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/coverage or by calling 1-866-236-1702.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Preferred Provider **$500**/Individual. **$1,500**/Family. Non-Preferred Provider **$1,000**/Individual. **$3,000**/Family. Doesn't apply to preventive care and services that charge a copay.	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?	Yes. ER **$400**; Inpatient **$200**/**$300**; and Outpatient **$150**/**$250**. There are no other specific **deductibles**.	You must pay all the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. Preferred Provider **$4,000**/Individual. **$12,000**/Family. Non-Preferred Provider **$8,000**/Individual. **$24,000**/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, preauthorization penalties, 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**.
Does this plan use a network of providers?	Yes. Please call 1-866-236-1702 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**.

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

Common Medical Event	Services You May Need	Your cost if you use a Preferred Provider	Your cost if you use a Non-Preferred 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	40% coinsurance	---none---
	Specialist visit	$60 copay/visit	40% coinsurance	
	Other practitioner office visit	20% coinsurance	40% coinsurance	Acupuncture treatment and chiropractic care each limited to 25 visits/year
	Preventive care/screening/immunization	No Charge	40% coinsurance	---none---
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	---none---
	Imaging (CT / PET scans, MRIs)	20% coinsurance	40% coinsurance	Preauthorization required for CT/PET scans.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsnm.com/member/rx_drugs.html	Preferred Generic Drugs	No Charge	No Charge	Retail-limited to a 30-day supply. Mail-order limited to a 90-day supply, in-network only. An additional 50% coinsurance applies to out-of-network prescriptions. 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/Retail-$20/Mail	$10/Retail	
	Preferred Brand Drugs	$50/Retail-$100/Mail	$50/Retail	
	Non-Preferred Brand Drugs	$100/Retail-$200/ Mail	$100/Retail	
	Specialty Drugs	$150 /prescription	$150/prescription	

Common Medical Event	Services You May Need	Your cost if you use a Preferred Provider	Your cost if you use a Non-Preferred Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Additional $150 Preferred/$250 Non-Preferred per occurrence deductible.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	---none---
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	Additional $400 per occurrence deductible; waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Preauthorization required for non-emergency air ambulance.
	Urgent care	$60 copay/visit	40% coinsurance	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Additional $200 Preferred/$300 Non-Preferred per occurrence deductible. Preauthorization required.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 copay/visit	40% coinsurance	Includes office, home, outpatient, and IOP services; inpatient and partial hospitalization (IOP, partial hospitalization, & inpatient require preauthorization). Inpatient: Additional $250 Preferred/ $350 Non-Preferred per occurrence deductible.
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	
	Substance use disorder outpatient services	$30 copay/visit	40% coinsurance	
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Prenatal and postnatal care	$30/$60 copay/visit	40% coinsurance	Copay charged for initial visit only.
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	Additional $200 Preferred/$300 Non-Preferred per occurrence deductible.

Common Medical Event	Services You May Need	Your cost if you use a Preferred Provider	Your cost if you use a Non-Preferred Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Max. 100 visits/year.
	Rehabilitation services	20% coinsurance	40% coinsurance	Includes physical, occupational, and speech therapies in an office or outpatient setting.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Max. 60 days/year.
	Durable medical equipment	20% coinsurance	40% coinsurance	---none---
	Hospice service	20% coinsurance	40% coinsurance	Max. 45 visits/year.
If your child needs dental or eye care	Eye exam	No Charge	Covered	One visit per year. Reimbursed up to $40 out-of-network.
	Glasses	Covered	Covered	One pair of glasses per year. Up to $100 in-network. Reimbursed up to $50 out-of-network.
	Dental check-up	Not Covered	Not Covered	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)
- 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 (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 (For members age 21 and younger)
- Non-emergency care when traveling outside the U.S.

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.

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.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-236-1702.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-236-1702.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-236-1702.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-236-1702.

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** $5,690
- **Patient pays** $1,850

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	$700
Copays	$30
Coinsurance	$970
Limits or exclusions	$150
Total	**$1,850**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,350
- **Patient pays** $1,050

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	$500
Copays	$250
Coinsurance	$220
Limits or exclusions	$80
Total	**$1,050**

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.