




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.nmmip.org or by calling 1-844-728-7896 or TTY: 1-844-728-7897.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	Per calendar year: for Network and Non-Network providers \$2,000 .	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 1 st). 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?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. Per calendar year: for Network and Non-Network providers \$1,300 .	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 ?	Deductible, prescription drug copays, premiums, balance billed charges, non-network co-insurance, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers ?	Yes. See www.cigna.com or call 1-844-728-7896 or TTY: 1-844-728-7897 for a list of Network providers .	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 can see the specialist you choose without permission from this plan.
Are there services this	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your

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plan doesn't cover?	policy or plan document for additional information about excluded services .
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- **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 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**.)
 - This plan may encourage you to use Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% co-insurance*	30% co-insurance*	--None--
	Specialist visit	20% co-insurance*	30% co-insurance*	--None--
	Other practitioner office visit	20% co-insurance*	30% co-insurance*	Acupuncture treatment and chiropractic care are each limited to 25 visits per year, unless for rehabilitative or habilitative purposes.
	Preventive care/screening/immunization	No Charge	30% co-insurance*	--None--
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance*	30% co-insurance*	--None--
	Imaging (CT/PET scans, MRIs)	20% co-insurance*	30% co-insurance*	--None--

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Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.medtrakrx.com.</p>	Generic	<u>Retail/Maintenance</u> \$10 / \$30	Not Covered	<p>Per calendar year: maximum prescription drug out-of-pocket amount is \$3,300.</p> <p><u>Retail Medications</u> - a 34-day. <u>Maintenance: Retail and Mail-Order Medications</u> – a 90-day supply. <u>Specialty Drugs</u> - not available through mail order.</p> <p>Experimental and Investigational drugs are not covered.</p>
	Brand (with no Generic equivalent)	<u>Retail/Maintenance</u> Greater of \$10 or 30% up to \$250 max co-pay / Greater of \$30 or 30% up to \$750 max co-pay	Not Covered	
	Brand (with Generic equivalent)	<u>Retail/Maintenance</u> \$10 plus generic /formulary price difference; \$30 plus generic /formulary price difference	Not Covered	
	Specialty Drugs	\$30% up to a \$250 maximum co-pay	Not Covered	
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	20% co-insurance*	30% co-insurance*	--None--
	Physician/surgeon fees	20% co-insurance*	30% co-insurance*	--None--
<p>If you need immediate medical attention</p>	Emergency room services	20% co-insurance*	20% co-insurance*	--None--
	Emergency medical transportation	20% co-insurance*	20% co-insurance*	--None--
	Urgent care	20% co-insurance*	30% co-insurance*	--None--
<p>If you have a hospital stay</p>	Facility fee (e.g., hospital room)	20% co-insurance*	30% co-insurance*	Admission approval required.
	Physician/surgeon fee	20% co-insurance*	30% co-insurance*	Admission approval required.

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Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance*	30% co-insurance*	Includes office, home, outpatient, and IOP services; admission approval required for Inpatient, Residential Treatment and Partial Hospitalization (IOP, Inpatient and Partial Hospitalization).
	Mental/Behavioral health inpatient services	20% co-insurance*	30% co-insurance*	
	Substance use disorder outpatient services	20% co-insurance*	30% co-insurance*	
	Substance use disorder inpatient services	20% co-insurance*	30% co-insurance*	
If you are pregnant	Prenatal and postnatal care	No Charge	30% co-insurance*	--None--
	Delivery and all inpatient services	20% co-insurance*	30% co-insurance*	Admission approval required only for normal delivery stays more than 48 hours or C-section 96 hours.
If you need help recovering or have other special health needs	Home health care	20% co-insurance*	30% co-insurance*	Coverage limited to 100 visits/ calendar year.
	Rehabilitation services	20% co-insurance*	30% co-insurance*	Includes physical, occupational and speech therapies in an office or outpatient setting.
	Habilitation services	20% co-insurance*	30% co-insurance*	
	Skilled nursing care	20% co-insurance*	30% co-insurance*	Coverage limited to 100 days/ calendar year.
	Durable medical equipment	20% co-insurance*	30% co-insurance*	--None--
	Hospice service	20% co-insurance*	30% co-insurance*	--None--
If your child needs dental or eye care	Eye exam	No Charge	No Charge	Must be under age of 19: limited to one eye exam every 12 months, eyeglasses every 12 months, replacement lenses and minor repairs to eyeglasses.
	Glasses	No Charge	No Charge	
	Dental check-up	No Charge	No Charge	Must be under age of 19: limited to twice per calendar year.

***Benefit subject to the Medical Deductible**

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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 | • Long-Term Care | • Routine Eye Care (Adult) |
| • Dental Care (Adults) | • Private Duty Nursing | • Routine Foot Care (Unless you are diabetic) |

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 Treatment (Max. 25 visits/year) | • Coverage provided outside the United States. | • Non-emergency care when traveling outside the U.S. |
| • Bariatric Surgery | • Hearing Aids (For members up to age 21) | • Weight Loss Programs (Health education and counseling) |
| • Chiropractic Care (Max. 25 visits/year) | • Infertility Treatment (Treat medical conditions causing infertility) | |

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1-844-728-7896. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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 can contact: NMMIP, PO Box 1090 Great Bend, Kansas 67530, (844) 728-7896. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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.

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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.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-844-728-7896 or TTY: 1-844-728-7897

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-728-7896 or TTY: 1-844-728-7897

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-728-7896 or TTY: 1-844-728-7897

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-728-7896 or TTY: 1-844-728-7897

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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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 this plan. The actual care you receive will be different from these examples, and the cost of that care will also 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 \$4,850
- Patient pays \$2,690

Sample care costs: Individual Type Coverage

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	\$2,000
Copays	\$50
Coinsurance	\$600
Limits or exclusions	\$40
Total	\$2,690

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

- Amount owed to providers: \$5,400
- Plan pays \$2,520
- Patient pays \$2,880

Sample care costs: Individual Type Coverage

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	\$2,000
Copays	\$400
Coinsurance	\$0
Limits or exclusions	\$80
Total	\$2,880

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Questions and answers about the 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.

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