



**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/static/nm/pdf/policy-forms/2017/75605NM0390038-01.pdf](http://www.bcbsnm.com/static/nm/pdf/policy-forms/2017/75605NM0390038-01.pdf) or by calling 1-866-236-1702.

| Important Questions                                       | Answers  | Why this Matters:   |
|---|--|---|
| <b>What is the overall deductible?</b>                    | <b>\$5,000</b> /Individual.<br><b>\$13,100</b> /Family.<br>Doesn't apply to preventive care.     | You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> 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 <b>deductible</b> .   |
| <b>Are there other deductibles for specific services?</b> | No.  | You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.  |
| <b>Is there an out-of-pocket limit on my expenses?</b>    | Yes. <b>\$6,550</b> /Individual.<br><b>\$13,100</b> /Family.                                     | The <b>out-of-pocket</b> 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.  |
| <b>What is not included in the out-of-pocket limit?</b>   | Premiums and health care this plan doesn't cover.  | Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .  |
| <b>Does this plan use a network of providers?</b>         | Yes. Please call <b>1-866-236-1702</b> or see <a href="http://www.bcbsnm.com">www.bcbsnm.com</a> | If you use an in-network doctor or other health care <b>provider</b> , 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 <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> . |
| <b>Do I need a referral to see a specialist?</b>          | No. You don't need a referral to see a specialist.   | You can see the <b>specialist</b> you choose without permission from this plan.   |
| <b>Are there services this plan doesn't cover?</b>        | 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 <b>excluded services</b> .   |

**Questions:** Call 1-866-236-1702 or visit us at [www.bcbsnm.com/coverage](http://www.bcbsnm.com/coverage).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf](http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf) or call 1-866-236-1702 to request a copy.



- **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 Participating **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

| Common Medical Event  | Services You May Need                            | Your cost if you use a Participating Provider                        | Your cost if you use a Non-Participating Provider | Limitations & Exceptions   |
|---|--|--|---|--|
| <b>If you visit a health care provider's office or clinic</b>   | Primary care visit to treat an injury or illness | 40% coinsurance  | Not Covered                                       | ---none---   |
|   | Specialist visit                                 | 40% coinsurance  | Not Covered                                       |  |
|   | Other practitioner office visit                  | 40% coinsurance  | Not Covered                                       | Acupuncture treatment and chiropractic care each limited to 20 visits/year, unless for rehabilitative or habilitative purposes.  |
|   | Preventive care/screening/immunization           | No Charge  | Not Covered                                       | ---none---   |
| <b>If you have a test</b>   | Diagnostic test (x-ray, blood work)              | 50% coinsurance  | Not Covered                                       | ---none---   |
|   | Imaging (CT / PET scans, MRIs)                   | 50% coinsurance  | Not Covered                                       |  |
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <b>prescription drug coverage</b> is available at <a href="https://www.myprime.com/content/dam/prime/memberportal/forms/AuthorForms/IVL/2017/2017_IL_5T_EX.pdf">https://www.myprime.com/content/dam/prime/memberportal/forms/AuthorForms/IVL/2017/2017_IL_5T_EX.pdf</a> | Preferred generic drugs                          | Preferred -<br>30% coinsurance<br>Participating -<br>35% coinsurance | Not Covered                                       | Lower coinsurance applies to participating preferred pharmacy. Retail limited to a 30-day supply. 90-day supply available via mail order or at a network of select retail pharmacies. 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                      | Preferred -<br>30% coinsurance<br>Participating -<br>35% coinsurance | Not Covered                                       |  |
|   | Preferred brand drugs                            | Preferred -<br>40% coinsurance<br>Participating -<br>50% coinsurance | Not Covered                                       |  |
|   | Non-preferred brand drugs                        | 50% coinsurance  | Not Covered                                       |  |
|   | Specialty drugs                                  | 50% coinsurance  | Not Covered                                       |  |
| <b>If you have outpatient surgery</b>   | Facility fee (e.g., ambulatory surgery center)   | 50% coinsurance  | Not Covered                                       | Abortion is not covered except in limited circumstances.   |
|   | Physician/surgeon fees                           | 40% coinsurance  | Not Covered                                       |  |

| Common Medical Event  | Services You May Need                        | Your cost if you use a Participating Provider | Your cost if you use a Non-Participating Provider | Limitations & Exceptions  |
|---|--|---|---|---|
| <b>If you need immediate medical attention</b>                                | Emergency room services                      | 40% coinsurance                               | 40% coinsurance                                   | ---none---  |
|   | Emergency medical transportation             | 40% coinsurance                               | 40% coinsurance                                   | Preauthorization required for non-emergency air ambulance. Failure to preauthorize may result in claim denial.  |
|   | Urgent care                                  | 40% coinsurance                               | 40% coinsurance                                   | ---none---  |
| <b>If you have a hospital stay</b>  | Facility fee (e.g., hospital room)           | 40% coinsurance                               | Not Covered                                       | Preauthorization required. Failure to preauthorize may result in claim denial. Preauthorization requirement is waived if admitted from the emergency room.  |
|   | Physician/surgeon fee                        | 40% coinsurance                               | Not Covered                                       | ---none---  |
| <b>If you have mental health, behavioral health, or substance abuse needs</b> | Mental/Behavioral health outpatient services | 40% coinsurance                               | Not Covered                                       | Preauthorization is required for psychological testing; neuropsychological testing; electroconvulsive therapy; repetitive transcranial magnetic stimulation; intensive outpatient treatment; inpatient services; residential treatment center; Autism Spectrum Disorder; and partial hospitalization. |
|   | Mental/Behavioral health inpatient services  | 40% coinsurance                               | Not Covered                                       |   |
|   | Substance use disorder outpatient services   | 40% coinsurance                               | Not Covered                                       |   |
|   | Substance use disorder inpatient services    | 40% coinsurance                               | Not Covered                                       |   |
| <b>If you are pregnant</b>  | Prenatal and postnatal care                  | 40% coinsurance                               | Not Covered                                       | ---none---  |
|   | Delivery and all inpatient services          | 40% coinsurance                               | Not Covered                                       |   |
| <b>If you need help recovering or have other special health needs</b>         | Home health care                             | 40% coinsurance                               | Not Covered                                       | Max. 100 visits/year  |
|   | Rehabilitation services                      | 40% coinsurance                               | Not Covered                                       | Includes physical, occupational, and speech therapies in an office or outpatient setting. Also includes therapeutic services by a Chiropractor or Doctor of Oriental Medicine.  |
|   | Habilitation services                        | 40% coinsurance                               | Not Covered                                       |   |
|   | Skilled nursing care                         | 40% coinsurance                               | Not Covered                                       | Max. 60 days/year   |
|   | Durable medical equipment                    | 40% coinsurance                               | Not Covered                                       | ---none---  |
|   | Hospice service                              | 40% coinsurance                               | Not Covered                                       |   |

| Common Medical Event                          | Services You May Need | Your cost if you use a Participating Provider | Your cost if you use a Non-Participating Provider | Limitations & Exceptions  |
|---|-----------------------|---|---|---|
| <b>If your child needs dental or eye care</b> | Eye exam              | No Charge                                     | Covered   | One visit per year. Reimbursed up to \$30 out-of-network. See benefit booklet for network details.  |
|   | Glasses               | Covered up to \$100 after deductible          | Not Covered                                       | One pair of glasses per year. Up to \$100 in-network. Any charge over \$100 in-network will receive 20% off the remaining balance. Reimbursed up to \$50 out-of-network. See benefit booklet for network details. |
|   | 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.)

- Abortions (except where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed)
- Cosmetic surgery
- Dental Care (Routine dental for adults)
- Infertility treatment (except for diagnosis and medically indicated treatments for physical conditions causing infertility)
- 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)
- Weight loss programs (except for health education and counseling services)

#### 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. 20 visits/year)
- Bariatric surgery (Limited to one per lifetime, based on medical necessity)
- Chiropractic care (Max. 20 visits/year)
- Hearing aids (Up to age 21 and limited to 1 item every 3 years)

## 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 1-866-236-1702. You may also contact the Office of Superintendent of Insurance toll-free at 1-855-427-5674.

## 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 may also contact the Office of Superintendent of Insurance toll-free at 1-855-427-5674 or [www.osi.state.nm.us](http://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.**

—————*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 \$1,440
- Patient pays \$6,100

#### 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           |
| <b>Total</b>               | <b>\$7,540</b> |

#### Patient pays:

|                      |                |
|----------------------|----------------|
| Deductibles          | \$5,000        |
| Copays               | \$0            |
| Coinsurance          | \$900          |
| Limits or exclusions | \$200          |
| <b>Total</b>         | <b>\$6,100</b> |

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

- Amount owed to providers: \$5,400
- Plan pays \$220
- Patient pays \$5,180

#### 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          |
| <b>Total</b>                   | <b>\$5,400</b> |

#### Patient pays:

|                      |                |
|----------------------|----------------|
| Deductibles          | \$5,000        |
| Copays               | \$0            |
| Coinsurance          | \$100          |
| Limits or exclusions | \$80           |
| <b>Total</b>         | <b>\$5,180</b> |

## 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?

**X 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?

**X 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.

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If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost.  
To talk to an interpreter, call 866-236-1702.

|                     |  |
|---------------------|--|
| العربية<br>Arabic   | إن كان لديك أو لدى شخص تساعدك أسئلة، ف لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 866-236-1702.   |
| 繁體中文<br>Chinese     | 如果您，或您正在協助的對象，對此有疑問，您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員，請撥電話 號碼 866-236-1702。   |
| Français<br>French  | Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 866-236-1702.         |
| Deutsch<br>German   | Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 866-236-1702 an. |
| हिंदी<br>Hindi      | यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 866-236-1702 पर काल करें।                              |
| Italiano<br>Italian | Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 866-236-1702.                       |
| 日本語<br>Japanese     | ご本人様、またはお客様の身の回りの方でも、ご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入力したりすることができます。料金はかかりません。通訳とお話される場合、866-236-1702 までお電話ください。   |
| 한국어<br>Korean       | 만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 866-236-1702 로 전화하십시오.  |
| Diné<br>Navajo      | T'áá ni, éí doodago ła'da bíká anáníłwo'ígíí, na'ídiłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídiłkidígíí bee nił hodoonih. Ata'dahalne'ígíí bich'i' hodíłnih kwe'é 866-236-1702.                  |
| فارسی<br>Persian    | اگر شما، یا کسی که شما به او کمک می کنید، سوالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 866-236-1702 تماس حاصل نمایید.                 |



|                          |   |
|--------------------------|---|
| Русский<br>Russian       | Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 866-236-1702.     |
| Español<br>Spanish       | Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 866-236-1702.                              |
| Tagalog<br>Tagalog       | Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 866-236-1702. |
| ไทย<br>Thai              | หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีข้อสงสัยใด ๆ คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่ามโดยติดต่อที่หมายเลข 866-236-1702.   |
| Tiếng Việt<br>Vietnamese | Nếu quý vị, hoặc người mà quý vị đang giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 866-236-1702.                      |