



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.mynmhc.org or by calling (855) 7MY-NMHC.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$6,850 individual/\$13,700 family. Doesn't apply to preventive care or services where a copay is listed.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible . If a service lists a copay amount (\$ per visit, per test, per prescription, per surgery, per trip, per admit) the deductible does not apply to that service.
Are there other <u>deductibles</u> for specific services?	No. There are no other specific deductibles.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. For participating providers \$6,850 individual / \$13,700 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network</u> of <u>providers</u> ?	Yes. See www.mynmhc.org or call (855) 7MY-NMHC for a list of participating providers.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a <u>specialist</u> ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .



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

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge first 3 visits, no charge after deductible	Not Covered	_____none_____
	Specialist visit	No Charge after deductible.	Not Covered	_____none_____
	Other practitioner office visit	No Charge after deductible for chiropractic and acupuncture.	Not Covered	Coverage is limited to a \$1,500 annual maximum for each type of provider. \$1500 limit does not apply to services for rehabilitation and habilitation.
	Preventive care/screening/immunization	No Charge	Not Covered	_____none_____
If you have a test	Diagnostic test (x-ray, blood work)	No Charge after deductible.	Not Covered	_____none_____
	Imaging (CT/PET scans, MRIs)	No Charge after deductible.	Not Covered	Failure to obtain Prior Approval may result in a denial of coverage.
If you need drugs to treat your illness or condition	Generic drugs	No Charge after deductible.	Not Covered	Covers up to a 30-day retail supply; 90-day mail order supply
	Preferred brand drugs	No Charge after deductible.	Not Covered	Covers up to a 30-day retail supply; 90-day mail order supply

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Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
More information about <u>prescription drug coverage</u> is available at www.mynmhc.org .	Non-preferred brand drugs	No Charge after deductible.	Not Covered	Covers up to a 30-day retail supply; 90-day mail order supply
	Specialty drugs	No Charge after deductible.	Not Covered	Covers up to a 30-day supply, retail. Failure to obtain Prior Approval may result in a denial of coverage.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge after deductible.	Not Covered	Failure to obtain Prior Approval may result in a denial of coverage.
	Physician/surgeon fees	No Charge after deductible.	Not Covered	Failure to obtain Prior Approval may result in a denial of coverage.
If you need immediate medical attention	Emergency room services	No Charge after deductible.	No Charge after deductible	_____none_____
	Emergency medical transportation	No Charge after deductible.	No Charge after deductible	_____none_____
	Urgent care	No Charge after deductible.	No Charge after deductible	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge after deductible.	Not Covered	Failure to obtain Prior Approval may result in a denial of coverage.
	Physician/surgeon fee	No Charge after deductible.	Not Covered	Failure to obtain Prior Approval may result in a denial of coverage.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge first 3 visits, no charge after deductible	Not Covered	Failure to obtain Prior Approval may result in a denial of coverage.
	Mental/Behavioral health inpatient services	No Charge after deductible.	Not Covered	Failure to obtain Prior Approval may result in a denial of coverage.

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Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Substance use disorder outpatient services	No charge first 3 visits, no charge after deductible	Not Covered	Failure to obtain Prior Approval may result in a denial of coverage.
	Substance use disorder inpatient services	No Charge after deductible.	Not Covered	Failure to obtain Prior Approval may result in a denial of coverage.
If you are pregnant	Prenatal and postnatal care	No Charge after deductible.	Not Covered	_____none_____
	Delivery and all inpatient services	No Charge after deductible.	Not Covered	_____none_____
If you need help recovering or have other special health needs	Home health care	No Charge after deductible.	Not Covered	Coverage is limited to 100 visits per plan year.
	Rehabilitation services	No Charge after deductible.	Not Covered	Failure to obtain Prior Approval may result in a denial of coverage.
	Habilitation services	No Charge after deductible.	Not Covered	Failure to obtain Prior Approval may result in a denial of coverage.
	Skilled nursing care	No Charge after deductible.	Not Covered	Coverage is limited to 60 days/visits per plan year.
	Durable medical equipment	No Charge after deductible.	Not Covered	Failure to obtain Prior Approval may result in a denial of coverage.
	Hospice service	No Charge after deductible.	Not Covered	Coverage is limited to \$10,000 per member, per lifetime.
If your child needs dental or eye care	Eye exam	No Charge	50% coinsurance	Coverage is limited to one exam per calendar year.
	Glasses	No Charge	50% coinsurance	Coverage is limited to one pair of lenses and frames per calendar year.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Dental check-up	Not Covered	Not Covered	Pediatric dental coverage can be purchased separately as a stand-alone policy.

Excluded Services & Other Covered Services:

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

- | | | |
|----------------------------|---|------------------------|
| • Cosmetic surgery | • Dental Care (Adult and Child) | • Hearing aids (Adult) |
| • Long Term Care | • Non-emergency care when traveling outside the U.S | • Private-duty nursing |
| • Routine Eye Care (Adult) | | |

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

- | | | |
|----------------------------|--------------------------------------|------------------------|
| • Acupuncture | • Bariatric surgery | • Chiropractic care |
| • Infertility Treatment | • Routine Foot Care (diabetics only) | • Weight Loss Programs |
| • Termination of pregnancy | | |

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your premium. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at (855) 7MY-NMHC. You may also contact the Office of the Superintendent of Insurance (OSI) at (855) 4ASK-OSI; by fax at (505) 827-4734; or Completed on-line with an OSI Complaint Form available at <http://www.osi.state.nm.us>.

Your Complaint and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a complaint, sometimes called a grievance. For questions about your rights, this notice, or assistance, you can contact New Mexico Health Connections at (855) 7MY-NMHC. In addition to speaking to one of our Customer Care Representatives by phone, you can also express your Concerns by walk-in interview or arranged appointment at the address below.

New Mexico Health Connections
2440 Louisiana Blvd. NE, Suite 601
Albuquerque, NM 87110

You may also submit your Concerns in writing to the above noted address. You may also contact the OSI by mail to the Office of the Superintendent of Insurance, P.O. Box 1689, Santa Fe, New Mexico 87504-1689; or Email to mhcb.grievance@state.nm.us. You may fax to the OSI, ATTN: Superintendent at (505) 827-4734; or Complete an on-line Complaint Form available at <http://www.osi.state.nm.us>.

Does This Coverage Provide Minimal Essential Coverage?

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

Does This Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits to a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does not meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-769-6642.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-769-6642.

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

About these Coverage Examples:

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



This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers: \$7,540**
- **Plan pays \$640**
- **Patient pays \$6,900**

Sample care costs:

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

Patient pays:

Deductibles	\$6,750
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$150
Total	\$6,900

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

- Amount owed to providers: \$5,400**
- **Plan pays \$190**
- **Patient pays \$5,210**

Sample care costs:

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

Patient pays:

Deductibles	\$5,130
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$80
Total	\$5,210

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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