


Important Questions	Answers	Why This Matters:
<p> <b>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.</b> For more information about your coverage, or to get a copy of the complete terms of coverage, call 866-306-1882 or visit <a href="http://www.nmmip.org">www.nmmip.org</a>. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other underlined terms see the Glossary. You can view the Glossary at <a href="http://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a> or call 866-306-1882 to request a copy.</p>		
<p><b>What is the overall deductible?</b></p>	<p><b>Per Calendar Year:</b>  <u>\$500/Individual</u></p>	<p>Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay.</p>
<p><b>Are there services covered before you meet your deductible?</b></p>	<p><b>Yes.</b> <u>Preventive care</u>, <u>Pre-admission testing</u>, <u>Home Health</u>, and <u>Hospice</u>, is covered before you meet your deductible.</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 deductible. See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>."</p>
<p><b>Are there other deductibles for specific services?</b></p>	<p><b>No.</b> There are no other specific <u>deductibles</u>.</p>	<p>You don't have to meet <u>deductibles</u> for specific services.</p>
<p><b>What is the out-of-pocket limit for this plan?</b></p>	<p><b>Per Calendar Year:</b>  <u>\$3,300/Individual</u></p>	<p>The <u>out-of-pocket</u> limit is the most you could pay in a year for covered services.</p>
<p><b>What is not included in the out-of-pocket limit?</b></p>	<p><u>Prescription drugs</u>, <u>premiums</u>, <u>balance-billing charges</u>, and <u>health care</u> that 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>
<p><b>Will you pay less if you use a network provider?</b></p>	<p><b>No.</b></p>	<p>This <u>plan</u> uses a <u>provider network</u>. Services received from a <u>non-participating provider</u>, are not covered unless emergent or urgent. If you receive services from an <u>out-of-network facility</u>, you may receive a bill from the facility for the difference between the facility charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>participating provider</u> might use a <u>non-participating provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.</p>
<p><b>Do you need a referral to see a specialist?</b></p>	<p><b>No.</b> You don't need a referral to see a specialist.</p>	<p>You can see the <u>specialist</u> you choose without a referral.</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	Participating Provider (You will pay the least)	Limitations, Exceptions, & Other Important Information
<p><b>If you visit a health care provider's office or clinic</b></p>	<p><u>Primary care visit to treat an injury or illness</u></p>	<p>20% coinsurance after deductible</p>	<p><b>Office Surgery and related services/Allergy Injections and Serum/Therapeutic Injections/ Allergy Testing/X-ray/Lab/Diagnostic Testing/All other office related services:</b>  <b>Participating Provider:</b> 20% coinsurance after deductible</p> <p><b>Acupuncture:</b>  <b>Participating Provider:</b> 20% coinsurance after deductible  <b>12 visits in 90 days; an additional 8 visits may be allowed if improvement.</b>  <b>(Limited to 20 visits per calendar year)</b></p>
	<p><u>Specialist visit</u></p>	<p>20% coinsurance after deductible</p>	
	<p><u>Preventive care/screening/immunization</u></p>	<p>No Charge</p>	<p>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.</p>
<p><b>If you have a test</b></p>	<p><u>Diagnostic test (x-ray, blood work)</u></p>	<p>20% coinsurance after deductible</p>	<p>None</p>
	<p><u>Imaging (CT/PET scans, MRIs)</u></p>	<p>20% coinsurance after deductible</p>	<p>Authorization must be obtained. (excludes bone density studies)</p>

Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Limitations, Exceptions, & Other Important Information
<p><b>If you need drugs to treat your illness or condition</b>            More information about <b>prescription drug coverage</b> is available at <a href="http://www.elixirsolutions.com">www.elixirsolutions.com</a></p>	<u>Generic drugs</u>	<p>The policy will coordinate, as a secondary payer, prescription drug benefits with your Medicare Part D insurance carrier.</p>	<p>The policy pays secondary to Medicare.</p> <p>You must be enrolled in Medicare Part A, Part B and Part D to receive outpatient prescription drug benefits from this policy.</p> <p>Prescriptions must be filled at a participating pharmacy with your NMMIP ID card.</p>
	<u>Preferred brand drugs</u>		
	<u>Non-preferred brand drugs</u>		
	<u>Specialty drugs</u>		
<p><b>If you have outpatient surgery</b></p>	<u>Facility fee (e.g., ambulatory surgery center)</u>	20% coinsurance after deductible	Authorization must be obtained.
	<u>Physician/surgeon fees</u>	20% coinsurance after deductible	None
<p><b>If you need immediate medical attention</b></p>	<u>Emergency room care</u>	20% coinsurance after deductible	None
	<u>Emergency medical transportation</u>	20% coinsurance after deductible	Transportation limited to the nearest hospital or skilled nursing facility that can provide the necessary medical treatment.
	<u>Urgent care</u>	20% coinsurance after deductible	none
<p><b>If you have a hospital stay</b></p>	<u>Facility fee (e.g., hospital room)</u>	20% coinsurance after deductible	Authorization must be obtained.
	<u>Physician/surgeon Fees</u>	20% coinsurance after deductible	none

Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Limitations, Exceptions, & Other Important Information
<p><b>If you need mental health, behavioral health, or substance abuse services</b></p>	<p><u>Outpatient services</u></p>	<p>No Charge</p>	<p>none</p>
	<p><u>Inpatient services</u></p>	<p>No Charge</p>	<p>Authorization must be obtained.</p>
<p><b>If you are pregnant</b></p>	<p><u>Office visits</u></p>	<p>20% coinsurance after deductible</p>	<p>Cost sharing does not apply for certain Network prenatal/preventive services required by PPACA. Depending on the type of services, deductible/coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)</p>
	<p><u>Childbirth/delivery professional services</u></p>	<p>20% coinsurance after deductible</p>	
	<p><u>Childbirth/delivery facility services</u></p>	<p>20% coinsurance after deductible</p>	<p>Authorization must be obtained for inpatient stays longer than 48 hours for vaginal delivery or 96 hours for cesarean delivery.</p>

Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	<u>Home health care</u>	No Charge	Limited to 100 visits per calendar year.
	<u>Rehabilitation services</u>	20% coinsurance after deductible	<b>PT/OT/ST:</b> 20% coinsurance after deductible
	<u>Habilitation services</u>	20% coinsurance after deductible	<b>ABA Therapy and Cognitive Rehab:</b> No Charge
If you need help recovering or have other special health needs “cont.d”	<u>Skilled nursing care</u>	20% coinsurance after deductible	Authorization must be obtained. Limited to 100 days per calendar year.
	<u>Durable medical equipment</u>	20% coinsurance after deductible	None
	<u>Hospice services</u>	No Charge	Authorization must be obtained for inpatient stays.
	<u>Children’s eye exam</u>	No Charge	Birth up to 19 years of age. Limited to one eye exam every 12 months.
If your child needs dental or eye care	<u>Children’s glasses</u>	No Charge	Limited to one pair of eyeglasses every 12 months. replacement lenses and minor repairs to glasses
	<u>Children’s dental check-up</u>	No Charge	Birth up to 19 years of age. Limited to one exam, cleaning & polishing every 12 months

## 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 <u>excluded services</u> .)		
<ul style="list-style-type: none"><li>• Cosmetic surgery</li><li>• Dental care (adult)</li></ul>	<ul style="list-style-type: none"><li>• Long-Term Care</li><li>• Private-Duty Nursing.</li></ul>	<ul style="list-style-type: none"><li>• Routine eye care (adult)</li><li>• Routine foot care (unless you are diabetic)</li></ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"><li>• Acupuncture (Limited to 20 visits per calendar year)</li><li>• Bariatric Surgery</li><li>• Chiropractic Care (Limited to 20 visits per calendar year)</li></ul>	<ul style="list-style-type: none"><li>• Hearing aids</li><li>• Infertility Treatment (Treat medical conditions causing infertility)</li></ul>	<ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the U.S.</li><li>• Weight loss programs (Health education and counseling)</li></ul>

**Your Rights to Continue Coverage:** There are no rights to continue coverage under this policy.

## 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: NMMIP, PO Box 1090, Great Bend, KS 67530, (844) 278-7896. 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](http://www.osi.state.nm.us).

## Does this plan provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

## 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 866-306-1882.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 866-306-1882.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 866-306-1882.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 866-306-1882.

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*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 \$500
- Specialist copay \$0
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

**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*)

<b>Total Example Cost</b>	<b>\$12,840</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$0
Coinsurance	\$2,460
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$3,000</b>

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

- The plan's overall deductible \$500
- Specialist copay \$0
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

**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*)

<b>Total Example Cost</b>	<b>\$7,460</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$0
Coinsurance	\$1,380
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,940</b>

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

- The plan's overall deductible \$500
- Specialist copay \$0
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,000</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$0
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$890</b>