, etc. for services that are not medically necessary, such as licensing, certification, employment, insurance and foreign travel are not covered.
Practitioner/Provider Services	Primary Care Provider (PCP) Visit	\$40 per visit	40%	No	No	See page 10 to learn more about PCPs.
	Specialist Provider Visit	\$55 per visit	40%	No	No	Presbyterian Health Plan (PHP) does not require you to get a written referral to see a specialist. However, some specialists may require referrals even if PHP does not. You should talk to your PCP about any specialists you plan to visit.
	Behavioral (Mental) Health Provider Visit	\$40 per visit	40%	No	No	To obtain behavioral health services, you may self-refer or call PHP's behavioral health unit at (505) 923-5470 or 1-800-453-4347.
	Maternity Care Pre- and Postnatal	\$40 per visit up to \$300	40%	No	No	Up to \$300 per pregnancy. Delivery subject to inpatient cost sharing and prior authorization. Elective home births and services are not covered. Be sure to enroll your newborn in your health plan within 31 days of birth.
	On-Campus Student Health Center	\$40 per visit	\$40 per visit	No	No	Dependent students may receive limited medical care at a Student Health Center (in-state or out-of-state). Levels of care vary with each center.
Urgent and Emergency	Urgent Care	\$45 per visit	\$55 per visit	No	Yes	Sometimes it is necessary to get urgent or emergency care from an out-of-network provider. You'll save money if you receive your follow-up care with an in-network provider.
	Emergency Room Visit	\$150 per visit (waived if admitted)		No	Yes	
	Emergency Medical Transportation	\$50 ground, \$100 air per occurrence		No	Yes	

¹ Out-of-network benefits are limited to reasonable and customary charges. You are responsible for any balance due above reasonable and customary charges. Deductible applies to all out-of-network services.

Plan Benefits/Coverage		In-Network Member Costs	Out-of-Network Member Costs ¹	Prior Authorization Required	Subject to Deductible	Important Details/Limitations
Diagnostic Services	Laboratory Tests	\$0	40%	No	No	If your provider sends out lab work, be sure that laboratory is in-network. Using an in-network provider or facility saves you money.
	Radiology, X-ray, Ultrasound	\$0	40%	No	No	
	Imaging and Scanning	\$125 PET/MRI \$75 CT Scan	40%	Yes	Yes	
	Home/Sleep Studies	\$50 per study	40%	No	Yes	
	Gastrointestinal Lab Procedures	\$175 per visit	40%	No	Yes	Such as upper GI tests and endoscopies.
Inpatient and Outpatient Services	Hospital Inpatient Stay	\$500 per admission	40%	Yes	Yes	For physical health, behavioral health, alcoholism and substance abuse.
	Certified Hospice Care	\$500 inpatient \$0 in-home	40%	Yes	Yes inpatient, No in-home	Services must be provided by an approved hospice program.
	Skilled Nursing Care	\$500 per admission	40%	Yes	Yes	Up to 60 days per plan year per member.
	Home Healthcare	\$0	40%	Yes	No	Private nursing duty and custodial care needs are not covered as part of home healthcare.
	Outpatient Surgery	20% up to \$500 per visit	40%	Yes	Yes	
	Cardiac Catheterization Lab	\$200 per visit	40%	No	Yes	In a cardiac cath lab, doctors can diagnose and treat heart problems using catheters instead of surgery.
Rehabilitation and Therapy	Outpatient Speech Therapy, Physical Therapy, Occupational Therapy	\$55 per session	40%	No	No	Up to 24 visits per plan year combined per member.
	Chiropractic and Acupuncture	\$55 per session	40%	No	No	Each limited to 20 visits per plan year. These services and other complementary therapies (e.g., massage) are limited. Please refer to your Group Subscriber Agreement.
	Cardiac Rehabilitation	\$40 per session	40%	No	No	Up to 12 sessions continuous ECG monitoring and 24 sessions intermittent ECG monitoring per plan year per member.
	Pulmonary Rehabilitation	\$40 per session	40%	No	No	Up to 24 sessions per plan year per member.
	Radiation Therapy and Chemotherapy	\$0	40%	No	Yes	Please refer to your Group Subscriber Agreement for information on cancer clinical trials.

¹ Out-of-network benefits are limited to reasonable and customary charges. You are responsible for any balance due above reasonable and customary charges. Deductible applies to all out-of-network services.

Plan Benefits/Coverage		In-Network Member Costs	Out-of-Network Member Costs ¹	Prior Authorization Required	Subject to Deductible	Important Details/Limitations
Other Services	Infertility Services	50%	50%	Yes	Yes	
	Durable Medical Equipment	50%		Yes	Yes	Such as diabetes supplies, orthotic appliances, prosthetic devices, and hearing aids (up to age 19).
	Allergy Testing and Serum (Extracts)	20%	40%	No	Yes	Allergy injections are included in office visit copay (copay is waived if nursing visit only).
	Dialysis	20%	40%	No	Yes	
Prescription Drug Coverage						
Retail 30 days	Generic (Preferred)	\$10	Not Covered	No	No	Generic drugs are a good alternative to brand-name drugs. Like brand-name drugs, they are regulated by the Food and Drug Administration (FDA). They have the same active ingredients, safety, effectiveness and quality as brand-name drugs, but typically cost much less. If you currently take a brand-name prescription drug, ask your pharmacist or doctor if there is a generic alternative.
	Brand (Preferred)	\$30				
	Brand (Non-Preferred)	\$50				
	Specialty Pharmaceuticals	20% up to \$400 per medication				
Mail Order 90 days	Generic (Preferred)	\$20				
	Brand (Preferred)	\$75				
	Brand (Non-Preferred)	\$150				
Unique Services Reimbursement		\$250 per calendar year			See page 2 for details.	
The benefit information provided is a brief summary, not a comprehensive description of benefits, limitations and/or exclusions. For more information, contact us at (505) 923-7787, 1-855-261-7737, TTY Relay 711, or refer to the Group Subscriber Agreement, which can be found online at www.phs.org/cabq .						

¹ Out-of-network benefits are limited to reasonable and customary charges. You are responsible for any balance due above reasonable and customary charges. Deductible applies to all out-of-network services.

Understanding how your cost sharing works

You don't need to be surprised by your costs when you receive medical care. Taking time to read definitions and examples can help you understand your costs. We also recommend you watch a short video on cost sharing at www.phs.org/cabq and log in to myPRES to use our Treatment Cost Calculator. (See page 14 to learn more about myPRES.) Please call your dedicated customer service team with questions. They can explain the examples on pages 8 and 9 to you.

Important insurance terms to know

- **Out-of-pocket maximum:** The maximum dollar amount that you will pay in a plan year for covered services. All out-of-pocket costs for covered services go toward your maximum such as copayments, coinsurance and deductibles. After you have met the out-of-pocket maximum, the plan will pay 100 percent of covered services.
- **Deductible:** The amount that you pay before your plan pays. The deductible does not apply to all services.
- **Coinsurance:** The percentage amount of a covered healthcare service that is partially paid by you and partially paid by the health plan.
- **Copayment (copay):** The fixed dollar amount you are required to pay for a healthcare service.
- **Allowed amount:** The amount that the health plan agrees to pay a provider for a service. It is usually less than the total amount billed and can be considered the member discount before cost sharing begins.
- **Out-of-network provider:** A provider (doctor, facility, etc.) that does not have an agreement with Presbyterian Health Plan for reimbursement of services to health plan members.
- **Reasonable and customary:** The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. This amount sometimes is used to determine the allowed amount especially when paying out-of-network providers.



The life cycle of a claim

From the day of your doctor's appointment or other medical service to receiving your Explanation of Benefits (EOB) in the mail, this is how Presbyterian Health Plan processes your claims:

1. You present your ID card at the doctor's office.
2. After your visit, your doctor's office will send us a claim. **A claim is a request for payment that you or your provider submits to your health insurer when you receive services or items you think are covered.**
3. We process your claim according to your plan's benefits.
4. We send you an EOB that explains how your claim was processed. We send a statement, along with any applicable payment, to your doctor's office.
5. Your doctor will bill you for any remaining balance. Sometimes this amount is collected before you leave the doctor's office. If so, you probably won't receive a bill.

Tip: Review your EOBs carefully. EOBs tell you what your plan has paid on your behalf and exactly what you should be paying for healthcare services (this is called cost sharing).

How a family deductible works

For in-network services, the individual deductible is \$100 and the family deductible is \$200. If you go out-of-network, those deductibles and out-of-pocket maximums are calculated separately from the in-network amounts.

If you have family coverage, any combination of family members can satisfy the deductible, but no one member can contribute more than his or her individual amount. Once a member meets his or her individual amount, that deductible is considered met.

The chart below illustrates a family deductible.

Note: This chart is for illustrative purposes only.



Claim	Who	Amount Allowed for Service	Deductible Applies?	Individual Deductible Remaining (at time of claim)	Family Deductible Remaining (at time of claim)	Deductible Owed/Paid	Explanation
#1 (first claim of plan year)	Dad	\$500	Yes	\$100	\$200	\$100	Dad met his \$100 individual deductible with this claim.
#2	Mom	\$75	Yes	\$100	\$100 (Dad met \$100 of family deductible with first claim)	\$75	Both individual and family deductibles are not yet met at the time of this claim.
#3	Dad	\$100	Yes	\$0	\$25	\$0	Dad already met his individual deductible.
#4	Son	\$150	No	\$100	\$25	\$0	Service is not subject to deductible (e.g., preventive care).
#5	Daughter	\$300	Yes	\$100	\$25	\$25	Daughter has not met her individual deductible, but only \$25 remains on the family deductible.
#6	Mom	\$250	Yes	\$25	\$0	\$0	Family has met its deductible. No more deductible owed for the rest of the year.

Family out-of-pocket maximums work the same way. Remember, the out-of-pocket maximum (\$12,700 for families) includes all costs for *covered* services, including deductibles, copayments and coinsurance. In-network and out-of-network out-of-pocket maximums are calculated separately.

Cost sharing example 1: Outpatient surgery using an in-network provider

Total billed charges	\$2,500	Total amount for service (without plan discount).
Allowed amount	\$2,000	Amount plan and provider agreed on per contract.
Deductible owed	\$100	This would be \$0 after individual or family deductible is met. Deductible does not apply to all services.
Amount owed after deductible	\$1,900	Allowed amount minus deductible owed.
Member coinsurance	\$380	Per benefit summary, member pays 20% up to \$500. If copay, this would be a flat dollar amount.
Plan pays	\$1,520	Plan pays remaining 80%. If copay, plan pays remaining balance after copay.
Total amount member pays	\$480	Deductible owed + coinsurance or copay.

Cost sharing example 2: Outpatient surgery using an out-of-network provider (e.g., UNMH)

Total billed charges	\$2,500	Total amount for service (without plan discount).
Allowed amount	\$2,000	Pre-determined "reasonable and customary" amount.
Deductible owed	\$500	This would be \$0 after the individual or family deductible is met. Deductible does not apply to all services.
Amount owed after deductible	\$1,500	Allowed amount minus deductible owed.
Member coinsurance	\$600	Per benefit summary, member pays 40%. If the service required a copayment, this would be flat dollar amount.
Plan pays	\$900	Plan pays remaining 60%. If copay, plan pays remaining balance after copay.
Unpaid amount	\$500	Difference between total charged and total allowed.
Total amount member pays	\$1,100 – up to \$1,600	Deductible owed + coinsurance or copay + the provider <i>may</i> bill you for the \$500 difference because provider doesn't have a health plan contract requiring it to write off the difference between the total billed and the "reasonable and customary" payment.

Your primary care provider and plan benefits can help you stay well.

Your primary care provider

You and all covered members of your family should select an in-network primary care provider (PCP) to manage your healthcare needs. PCPs can include the following:

- General practice doctors
- Family practice doctors
- Internists (internal medicine doctors)
- Pediatricians
- Obstetricians/gynecologists
- Nurse practitioners

What services does a PCP provide?

Establishing a relationship with your PCP is an important part of your healthcare. Your PCP treats you when you are ill, helps you prevent illness and promotes a healthier lifestyle. Your PCP develops an understanding of your health history so that he or she can address all of your health concerns.

How do I find a PCP?

Use Presbyterian's provider search tool at www.phs.org/directory or by calling customer service at (505) 923-7787.

Presbyterian's Mobile Health Center: Bringing care to you

Our Mobile Health Center is a 45-foot van that offers non-work-related routine healthcare and urgent care services exclusively to you as a City of Albuquerque and participating entities employee, plus your enrolled dependents.

Appointments are available for **no copay** on a scheduled or walk-in basis (as time permits). Standard out-of-pocket expenses will apply if you are referred outside the Mobile Health Center for more specialized services.

Call (505) 220-6562 for an appointment.

Direct access to medical advice – 24 hours a day, 7 days a week, 365 days a year

Whenever you have a healthcare question, call NurseAdvice New Mexico toll-free 1-866-221-9679, around the clock, every day of the year. Registered nurses offer you suggestions for self-care measures and provide general health information on a broad range of healthcare topics.

Coordinated care: The right care at the right time

Presbyterian Health Plan has a team of experienced healthcare professionals to help you achieve your best health. These team members support the care you receive from your PCP. Some examples of care coordination include:

- Treatment plans for rehabilitation and therapies
- Admission to and discharge from the hospital or skilled nursing facilities
- Home healthcare/hospice care
- Healthy Solutions: A disease management program for members who have diabetes or heart disease

To learn more, call customer service.

The information in this section is a brief description of your benefits. For complete information, please refer to your Group Subscriber Agreement, which can be found online at www.phs.org/cabq.



Some healthcare services require prior authorization.

Some healthcare services – such as hospital admissions or surgeries – as well as supplies and medications require approval from Presbyterian Health Plan *before* you can receive them. This is called prior authorization. Depending on whether the services you need are from an in-network or out-of-network provider, either you or the provider will be responsible for obtaining prior authorization.

- If you are receiving your services and/or supplies from an **in-network provider**, the provider is responsible for doing this on your behalf. If the provider fails to obtain approval, you will **not** be held liable for any charges that result.
- If you are receiving your services and/or supplies from an **out-of-network provider**, it is *your* responsibility to obtain approval for services beforehand. If you don't obtain prior authorization for your out-of-network services and/or supplies (except for emergency care), the services may be subject to penalties or may not be covered by Presbyterian Health Plan, and you **may** be responsible for the resulting charges.

If your service is not approved, Presbyterian Health Plan will send you a letter explaining why. The letter will also inform you of your right to appeal this decision and give you instructions on how to do so.

This is a brief description of prior authorization requirements and processes. Please refer to your Group Subscriber Agreement, which can be found online at www.phs.org/cabq, for a complete list of services that require prior authorization.

If you have a complaint

We are committed to providing you with high-quality care and service. If you're not satisfied, we want to know. There are two types of complaints you can file if you are not satisfied with the coverage of your services or with your care:

Grievance	Appeal
An official notice of your dissatisfaction with your health plan or your care.	A formal request for review of a decision or action that Presbyterian Health Plan has made that affects your healthcare, e.g., a denial or limitation of a service.
You must file your grievance within 30 calendar days of the date that you had the problem.	You must file your appeal within 90 calendar days of the date that you received notice of Presbyterian Health Plan's decision.
Most grievances take up to 30 days to resolve.	Most appeals take up to 30 days to resolve. If you believe your health will be in danger if you wait that long, you may ask for an expedited appeal.

You can file a grievance or an appeal in one of three ways:

- Write to:
Presbyterian Health Plan, Inc.
Appeal and Grievance
Department
P.O. Box 27489
Albuquerque, NM 87125-7489
- Email cabqinquiry@phs.org
- Call (505) 923-7787

The Managed Health Care Bureau of the Office of the Superintendent of Insurance is also available to assist you with grievances, questions, or complaints. Contact them at 1-855-4ASK-OSI (1-855-427-5674).



This description is a brief summary of the appeals and grievance processes. For a complete description, please refer to your Group Subscriber Agreement, which can be found online at www.phs.org/cabq.

Using your pharmacy benefits wisely helps you stay healthy

Your health plan includes coverage for drugs prescribed by a provider and purchased through a pharmacy in our network (also called a participating pharmacy). To find participating pharmacies, go to www.phs.org and log in to your myPRES account. Select *Manage My Prescriptions*. Click *Go* under *My Pharmacy Portal*. Then select the *Find pharmacies* link.

For information about approved prescription medications, please look at the **formulary**, also called a drug list. It shows you what medications are preferred by your health plan. You can find the formulary online: www.phs.org/cabq. Refer to your benefit summary starting on page 4 for cost-sharing information.

If the drug you need is not on the formulary, you can call customer service to make sure that your drug is not covered. If customer service confirms that we do not cover your drug, you may:

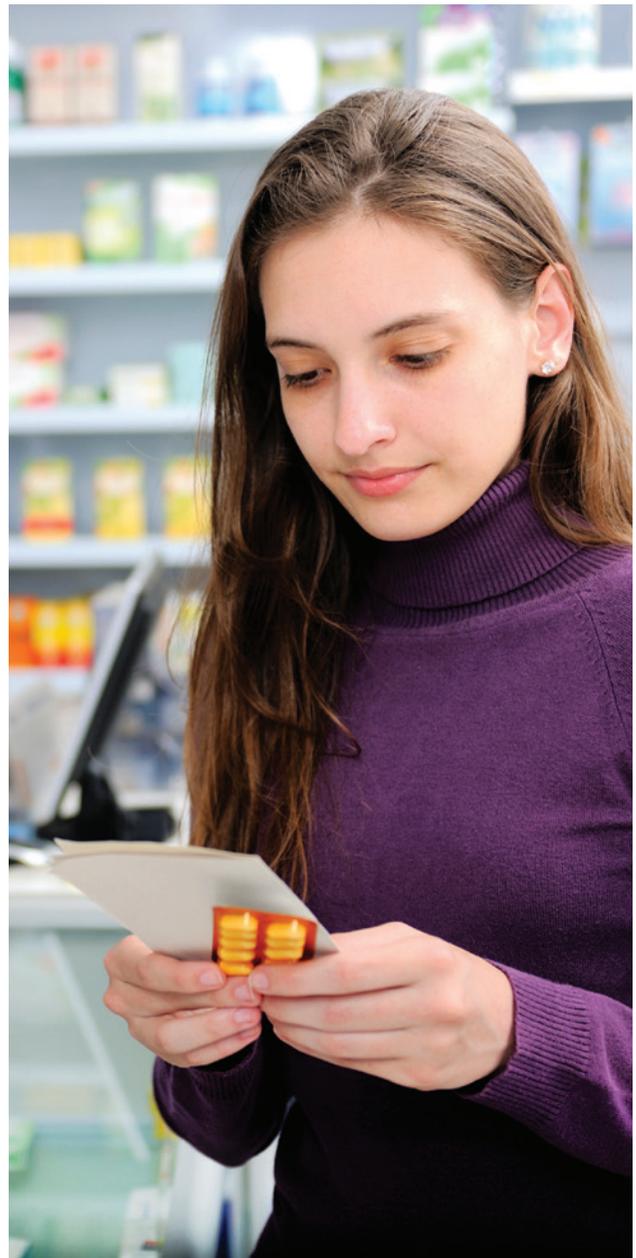
- Ask your doctor if you can switch to another drug that Presbyterian Health Plan covers; or
- You or your doctor may ask Presbyterian Health Plan to make an exception to cover your drug. This is called a pharmacy exception. To learn more about pharmacy exceptions or to initiate a request, please call customer service.

Save time and money by using mail order

You may purchase a 90-day supply of maintenance medications as prescribed by your doctor and have them delivered to your home or workplace. As a City of Albuquerque member, using mail order can save you up to 33 percent every 90 days.

For more information on this service offered through Walgreens Mail Service Pharmacy, contact customer service. You may also visit www.phs.org/cabq (scroll down to *Mail Service Pharmacy Benefit*) for a Walgreens brochure and order form. Or visit the Walgreens Mail Service website, www.walgreens.com/mailemail.

This information is a brief summary, not a comprehensive description of benefits, limitations and/or exclusions. For complete information on your pharmacy benefits, please refer to your Group Subscriber Agreement. You also may call us at (505) 923-7787.



Tip: You will pay the smallest copayment if you choose generic drugs over brand-name drugs. Ask your doctor or pharmacist if a generic version of your prescription is available.

Find the benefit information you need, when you need it, at myPRES.

Reviewing your benefit information is quick, easy and convenient when you use myPRES. A myPRES account gives you secure, 24-hour access to your health plan information and member-exclusive tools and resources.

An important eco-friendly feature of myPRES is the ability to view and print your health plan benefit materials, such as your Group Subscriber Agreement. **You will no longer automatically receive paper copies of your benefit materials.***

Through myPRES, you also can:

- Check the status of your membership
- Change your primary care provider (PCP)
- Review your claims history
- Request replacement member ID cards
- Review your Explanation of Benefits (EOB)
- Look up a medical service cost estimate using our Treatment Cost Calculator

myPRES also can help you manage your prescriptions:

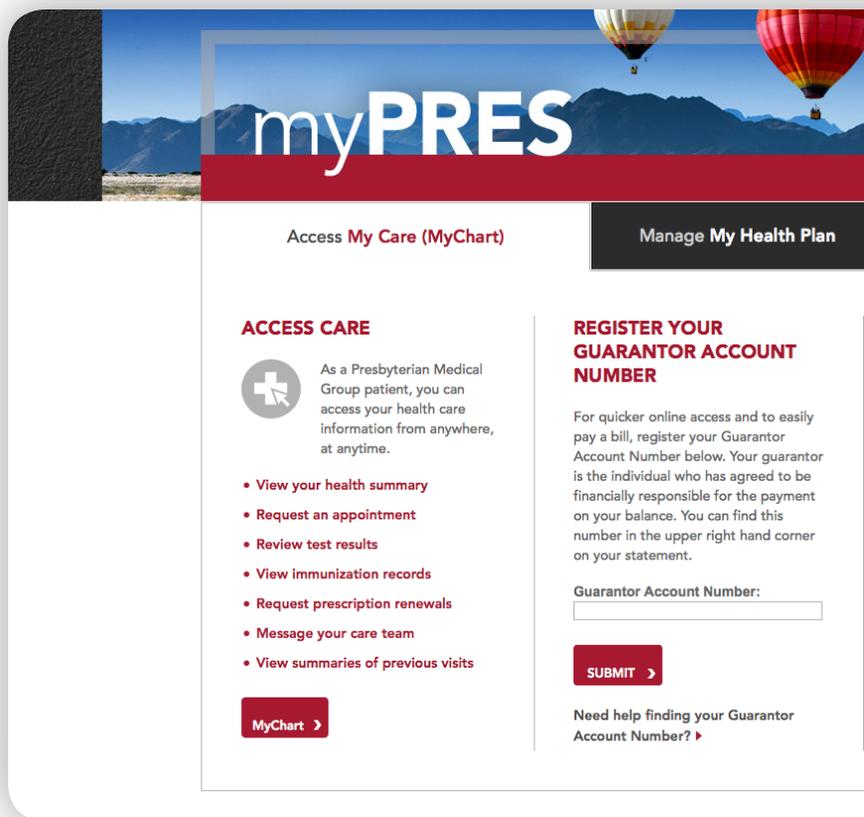
- Check your prescription services and benefits
- Get mail-order prescriptions of certain drugs
- Locate a pharmacy near you
- Learn more about your medications and possible side effects
- Check your medication claim history

Within myPRES is MyChart, Presbyterian's portal to parts of your electronic health record. MyChart allows Presbyterian Medical Group (PMG) patients to:

- View test and lab results
- Request an appointment
- Send messages to your care team
- Review summaries of recent visits

MyChart helps improve communication between you and members of your Presbyterian Medical Group care team.

*If you do not have Internet access or prefer to continue to receive your member materials by mail, please call customer service.

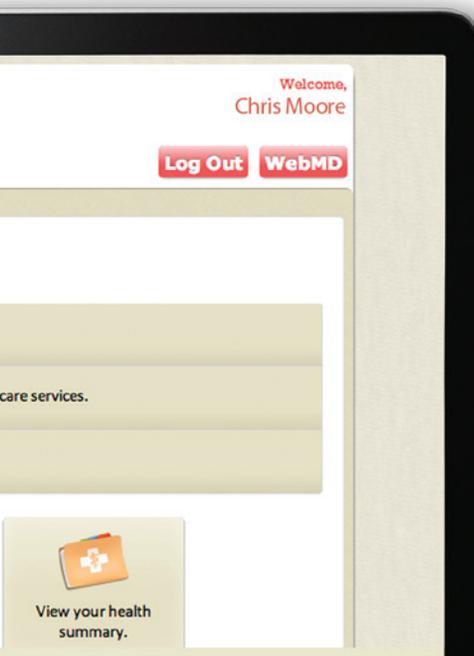
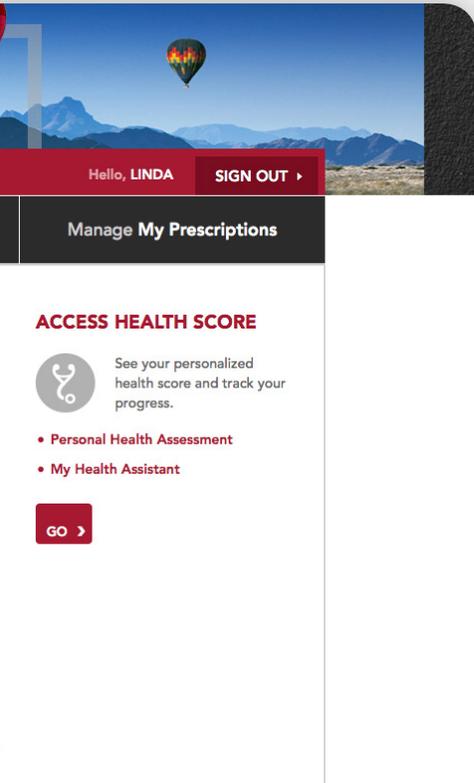


Understand how your health plan benefits work before you need them.

Our website <http://knowyourhealthplan.com> can help you save money and plan for an urgent or emergency situation. We invite you to watch a series of videos that help explain concepts like deductibles, copayments and provider networks.

If you have specific questions about claims, coverage or finding in-network providers, our Frequently Asked Questions page can provide more answers. Or you can call your City of Albuquerque dedicated customer service line. Thank you for being a Presbyterian Health Plan Member.

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A screenshot of the "Know Your Health Plan" website page. The header includes the Presbyterian Health Plan logo and navigation links for Home, FAQ, Videos, and For Members. The main heading is "Know Your Health Plan". Below this is a text box explaining the member library. The page is divided into three main sections: "Frequently Asked Questions" with a question mark background image, "Health Plan Education Videos" with a video player showing a man at a presentation, and "For Members" with a photo of a smiling woman in a purple top. The page number "page 15" is visible in the bottom right corner.

Know Your Health Plan

The Know Your Health Plan member library is designed to give New Mexico Presbyterian members information for staying educated about their health plan benefits. Here you'll find the most [frequently asked questions](#), [educational health plan videos](#), and [other health care resources in New Mexico](#).



Frequently Asked Questions

Answering your health plan questions quickly and efficiently is important to us. To better serve you, we have compiled a list of [frequently asked member questions](#) for your reference.



Health Plan Education Videos

Our [series of educational videos](#) will assist you in better understanding your health plan benefits. You will learn about:

- How to make the most out of your health plan benefits
- The difference between copays and deductibles
- How you can avoid costly medical bills by staying in-network vs. going out-of-network
- The difference between a doctor's referral and a prior authorization
- If you are on a high deductible health plan or want to know more about them, you'll enjoy watching the video on how consumer driven health plans work.



For Members

Assuring you have the healthcare information you need is important to us. Here are some [helpful healthcare resources and services](#) that are available to you as a Presbyterian member. We will regularly add to this list, so please be sure to check back with us when you have questions.





Presbyterian Health Plan, Inc.
P.O. Box 27489
Albuquerque, NM 87125-7489
www.phs.org

PRESRT STD
U.S. Postage
PAID
Albuquerque, NM
Permit No. 1971



Presbyterian Health Plan
Customer Service for
City of Albuquerque and
Participating Entities
Employees:

(505) 923-7787

Available 7:00 a.m. to 6:00 p.m.,
Monday through Friday

Email: cabqinquiry@phs.org

www.phs.org/cabq