# B826CMN Blue Community Bronze HMO[SM] 005



**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage for:** Individual/Family | **Plan Type:** HMO

**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.bcbsnm.com/member/policy-forms/ or by calling 1-800-423-1630.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$5,000**/Individual. **$12,700**/Family. Doesn't apply to preventive care or services that charge a copay. Copays don't count toward the overall deductible. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | No. | 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 out-of-pocket limit on my expenses?** | Yes. **$6,600**/Individual. **$13,200**/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 out-of-pocket limit?** | Premiums and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |
| **Does this plan use a network of providers?** | Yes. Please call **1-800-432-0750** or see **www.bcbsnm.com**. | 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 specialist?** | No. You don't need a referral to see a specialist. | 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 4. See your policy or plan document for additional information about **excluded services**. |



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- **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 health 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**.)
- The plan may encourage you to use HMO **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your cost if you use a BCBSNM HMO Provider | Your cost if you use a Non-BCBSNM HMO Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $30 copay/visit or 20% coinsurance | Not Covered | First 3 office visits are subject to copay; deductible and coinsurance apply for subsequent visits. |
| | Specialist visit | $60 copay/visit or 20% coinsurance | Not Covered | |
| | Other practitioner office visit | 20% coinsurance | Not Covered | Acupuncture treatment and chiropractic care each limited to 25 visits/year, unless for rehabilitative or habilitative purposes. |
| | Preventive care/screening/immunization | No Charge | Not Covered | ---none--- |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | Not Covered | ---none--- |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | Not Covered | |

| Common Medical Event | Services You May Need | Your cost if you use a BCBSNM HMO Provider | Your cost if you use a Non-BCBSNM HMO Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.bcbsnm.com/member/rx_drugs.html | Preferred generic drugs | 10% coinsurance | Not Covered | Retail-limited to a 30-day supply. Mail-order limited to a 90-day supply, in-network only. Specialty drugs are not available through mail-order. Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic drug is available. |
| | Non-preferred generic drugs | 10% coinsurance | Not Covered | |
| | Preferred brand drugs | 20% coinsurance | Not Covered | |
| | Non-preferred brand drugs | 30% coinsurance | Not Covered | |
| | Specialty drugs | 40% coinsurance | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | Not Covered | Elective abortion is not covered. |
| | Physician/surgeon fees | 20% coinsurance | Not Covered | |
| **If you need immediate medical attention** | Emergency room services | 20% coinsurance | 20% coinsurance | ---none--- |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | Preauthorization required for non-emergency air ambulance. |
| | Urgent care | $75 copay/visit | Not Covered | ---none--- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | Not Covered | Preauthorization required. |
| | Physician/surgeon fee | 20% coinsurance | Not Covered | ---none--- |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/behavioral health outpatient services | $30 copay/visit or 20% coinsurance | Not Covered | Includes office, home, outpatient, and IOP services; inpatient and partial hospitalization (IOP, partial hospitalization, & inpatient require preauthorization). First 3 office visits are subject to copay; deductible and coinsurance apply for subsequent visits. |
| | Mental/behavioral health inpatient services | 20% coinsurance | Not Covered | |
| | Substance use disorder outpatient services | $30 copay/visit or 20% coinsurance | Not Covered | |
| | Substance use disorder inpatient services | 20% coinsurance | Not Covered | |

| Common Medical Event | Services You May Need | Your cost if you use a BCBSNM HMO Provider | Your cost if you use a Non-BCBSNM HMO Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you are pregnant** | Prenatal and postnatal care | $30/$60 copay/visit or 20% coinsurance | Not Covered | Copay charged for initial visit only. First 3 office visits are subject to copay; deductible and coinsurance apply for subsequent visits. |
| | Delivery and all inpatient services | 20% coinsurance | Not Covered | ---none--- |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | Not Covered | Max. 100 visits/year. |
| | Rehabilitation services | 20% coinsurance | Not Covered | Includes physical, occupational, and speech therapies in an office or outpatient setting. |
| | Habilitation services | 20% coinsurance | Not Covered | |
| | Skilled nursing care | 20% coinsurance | Not Covered | Max. 60 days/year. |
| | Durable medical equipment | 20% coinsurance | Not Covered | ---none--- |
| | Hospice service | 20% coinsurance | Not Covered | |
| **If your child needs dental or eye care** | Eye exam | No Charge | Not Covered | One visit per year. |
| | Glasses | Covered | Not Covered | One pair of glasses per year. Up to $100 in-network. |
| | Dental check-up | Not Covered | Not Covered | Coverage is under your stand-alone dental plan. See dental plan information for details. |

## 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 (Routine dental for adults)
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (Adult)
- Routine foot care (Unless you are diabetic)
- Termination of pregnancy (Except in limited circumstances)

**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 (Max. 25 visits/year)
- Bariatric surgery (Based on medical necessity)
- Chiropractic care (Max. 25 visits/year)
- Hearing aids (Up to age 21)
- Infertility treatment (Diagnosis and treatment of medical condition causing infertility)
- Weight loss programs (Health education and counseling services)

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-800-423-1630. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

## Your Grievance 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 **grievance**. For questions about your rights, this notice, or assistance, you can contact Blue Cross and Blue Shield of New Mexico (BCBSNM) Appeals Unit at 1-800-423-1630. You may also 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 mhcb.grievance@state.nm.us or visit www.osi.state.nm.us.

## Does this Coverage Provide Minimum 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 of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-423-1630.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-423-1630.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-423-1630.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-423-1630.

*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 the plan. The actual care you receive will be different from these examples, and the cost of that care also will 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** $1,940
- **Patient pays** $5,600

**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 | $5,000 |
| Copays | $0 |
| Coinsurance | $450 |
| Limits or exclusions | $150 |
| **Total** | **$5,600** |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $280
- **Patient pays** $5,120

**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 | $5,000 |
| Copays | $0 |
| Coinsurance | $40 |
| Limits or exclusions | $80 |
| **Total** | **$5,120** |

# Questions and answers about 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.