


**\$500 Deductible Plan**

 **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 1-844-728-7896 or go to [www.nmmip.org](http://www.nmmip.org). 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](http://www.healthcare.gov/sbc-glossary) or call 1-844-728-7896 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                                                                                       | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|---------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | Per calendar year: <a href="#">Participating Providers</a> \$500/individual.                                                                                                                                                                                  | Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Network copayments</a> , <a href="#">network preventive care</a> , non-intensive mental health & substance abuse outpatient treatments, and <a href="#">prescription drugs</a> are covered before you meet your <a href="#">deductible</a> . | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                                                 |
| Are there other <a href="#">deductibles</a> for specific services?              | No. There are no other specific <a href="#">deductibles</a> .                                                                                                                                                                                                 | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | Per calendar year: <a href="#">Participating Providers</a> \$5,000/individual.                                                                                                                                                                                | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.                                                                                                                                  | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Will you pay less if you use a <a href="#">participating provider</a> ?         | Yes. Physician & Ancillary Provider Network: PHCS. Call (866) 930-7427 <a href="http://www.phcs.com">www.phcs.com</a> . For facilities: Zelis Provider Network. Call (844) 728-7896/ TTY (844) 728-7897 <a href="http://www.nmmip.org">www.nmmip.org</a>      | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use a <a href="#">non-participating provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">participating provider</a> might use a <a href="#">non-participating provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No. You don't need a referral to see a <a href="#">specialist</a> .                                                                                                                                                                                           | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |



All [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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                           |                                                        | Participating Provider<br>(You will pay the least)                                                                          | Non-Participating Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>If you visit a health care <a href="#">provider's</a> office or clinic</b>                                                                                                                             | Primary care visit to treat an injury or illness       | \$20 <a href="#">copay</a> /visit                                                                                           | Not Covered                                           | <p><a href="#">Copayment</a> covers the services performed in the office setting. All combined services rendered during the visit are covered under one <a href="#">copayment</a>.</p> <p>Acupuncture treatment and chiropractic care are subject to <a href="#">deductible</a> and 20% <a href="#">coinsurance</a>. Each are limited to 20 visits/calendar year.</p> <p>You may have to pay for services that aren't <a href="#">preventive</a>. Ask your <a href="#">provider</a> if the services you need are <a href="#">preventive</a>. Then check what your <a href="#">plan</a> will pay for.</p>                                                                                                                       |
|                                                                                                                                                                                                           | <a href="#">Specialist</a> visit                       | \$40 <a href="#">copay</a> /visit                                                                                           | Not Covered                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                                                                           | <a href="#">Preventive care/screening/immunization</a> | No Charge                                                                                                                   | Not Covered                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>If you have a test</b>                                                                                                                                                                                 | <a href="#">Diagnostic test</a> (x-ray, blood work)    | <a href="#">Laboratory</a> : \$20 <a href="#">copay</a> /visit<br><a href="#">X-ray</a> : \$20 <a href="#">copay</a> /visit | Not Covered                                           | Prior Approval required for CTs, PET scans, and MRIs (excludes bone density studies).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                                                                                                                                                                                                           | Imaging (CT/PET scans, MRIs)                           | 20% <a href="#">coinsurance</a>                                                                                             | Not Covered                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.medtrakrx.com">www.medtrakrx.com</a> | Generic drugs                                          | Acute: \$10 <a href="#">copay</a> /prescription<br>Maintenance: \$30 <a href="#">copay</a> /prescription                    | Not Covered                                           | <p><a href="#">Prescription drugs</a> apply to the medical total <a href="#">out-of-pocket limit</a>. After the medical <a href="#">out-of-pocket limit</a> is met, <a href="#">prescription drugs</a> are covered at no charge.</p> <p><a href="#">Acute Retail Medications</a>: up to a 34-day supply.<br/><a href="#">Maintenance (Retail and Mail-Order) Medications</a>: up to a 90-day supply.<br/><a href="#">Specialty Medications</a>: not available through mail order.</p> <p>Prior Approval required for any drug above \$1,500/dose, biologic drugs, or chemotherapeutic drugs.<br/>No prescription coverage if you use a non-network pharmacy.<br/>Experimental &amp; investigational drugs are not covered.</p> |
|                                                                                                                                                                                                           | Formulary drugs                                        | Acute: \$35 <a href="#">copay</a> /prescription<br>Maintenance: \$105 <a href="#">copay</a> /prescription                   |                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                                                                           | Non-Formulary drugs                                    | Acute: \$70 <a href="#">copay</a> /prescription<br>Maintenance: \$210 <a href="#">copay</a> /prescription                   |                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                                                                           | Specialty Drugs                                        | 30% <a href="#">coinsurance</a> , up to \$400/prescription                                                                  | Not Covered                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |



All [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                                                                                                                                                                                                                                                                                                              |
|---------------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | Participating Provider<br>(You will pay the least)                                                                                    | Non-Participating Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                     |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center)   | 20% <a href="#">coinsurance</a>                                                                                                       | Not Covered                                           | Prior Approval required.                                                                                                                                                                                                                                                                                                                                            |
|                                                                           | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a>                                                                                                       | Not Covered                                           | None                                                                                                                                                                                                                                                                                                                                                                |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$250 <a href="#">copay</a> /visit                                                                                                    |                                                       | <p><a href="#">Copayment</a> waived if confined under observation hours or admitted inpatient.</p> <p>Prior Approval required for 23-hour observation stays.</p> <p>Facility fees, professional fees, and ancillary fees charged for the services received in the emergency room during the emergency visit are considered under the <a href="#">copayment</a>.</p> |
|                                                                           | <a href="#">Emergency medical transportation</a> | 20% <a href="#">coinsurance</a>                                                                                                       | 20% <a href="#">coinsurance</a>                       | Transportation limited to the nearest hospital or skilled nursing facility that can provide the necessary medical treatment. Non-emergency transport requires prior approval.                                                                                                                                                                                       |
|                                                                           | <a href="#">Urgent care</a>                      | \$40 <a href="#">copay</a> /visit                                                                                                     | \$40 <a href="#">copay</a> /visit                     | <a href="#">Copayment</a> covers the services performed in the <a href="#">urgent care</a> setting. All combined services rendered during the <a href="#">urgent care</a> visit are covered under one <a href="#">copayment</a> .                                                                                                                                   |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | 20% <a href="#">coinsurance</a>                                                                                                       | Not Covered                                           | Prior Approval required.                                                                                                                                                                                                                                                                                                                                            |
|                                                                           | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a>                                                                                                       | Not Covered                                           | None                                                                                                                                                                                                                                                                                                                                                                |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | <u>Non-Intensive Outpatient (Office Visit): No Charge</u><br><br><u>Intensive Outpatient Program: 20% <a href="#">coinsurance</a></u> | Not Covered                                           | Prior Approval required for psychiatric or substance abuse treatment requiring intensive outpatient, residential, or partial outpatient programs.                                                                                                                                                                                                                   |
|                                                                           | Inpatient services                               | 20% <a href="#">coinsurance</a>                                                                                                       | Not Covered                                           | Prior Approval required.                                                                                                                                                                                                                                                                                                                                            |



All [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                                                                                                                                                                                                                                                |
|----------------------------------------------------------------|-------------------------------------------|----------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                           | Participating Provider<br>(You will pay the least) | Non-Participating Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                       |
| If you are pregnant                                            | Office visits                             | No Charge                                          | Not Covered                                           | <a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">deductible</a> and <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|                                                                | Childbirth/delivery professional services | 20% <a href="#">coinsurance</a>                    | Not Covered                                           |                                                                                                                                                                                                                                                                                                       |
|                                                                | Childbirth/delivery facility services     | 20% <a href="#">coinsurance</a>                    | Not Covered                                           |                                                                                                                                                                                                                                                                                                       |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | 20% <a href="#">coinsurance</a>                    | Not Covered                                           | Prior Approval required. Limited to 100 visits/calendar year.                                                                                                                                                                                                                                         |
|                                                                | <a href="#">Rehabilitation services</a>   | 20% <a href="#">coinsurance</a>                    | Not Covered                                           | Prior Approval required for physical, occupational and speech therapies.                                                                                                                                                                                                                              |
|                                                                | <a href="#">Habilitation services</a>     | 20% <a href="#">coinsurance</a>                    | Not Covered                                           |                                                                                                                                                                                                                                                                                                       |
|                                                                | <a href="#">Skilled nursing care</a>      | 20% <a href="#">coinsurance</a>                    | Not Covered                                           | Prior Approval required. Limited to 60 days/calendar year.                                                                                                                                                                                                                                            |
|                                                                | <a href="#">Durable medical equipment</a> | 20% <a href="#">coinsurance</a>                    | Not Covered                                           | Prior Approval required.                                                                                                                                                                                                                                                                              |
|                                                                | <a href="#">Hospice services</a>          | 20% <a href="#">coinsurance</a>                    | Not Covered                                           | Prior Approval required.                                                                                                                                                                                                                                                                              |



All **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                                           |
|-----------------------------------------------|----------------------------|----------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------------------------------------------------|
|                                               |                            | Participating Provider<br>(You will pay the least) | Non-Participating Provider<br>(You will pay the most) |                                                                                                  |
| <b>If your child needs dental or eye care</b> | Children’s eye exam        | No Charge - Birth up to 19 years                   |                                                       | Limited to one exam/calendar year.                                                               |
|                                               | Children’s glasses         | No Charge - Birth up to 19 years                   |                                                       | Limited to one pair of glasses every 12 months, replacement lenses and minor repairs to glasses. |
|                                               | Children’s dental check-up | No Charge – Birth up to 19 years                   |                                                       | Limited to one exam, cleaning & polishing/calendar year. Excludes dental x-rays.                 |

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

**Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)**

- |                                           |                                                                        |                                                          |
|-------------------------------------------|------------------------------------------------------------------------|----------------------------------------------------------|
| • Acupuncture (Max. 20 visits/year)       | • Hearing Aids (For members up to age 21)                              | • Non-emergency care when traveling outside the U.S.     |
| • Bariatric Surgery                       | • Infertility Treatment (Treat medical conditions causing infertility) | • Weight loss programs (Health education and counseling) |
| • Chiropractic Care (Max. 20 visits/year) |                                                                        |                                                          |

**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 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 (800) 290-1368.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 290-1368.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 (800) 290-1368.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' (800) 290-1368.

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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
- [Primary care copayment](#) \$20
- [Hospital \(facility\) coinsurance](#) 20%
- Other [coinsurance](#) 20%

**This EXAMPLE event includes services like:**

Primary care 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> |
|---------------------------|-----------------|

**In this example, Peg would pay:**

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$500          |
| Copayments                        | \$440          |
| Coinsurance                       | \$2,270        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$3,270</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 copayment](#) \$40
- [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> |
|---------------------------|----------------|

**In this example, Joe would pay:**

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$500          |
| Copayments                        | \$1,330        |
| Coinsurance                       | \$350          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Joe would pay is</b> | <b>\$2,240</b> |

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$40
- [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>\$2,010</b> |
|---------------------------|----------------|

**In this example, Mia would pay:**

| <i>Cost Sharing</i>               |              |
|-----------------------------------|--------------|
| Deductibles                       | \$500        |
| Copayments                        | \$140        |
| Coinsurance                       | \$210        |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$850</b> |