



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 including your plan's Plan document, visit www.bcbsnm.com or call toll-free 1-888-966-7742. 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 BCBS of NM toll-free at 1-888-966-7742 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network EPO Provider per calendar year: \$500/individual; \$1,000/family. No coverage from <u>Out-of-Network Providers</u> , except in an emergency situation.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your deductible?	Yes. Outpatient <u>prescription drugs</u> , dental and the following services performed by <u>network providers</u> : office/home visits (except for behavioral health visits), <u>preventive care</u> , acupuncture, chiropractic services, vision, telehealth, ambulance services, <u>hospice services</u> , x-ray and imaging, lab tests, outpatient rehabilitation visits, insulin pump supplies, and <u>urgent care</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. \$50/individual, \$150/family <u>deductible</u> per year for either the High Option or Low Option Dental <u>plans</u> . There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before the dental <u>plan</u> begins to pay for these services.
What is the out-of-pocket limit for this plan?	Medical <u>Plan</u> EPO <u>Network Provider</u> per calendar year: \$3,250/person; \$6,500/family. <u>In-network</u> outpatient <u>prescription drugs</u> per calendar year: \$3,100/person; \$6,200/family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, dental/vision (if elected), and penalties for failure to obtain <u>preauthorization</u> . <u>Cost sharing</u> for certain non-essential <u>specialty drugs</u> does not count toward the separate Rx <u>out-of-pocket limit</u> .	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. For a list of <u>in-network preferred providers</u> within the state of New Mexico through New Mexico Blue Cross and Blue Shield, see www.bcbsnm.com or call toll free at 1-888-966-7742. For a list of BlueCard Access <u>providers</u> outside of the state of New Mexico, call toll-free 1-800-810-2583.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the full cost if you use an <u>out-of-network provider</u> . Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 copayment /visit. <u>Deductible</u> does not apply.	Not covered.	20% coinsurance for in-network office surgery including casts, splints and dressings.
	<u>Specialist</u> visit	\$35 copayment /visit. <u>Deductible</u> does not apply.	Not covered.	20% coinsurance for in-network office surgery including casts, splints and dressings.
	<u>Preventive care/screening/immunization</u>	No charge. <u>Deductible</u> does not apply.	Not covered.	<u>Plan</u> covers required <u>preventive services</u> and supplies described at: https://www.healthcare.gov/what-are-my-preventive-care-benefits/ . Age and frequency guidelines apply to covered <u>preventive care</u> . You may have to pay for services that aren't <u>preventive care</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Office/freestanding facility: You pay the lesser of \$25 copayment per day or the <u>Plan's allowed amount</u> and no charge for the test interpretation fee. <u>Deductible</u> does not apply. Outpatient hospital: You pay the lesser of \$50 copayment per day or the <u>Plan's allowed amount</u> and no charge for test interpretation fee. <u>Deductible</u> does not apply.	Not covered.	Coumadin lab (Prothrombin time test): \$10 copayment/test in-network.
	Imaging (CT/PET scans, MRIs)	You pay the lesser of \$500 copayment per day or the 20% of the <u>Plan's allowed amount</u> and no charge for the test interpretation fee. <u>Deductible</u> does not apply.	Not covered.	<u>Preauthorization</u> is required to avoid non-payment.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at CVS Caremark at www.caremark.com or call 1-877-787-0652.</p>	Generic drugs	<p>Retail Pharmacy for 30-day supply: \$10 copayment/prescription.</p> <p>Mail Order and 90-day Retail for a 90-day supply: \$22 copayment/prescription.</p> <p><u>Deductible</u> does not apply.</p> <p>No charge for FDA-approved generic contraceptives.</p>	<p>You pay 100%. <u>Plan</u> reimburses no more than it would have paid had you used an <u>In-Network</u> Retail pharmacy. <u>Deductible</u> does not apply.</p>	<p>More information about <u>prescription drug coverage</u> is available at CVS Caremark at www.caremark.com or call 1-877-787-0652.</p> <ul style="list-style-type: none"> • No coverage for prescription medication that has an over-the-counter (OTC) equivalent (unless mandated by law to be covered). • If you purchase a brand drug when generic drug is available, you pay the brand drug <u>cost sharing</u> plus the difference in cost between the brand drug and the generic drug. • If the cost of the drug is less than the <u>copayment</u>, you pay just the drug cost. • Some prescriptions are subject to <u>preauthorization</u>, quantity limits or step therapy requirements. • Retail and Mail order drugs accumulate to the Outpatient Drug <u>Out-of-Pocket Limit</u> noted on page 1.
	Preferred brand drugs	<p>Retail Pharmacy for 30-day supply: 30% coinsurance with minimum \$30 & maximum \$60 per prescription;</p> <p>Mail Order and 90-day Retail for 90-day supply: \$60 copayment/prescription.</p> <p><u>Deductible</u> does not apply. No charge for FDA-approved brand name contraceptives if a generic is medically inappropriate.</p>		
	Non-preferred brand drugs	<p>Retail Pharmacy for 30-day supply: 70% coinsurance;</p> <p>Mail Order and 90-day Retail for 90-day supply: 70% coinsurance.</p> <p><u>Deductible</u> does not apply.</p>		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Specialty drugs</u>	For up to a 30-day supply, you pay a \$55 copayment/prescription (for generic), \$80 copayment/prescription (for preferred) and \$130 copayment/prescription (for non-preferred). <u>Deductible</u> does not apply. No charge for certain non-essential <u>specialty drugs</u> on the PrudentRx <u>Specialty Drug List</u> if you enroll in the program. If the <u>specialty drug</u> is not included on the <u>Specialty Drug List</u> , you will pay 30% <u>coinsurance</u> . If you opt out of PrudentRx, you will pay 30% <u>coinsurance</u> . To enroll, contact PrudentRx at 1-800-578-4403.	You pay 100%. <u>Plan</u> reimburses no more than it would have paid had you used an <u>In-Network Retail pharmacy</u> . <u>Deductible</u> does not apply.	<ul style="list-style-type: none"> <u>Specialty drugs</u> require <u>preauthorization</u> by calling CVS Specialty Pharmacy at 1-866-387-2573. For most <u>specialty drugs</u>, the contracted <u>specialty drug mail-order pharmacy</u> is required. These drugs must be filled via the CVS Specialty Pharmacy. Call 1-866-387-2573. <u>Specialty drugs</u> that are essential health benefits and obtained from <u>in-network</u> retail and mail order locations accumulate to the Outpatient Drug <u>Out-of-Pocket Limit</u> noted on page 1. Certain <u>specialty drugs</u> are filled through the PrudentRx program and exclusively dispensed by CVS Specialty Pharmacy. The PrudentRx <u>Specialty Drug list</u> is available at 1-800-578-4403. Non-essential health benefit specialty pharmacy drugs under the PrudentRx program do not accumulate to the Outpatient Drug <u>Out-of-Pocket Limit</u>.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150 copayment plus 20% coinsurance.	Not covered.	<u>Preauthorization</u> is required to avoid nonpayment.
	Physician/surgeon fees	\$150 copayment plus 20% coinsurance.	Not covered.	
If you need immediate medical attention	<u>Emergency room care</u>	\$150 copayment/visit plus 20% coinsurance	\$150 copayment/visit plus 20% coinsurance	Physician/ <u>provider's</u> professional fees may be billed separately.
	<u>Emergency medical transportation</u>	\$25 copayment per trip. <u>Deductible</u> does not apply.	Not covered.	Non-emergency air ambulance services covered only when <u>medically necessary</u> to transfer patient from one facility to another.
	<u>Urgent care</u>	\$45 copayment per visit. <u>Deductible</u> does not apply.	Not covered.	The <u>copayment</u> includes all services and supplies such as x-ray, lab and physician fees.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 copayment per admission plus 20% coinsurance.	Not covered.	Elective hospital admission requires <u>preauthorization</u> to avoid nonpayment. <u>Copayment</u> waived if readmitted for same condition within 15 days of discharge.
	Physician/surgeon fees	20% coinsurance.	Not covered.	Elective hospital admission requires <u>preauthorization</u> to avoid nonpayment.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: No charge. Other Outpatient: No charge.	Not covered.	<p>This <u>Plan</u> opted out of compliance with Mental Health Parity & Addiction Equity Act. Elective partial <u>hospitalization</u>, day treatment, hospital admission and residential treatment center admission requires <u>preauthorization</u> to avoid non-payment.</p> <ul style="list-style-type: none"> <u>Plan</u> covers services related to the diagnosis and treatment of Autism Spectrum Disorder (ASD) regardless of age. <u>Copayments</u> apply per visit/stay/program, not per day.
	Inpatient services	No charge.	Not covered.	
If you are pregnant	Office visits	No charge for office visits and ACA-required <u>preventive services</u> . <u>Deductible</u> does not apply. For initial office visit, \$25 copayment applies, <u>deductible</u> does not apply; thereafter, no charge.	Not covered.	<ul style="list-style-type: none"> There is no charge for prenatal services or treatment after initial office visit, including no charge for ultrasound, lab, and diagnostic testing. Depending on the type of services, a <u>copayment</u>, <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). <u>Preauthorization</u> required to avoid nonpayment if hospital stay is longer than 48 hours for vaginal delivery or 96 hours for C-section.
	Childbirth delivery professional services	20% coinsurance.	Not covered.	
	Childbirth delivery facility services	\$500 copayment per pregnancy plus 20% coinsurance.	Not covered.	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% coinsurance.	Not covered.	<u>Preauthorization</u> is required to avoid nonpayment.
	<u>Rehabilitation services</u>	Outpatient visits: \$25 copayment/visit up to \$250 , thereafter no charge for the remaining calendar year. <u>Deductible</u> does not apply. Inpatient Rehab. \$500 copayment/admission plus 20% coinsurance.	Not covered.	<u>Preauthorization</u> is required for inpatient rehab to avoid nonpayment. <u>Plan</u> covers services related to the diagnosis and treatment of Autism Spectrum Disorder (ASD) regardless of age.
	<u>Habilitation services</u>	Not covered.	Not covered.	You must pay 100% of these expenses, even when services are received <u>in-network</u> .
	<u>Skilled nursing care</u>	\$500 copayment/admission plus 20% coinsurance.	Not covered.	<u>Preauthorization</u> is required to avoid nonpayment. Maximum benefit is 60 days/calendar year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Durable medical equipment</u>	20% coinsurance. No charge (and no deductible) for breastfeeding pump & supplies and supplies for insulin pump.	Not covered.	<u>Durable medical equipment</u> over \$1,000 requires <u>preauthorization</u> to avoid nonpayment.
	<u>Hospice services</u>	No charge. <u>Deductible</u> does not apply.	Not covered.	Respite care benefit is limited to 10 days for each 6-month benefit period; 2 periods per lifetime. <u>Preauthorization</u> required to avoid nonpayment.
If your child needs dental or eye care	Children's eye exam	\$10 copayment/visit. <u>Deductible</u> does not apply.	Not covered.	These vision benefits are available if you elect a separate <u>Vision plan</u> .
	Children's glasses	\$15 copayment/eyeglasses. <u>Deductible</u> does not apply.	Not covered.	These vision benefits are available if you elect a separate <u>Vision plan</u> . Some types of lenses may be eligible for higher <u>out-of-network provider reimbursement</u> .
	Children's dental check-up	No charge. Dental <u>deductible</u> does not apply.	Your <u>coinsurance</u> varies on the dental <u>plan</u> you elect. <u>Deductible</u> does not apply.	Medical <u>deductible</u> does not apply. These dental benefits are available if you elect a separate <u>Dental plan</u> .

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Habilitation services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture, including spinal manipulations/chiropractic massage therapy, rolfing, and naprapathy, with combined benefit maximum of 30 visits per calendar year.
- Bariatric surgery
- Chiropractic care (visit limits combined with acupuncture, as noted above).
- Dental care (Adult) when you elect a separate Dental plan.
- Hearing aids: Under 21 years: No charge up to \$2,200/year; thereafter you pay 90% coinsurance in any 36-month period. Age 21 and older: No charge up to \$500/year; thereafter you pay 90% coinsurance in any 36-month period.
- Infertility treatment (limited treatment covered plus testing to determine the cause of infertility and certain surgical treatment procedures).
- Routine eye care (Adult) when you elect a separate Vision plan.
- Weight loss programs (when provided by a Physician, licensed nutritionist or registered dietician).

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is the 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. 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 on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the: **Medical Plan Claims Administrator (Blue Cross Blue Shield of New Mexico) at 1-888-966-7742 or Blue Cross and Blue Shield of New Mexico Appeals Unit at 1-800-205-9926** or visit www.bcbsnm.com. Additionally, a consumer assistance program can help you file your appeal. You may also contact the NM Office of the Superintendent of Insurance Managed Health Care Bureau at 1-855-427-5674 or by email at mhcb.grievance@state.nm.us. This website lists states with a Consumer Assistance Program: <https://www.cms.gov/cciio/resources/consumer-assistance-grants/>.

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 1-888-966-7742. Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiiigo holne' 1-888-966-7742.

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$35
■ Hospital (facility) <u>coinsurance</u>	\$500 + 20%
■ Other <u>coinsurance</u>	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
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In this example, Peg would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$620
<u>Coinsurance</u>	\$1,810
<u>What isn't covered</u>	
Limits or exclusions	\$20
The total Peg would pay is	\$2,950

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$35
■ Hospital (facility) <u>coinsurance</u>	\$500 + 20%
■ Other <u>coinsurance</u>	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
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In this example, Joe would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$700
<u>Coinsurance</u>	\$780
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,480

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$35
■ Hospital (facility) <u>coinsurance</u>	\$150 + 20%
■ Other <u>coinsurance</u>	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
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In this example, Mia would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$700
<u>Coinsurance</u>	\$30
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,230