




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 1-844-666-2521 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 ?	Preferred provider : \$175 Individual / \$350 Family Non-preferred provider : \$500 Individual / \$1,000 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 plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Services that charge a prescription drugs , diagnostic tests , and certain mental health and behavioral health services, and certain preventive care are 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 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 ?	Preferred provider : \$6,350 Individual / \$12,700 Family Non-preferred provider : \$12,700 Individual / \$25,400 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 , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , balance-billing charges, penalty amounts, 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 Preferred Provider Organization (PPO) Network at www.bcbsnm.com or call 1-844-666-2521 for a list of preferred providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use a non-preferred 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 a non-preferred 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
		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	\$40 copay /visit; deductible does not apply	40% coinsurance	None
	Specialist visit	\$55 copay /visit; deductible does not apply	40% coinsurance	None
	Preventive care/screening /immunization	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)	No Charge; deductible does not apply	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	\$125 copay /MRI/PET test \$75 copay /CT test deductible applies	40% coinsurance	Preauthorization may be required; see your benefit booklet* for details. Gynecological or obstetrical ultrasounds do not require preauthorization .
If you need drugs to treat your illness or condition More information about your pharmacy benefits please contact Optum Rx.	Generic drugs	N/A	N/A	Pharmacy benefits are administered by Optum Rx Pharmacy Benefits Management Phone number 800-372-8563
	Preferred brand drugs	N/A	N/A	
	Non-preferred brand drugs	N/A	N/A	
	Specialty drugs	N/A	N/A	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$500 copay /visit deductible applies	40% coinsurance	None
	Physician/surgeon fees	No Charge; deductible does not apply	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
		Preferred Provider (You will pay the least)	Non-preferred Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	Facility Charges: \$200 copay /visit deductible applies ER Physician Charges: No Charge; deductible does not apply	Facility Charges: \$200 copay /visit deductible applies ER Physician Charges: No Charge; deductible does not apply	None
	Emergency medical transportation	\$50 copay /trip ground \$100 copay /trip air deductible applies	\$50 copay /trip ground \$100 copay /trip air deductible applies	None
	Urgent care	\$50 copay /visit deductible applies	\$50 copay /visit deductible applies	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 copay /admit deductible applies	40% coinsurance	Requires preauthorization .
	Physician/surgeon fees	No Charge; deductible does not apply	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge; deductible does not apply	40% coinsurance	Preauthorization may be required; see your benefit booklet* for details.
	Inpatient services	No Charge; deductible does not apply	40% coinsurance	
If you are pregnant	Office visits	\$40/\$55 copay /visit; deductible does not apply	40% coinsurance	Copay charged for initial visit only. Cost sharing does not apply for preventive services . Depending on the type of services, a copayment or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No Charge; deductible does not apply	40% coinsurance	
	Childbirth/delivery facility services	\$500 copay /admit deductible applies	40% coinsurance	Requires preauthorization .

* 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 help recovering or have other special health needs	Home health care	No Charge; deductible does not apply	40% coinsurance	None
	Rehabilitation services	\$40 copay /visit; deductible does not apply	40% coinsurance	Includes physical, occupational, and speech therapies (office/outpatient). Preauthorization may be required.
	Habilitation services	\$40 copay /visit; deductible does not apply	40% coinsurance	
	Skilled nursing care	\$500 copay /admit deductible applies	40% coinsurance	Limited to 60 days per year. Requires preauthorization .
	Durable medical equipment	50% coinsurance deductible applies	50% coinsurance	None
	Hospice services	\$500 copay /admit deductible applies	40% coinsurance	No Charge for home hospice.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	If vision coverage purchased, see your vision plan information.
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	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 .)		
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) • Infertility treatment (limited to diagnosis only) 	<ul style="list-style-type: none"> • Long-term care • Private-duty nursing • Routine eye care (Adult) 	<ul style="list-style-type: none"> • 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.)		
<ul style="list-style-type: none"> • Acupuncture (20 visits per year) • Bariatric surgery 	<ul style="list-style-type: none"> • Chiropractic care (20 visits per year) • Coverage provided outside the United States. See www.bcbsnm.com 	<ul style="list-style-type: none"> • Hearing aids (only up to age 21; max 1 aids every 3 years) • 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 BeWellnm 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	\$175
■ Specialist copayment	\$55
■ Hospital (facility) copayment	\$500
■ Other coinsurance	50%

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	\$175
Copayments	\$700
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$70
The total Peg would pay is	\$945

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$175
■ Specialist copayment	\$55
■ Hospital (facility) copayment	\$500
■ Other coinsurance	50%

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	\$175
Copayments	\$800
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$400
The total Joe would pay is	\$1,675

Mia's Simple Fracture

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

■ The plan's overall deductible	\$175
■ Specialist copayment	\$55
■ Hospital (facility) copayment	\$500
■ Other coinsurance	50%

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	\$175
Copayments	\$700
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Mia would pay is	\$985

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 تساعدك 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 હક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કોલ કરો.
हिंदी Hindi	याँदे 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 anáníłwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóótí'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidgíí 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.