




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, call 1-877-878-LANL (5265) or at www.bcbsnm.com. 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 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<p><u>Preferred Provider</u>: \$250 Individual / \$750 Family</p> <p><u>Non-Preferred Provider</u>: \$500 Individual / \$1,500 Family</p>	<p>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>, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u>.</p>
Are there services covered before you meet your deductible?	<p>Yes. Services that charge a <u>copay</u>, <u>emergency room services</u>, and <u>Preferred preventive care</u> are covered before you meet your <u>deductible</u>.</p>	<p>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 www.healthcare.gov/coverage/preventive-care-benefits/.</p>
Are there other deductibles for specific services?	<p>No.</p>	<p>You don't have to meet <u>deductibles</u> for specific services.</p>
What is the out-of-pocket limit for this plan?	<p><u>Preferred Provider</u>: \$3,000 Individual / \$9,000 Family</p> <p><u>Non-Preferred Provider</u>: \$6,000 Individual / \$18,000 Family</p>	<p>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> has been met.</p>
What is not included in the out-of-pocket limit?	<p><u>Premiums</u>, <u>Non-Preferred inpatient facility copays</u>, <u>balance-billing</u> charges, penalty amounts, and health care this <u>plan</u> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>
Will you pay less if you use a network provider?	<p>Yes. See www.bcbsnm.com or call 1-877-878-LANL (5265) for a list of <u>preferred providers</u>.</p>	<p>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 most if you use an <u>out-of-network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</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.</p>
Do you need a referral to see a specialist?	<p>No.</p>	<p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>

 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
		Preferred Provider (You will pay the least)	Non-preferred 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	\$20 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$20 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No Charge; <u>deductible</u> does not apply	40% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</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)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior authorization may be required; see your benefit booklet* for details. Gynecological or obstetrical ultrasounds do not require prior authorization.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsnm.com

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-preferred Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at 1-800-838-4590	Generic drugs	\$15 retail - \$30 mail <u>copay/prescription</u> ; <u>deductible</u> does not apply	Not Covered	Retail covers a 30-day supply or 180 units, whichever is less. Mail-order covers a 60-day or 90-day supply or 540 units, whichever is less. Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available. <u>Specialty drugs</u> are not available through mail-order.
	Preferred brand drugs	\$30 retail - \$60 mail <u>copay/prescription</u> ; <u>deductible</u> does not apply	Not Covered	
	Non-preferred brand drugs	\$45 retail - \$90 mail <u>copay/prescription</u> ; <u>deductible</u> does not apply	Not Covered	
	<u>Specialty drugs</u>	\$45 retail <u>copay/prescription</u> ; <u>deductible</u> does not apply	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior authorization may be required for non-emergency surgery. Transgender services (must meet medical criteria).
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$75 <u>copay/visit</u> ; <u>deductible</u> does not apply	\$75 <u>copay/visit</u> ; <u>deductible</u> does not apply	<u>Copay</u> waived and 10% after <u>deductible</u> if admitted. ER physicians are subject to <u>deductible</u> & <u>coinsurance</u> .
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	<u>Preferred Provider deductible</u> applies.
	<u>Urgent care</u>	\$20 <u>copay/visit</u> ; <u>deductible</u> does not apply	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-preferred Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	\$250 <u>copay/admit</u> plus 40% <u>coinsurance</u>	Prior authorization may be required, unless for emergency; \$300 penalty if not prior authorized.
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <u>copay</u> /office visit; <u>deductible</u> does not apply 10% <u>coinsurance</u> for other outpatient services	40% <u>coinsurance</u>	Includes office, home, outpatient, and Intensive Outpatient Program services, transgender services (must meet medical criteria), inpatient, and partial <u>hospitalization</u> .
	Inpatient services	10% <u>coinsurance</u>	\$250 <u>copay/admit</u> plus 40% <u>coinsurance</u>	Intensive Outpatient Program, inpatient, and partial <u>hospitalization</u> prior authorization may be required; see your benefit booklet* for details; \$300 penalty if not prior authorized.
If you are pregnant	Office visits	\$20 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	<u>Copay</u> charged for initial visit only. <u>Cost sharing</u> does not apply for <u>preventive services</u> . 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.)
	Childbirth/delivery professional services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior authorization may be required; see your benefit booklet* for details; \$300 penalty if not prior authorized.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-preferred Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior authorization may be required; see your benefit booklet* for details. Limited to 100 visits per year for <u>Non-Preferred</u> .
	<u>Rehabilitation services</u>	\$20/therapist visit; <u>deductible</u> does not apply 10% <u>coinsurance</u> for other <u>providers</u>	40% <u>coinsurance</u>	Physical, occupational, and speech therapies (office/outpatient) limited to 20 visits per year each.
	<u>Habilitation services</u>	\$20 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	<u>Copay</u> applies to physical, occupational, and speech therapists in office or outpatient settings. Other <u>providers</u> includes, but is not limited to Chiropractors and Doctors of Oriental Medicine.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u> ; <u>deductible</u> does not apply	40% <u>coinsurance</u> ; <u>deductible</u> does not apply	Includes inpatient physical rehabilitation. Limited to 100 days per year <u>Preferred</u> , 70 days per year <u>Non-Preferred</u> . Prior authorization may be required; see your benefit booklet* for details; \$300 penalty if not prior authorized.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Hospice services</u>	10% <u>coinsurance</u> ; <u>deductible</u> does not apply	40% <u>coinsurance</u> ; <u>deductible</u> does not apply	Prior authorization may be required; see your benefit booklet* for details.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsnm.com

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-preferred Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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
- Dental care (Adult, routine dental)
- Infertility treatment (unless for medical condition causing the infertility)
- Long term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (unless you are diabetic)
- Weight loss programs

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

- Acupuncture (max 20 visits/year)
- Bariatric surgery (must meet medical criteria)
- Chiropractic care (including naprapathy max 20 visits/year)
- Hearing aids (up to age 21; 1 hearing aid per hearing impaired ear every 3 years; over 21 max \$2,200 for any 3-year period)
- Non-emergency care when traveling outside the U.S.

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 [plan](tel:1-877-878-LANL) at 1-877-878-LANL (5265), U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or 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 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: Blue Cross and Blue Shield of New Mexico (BCBSNM) [Appeals](#) Unit at 1-800-205-9926 or visit www.bcbsnm.com, or 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 www.osi.state.nm.us.

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 1-877-878-LANL (5265).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-878-LANL (5265).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-878-LANL (5265).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-878-LANL (5265).

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 plan's overall deductible \$250
- Specialist copayment \$20
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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>	\$250
<u>Copayments</u>	\$30
<u>Coinsurance</u>	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,540

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$250
- Specialist copayment \$20
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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>	\$250
<u>Copayments</u>	\$700
<u>Coinsurance</u>	\$70
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,040

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible \$250
- Specialist copayment \$20
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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>	\$250
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$550

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a [grievance](#).

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>

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 855-710-6984.

Español 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 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعد أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 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 855-710-6984。
Français 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 855-710-6984.
Deutsch 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 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવા કોઈ બીજા વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કોલ કરો.
हिंदी Hindi	यादे आपके या आप जिसको 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 855-710-6984 पर कॉल करें।
Italiano 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 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anáníwo'ígíí, na'ídiłkígo, ts'ídá bee ná ahóótí'i' t'áá níik'e níká a'doolwoł dóó bína'ídiłkígo bee ní h odoonih. Ata'dahalne'ígíí bich'í' hodíílnih kwe'é 855-710-6984.
فارسی 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 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiegokolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский 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 855-710-6984.
Tagalog 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 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.