



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 1-800-432-0750 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?	Blue Preferred: \$1,650 Individual / \$3,300 Family In-Network: \$1,650 Individual / \$3,300 Family Out-of-Network: \$3,250 Individual / \$6,500 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Certain preventive care is covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: \$3,200 Individual / \$9,200 Family Out-of-Network: \$6,500 Individual / \$19,500 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums , balance-billing 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 .
Will you pay less if you use a network provider?	Yes. See www.bcbsnm.com/sandia or call 1-877-498-7652 for a list of Blue Preferred providers / In-Network providers .	You pay the least if you use a provider in Blue Preferred tier. You pay more if you use a provider in-network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral .

 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
		Blue Preferred Provider (You will pay the least)	In-Network PPO Provider (You will pay more)	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	10% coinsurance	20% coinsurance	40% coinsurance	Virtual Visits – MDLive: \$10 copay ; deductible applies.
	Specialist visit	10% coinsurance	20% coinsurance	40% coinsurance	None
	Preventive care/screening/immunization	No Charge; deductible does not apply	No Charge; deductible does not apply	40% coinsurance	You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	20% coinsurance	40% coinsurance	No cost-sharing for COVID tests and vaccines.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	40% coinsurance	Preauthorization required for certain tests.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Blue Preferred Provider (You will pay the least)	In-Network PPO Provider (You will pay more)	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 prescription drug coverage is available at https://www.express-scripts.com</p>	Generic drugs	Retail: member pays 20% (min \$5/max \$10) after deductible; Mail Order: member pays 20% (min \$12.50/max \$25) after deductible	Retail: member pays 20% (min \$5/max \$10) after deductible ; Mail Order: member pays 20% (min \$12.50/max \$25) after deductible	Retail: 50% coinsurance after deductible Mail Order: Not Covered	Retail: 30-day supply; Mail Order: 90-day supply. Long-term medications (applicable to all pharmacy tiers except specialty medications) If you take a long-term medication, such as those used to treat high blood pressure or high cholesterol, you will need to make an important decision on where you fill that prescription.
	Preferred brand drugs	Retail: member pays 30%; (min \$30/max \$45) after deductible; Mail Order: member pays 30% (min \$75/max \$112.50) after deductible	Retail: member pays 30%; (min \$30/max \$45) after deductible ; Mail Order: member pays 30% (min \$75/max \$112.50) after deductible	Retail: 50% coinsurance after deductible Mail Order: Not Covered	Under your plan, you will pay the entire cost for a long-term medication at a retail pharmacy after the second purchase unless you participate in the Smart90 program. You can continue coverage by getting a 90-day supply through home delivery from Express Scripts® Pharmacy or at a participating Smart90 Anywhere Retail Pharmacy.
	Non-preferred brand drugs	Retail: member pays 40%; (min \$50/max \$75) after deductible; Mail Order: member pays 40% (min \$125/max \$187.50) after deductible	Retail: member pays 40%; (min \$50/max \$75) after deductible ; Mail Order: member pays 40% (min \$125/max \$187.50) after deductible	Retail: 50% coinsurance after deductible Mail Order: Not Covered	To find a Smart90 Anywhere Retail Pharmacy near you, log in or register at express-scripts.com/90day , then select “find a Pharmacy” from the menu under “Prescriptions”.
	Specialty drugs	Retail: member pays 40%; (min \$50/max \$75) after deductible; Mail Order: member pays 40% (min \$125/max \$187.50) after deductible	Retail: member pays 40%; (min \$50/max \$75) after deductible; Mail Order: member pays 40% (min \$125/max \$187.50) after deductible	Retail: 50% coinsurance after deductible Mail Order: Not Covered	Most specialty medications run through the Express Scripts’ Accredo Specialty Pharmacy; please check drug coverage prior to filling any prescriptions.

* 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
		Blue Preferred Provider (You will pay the least)	In-Network PPO Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	40% coinsurance	Preauthorization required.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	Facility Charges: 10% coinsurance ER Physician Charges: 10% coinsurance	Facility Charges: 20% coinsurance ER Physician Charges: 20% coinsurance	Facility Charges: 20% coinsurance ER Physician Charges: 20% coinsurance	None
	Emergency medical transportation	10% coinsurance	20% coinsurance	20% coinsurance	None
	Urgent care	10% coinsurance	20% coinsurance	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	40% coinsurance	Preauthorization required.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge after deductible	No Charge after deductible	40% coinsurance	Preauthorization may be required; see your benefit booklet* for details.
	Inpatient services	No Charge after deductible	No Charge after deductible	40% coinsurance	

* 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
		Blue Preferred Provider (You will pay the least)	In-Network PPO Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	10% coinsurance	20% coinsurance	40% coinsurance	<p>Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).</p> <p>Preauthorization required.</p>
	Childbirth/delivery professional services	10% coinsurance	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	20% coinsurance	40% coinsurance	None
	Rehabilitation services	10% coinsurance	20% coinsurance	40% coinsurance	Includes physical, occupational, and speech therapies (office/outpatient).
	Habilitation services	10% coinsurance	20% coinsurance	40% coinsurance	
	Skilled nursing care	10% coinsurance	20% coinsurance	40% coinsurance	None
	Durable medical equipment	10% coinsurance	20% coinsurance	40% coinsurance	None
	Hospice services	10% coinsurance	20% coinsurance	40% coinsurance	None

* 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
		Blue Preferred Provider (You will pay the least)	In-Network PPO Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	Eye exam only for non-refracted care due to illness or injury to eye; subject to deductible .
	Children's glasses	Not Covered	Not Covered	Not Covered	If vision coverage purchased, see your vision plan information. Initial pair of glasses/contact lenses when required due to loss of natural lens or cataract surgery; subject to deductible .
	Children's dental check-up	Not Covered	Not Covered	Not Covered	If dental coverage purchased, see your dental plan information.

[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)
- Long term care
- Infertility treatment (diagnosis of infertility covered)
- 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 \$750/year)
- Bariatric surgery (must meet BMI and medical criteria)
- Chiropractic care (max \$750/year)
- Hearing aids (for members age 20 and younger: 1 hearing aid/ear, every 36 months, includes ear molds, fitting, dispensing)
- Non-emergency care when traveling outside the U.S.

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

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](#) at 1-800-432-0750, 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](#) or the New Mexico State-Based Exchange BeWell at www.BeWellnm.com. 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 1-800-432-0750.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-432-0750.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-432-0750.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-432-0750.

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	\$1,650
■ Specialist coinsurance	10%
■ 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:

Cost Sharing	
Deductibles	\$1,650
Copayments	\$0
Coinsurance	\$1,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,810

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$1,650
■ Specialist coinsurance	10%
■ 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:

Cost Sharing	
Deductibles	\$1,650
Copayments	\$0
Coinsurance	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,570

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,650
■ Specialist coinsurance	10%
■ 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:

Cost Sharing	
Deductibles	\$1,650
Copayments	\$0
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,750

Health care coverage is important for everyone.	
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. 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. 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., 35 th Floor Chicago, IL 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/smartscreen/main.jsf Complaint Forms: https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

To receive language or communication assistance free of charge, please call us at 855-710-6984.	
Español	Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo.
العربية	لتلقي المساعدة اللغوية أو التواصل مجاناً، يرجى الاتصال بنا على الرقم 855-710-6984.
繁體中文	如欲獲得免費語言或溝通協助，請撥打855-710-6984與我們聯絡。
Français	Pour bénéficier gratuitement d'une assistance linguistique ou d'une aide à la communication, veuillez nous appeler au 855-710-6984.
Deutsch	Um kostenlose Sprach- oder Kommunikationshilfe zu erhalten, rufen Sie uns bitte unter 855-710-6984 an.
ગુજરાતી	ભાષા અથવા સંચાર સહાય મફતમાં મેળવવા માટે, કૃપા કરીને અમને 855-710-6984 પર કોલ કરો.
हिंदी	निःशुल्क भाषा या संचार सहायता प्राप्त करने के लिए, कृपया हमें 855-710-6984 पर कॉल करें।
Italiano	Per assistenza gratuita alla lingua o alla comunicazione, chiami il numero 855-710-6984.
한국어	언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요.
Navajo	Niná: Doo bilagáana bizaad dinit's'á'góó, shá ata' hodooni nínízingo, t'áájíik'eh bee náhaz'á. 1-866-560-4042 jį' hodíilni.
فارسی	برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید.
Polski	Aby uzyskać bezpłatną pomoc językową lub komunikacyjną, prosimy o kontakt pod numerem 855-710-6984.
Русский	Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984.
Tagalog	Para makatanggap ng tulong sa wika o komunikasyon nang walang bayad, pakitawagan kami sa 855-710-6984.
اردو	مفت میں زبان یا مواصلت کی مدد موصول کرنے کے لیے، براہ کرم ہمیں 855-710-6984 پر کال کریں۔
Tiếng Việt	Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984.