NM Medical Insurance Pool

Coverage for: Individual | Plan Type: EPO

$5,000 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. 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 1-844-728-7896 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Per calendar year: Participating Providers $5,000/individual.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Network copayments, network preventive care, non-intensive mental health & substance abuse outpatient treatments, and prescription drugs 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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No. There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Per calendar year: Participating Providers $7,350/individual.	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a participating provider?	Yes. Physician & Ancillary Provider Network: PHCS. Call (866) 930-7427 www.phcs.com. For facilities: Zelis Provider Network. Call (844) 728-7896/ TTY (844) 728-7897 www.nmmip.org	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-participating 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 participating provider might use a non-participating 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 don't need a referral to see a specialist.	You can see the specialist you choose without a referral.

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 (You will pay the least)	Non-Participating 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	$35 copay/visit	Not Covered	Copayment covers the services performed in the office setting. All combined services rendered during the visit are covered under one copayment. Acupuncture treatment and chiropractic care are subject to deductible and 20% coinsurance. Each are limited to 20 visits/calendar year.
	Specialist visit	$55 copay/visit	Not Covered	
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Laboratory: $40 copay/visit X-ray: $40 copay/visit	Not Covered	Prior Approval required for CTs, PET scans, and MRIs (excludes bone density studies).
	Imaging (CT/PET scans, MRIs)	40% coinsurance	Not Covered	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.medtrakrx.com	Generic drugs	Acute: $10 copay/prescription Maintenance: $30 copay/ prescription	Not Covered	Prescription drugs apply to the medical total out–of–pocket limit. After the medical out–of–pocket limit is met, prescription drugs are covered at no charge. Acute Retail Medications: up to a 34-day supply. Maintenance (Retail and Mail-Order) Medications: up to a 90-day supply. Specialty Medications: not available through mail order. Prior Approval required for any drug above $1,500/dose, biologic drugs, or chemotherapeutic drugs. No prescription coverage if you use a non-network pharmacy. Experimental & investigational drugs are not covered.
	Formulary drugs	Acute: $50 copay/prescription Maintenance: $150 copay/ prescription		
	Non-Formulary drugs	Acute: $100 copay/prescription Maintenance: $300 copay/ prescription		
	Specialty Drugs	30% coinsurance, up to $400/prescription	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	Not Covered	Prior Approval required.
	Physician/surgeon fees	40% coinsurance	Not Covered	None

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 (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$400 copay/visit		Copayment waived if confined under observation hours or admitted inpatient. Prior Approval required for 23-hour observation stays. Facility fees, professional fees, and ancillary fees charged for the services received in the emergency room during the emergency visit are considered under the copayment.
	Emergency medical transportation	40% coinsurance	40% coinsurance	Transportation limited to the nearest hospital or skilled nursing facility that can provide the necessary medical treatment. Non-emergency transport requires prior approval.
	Urgent care	$55 copay/visit	$55 copay/visit	Copayment covers the services performed in the urgent care setting. All combined services rendered during the urgent care visit are covered under one copayment.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	Not Covered	Prior Approval required.
	Physician/surgeon fees	40% coinsurance	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Non-Intensive Outpatient (Office Visit): No Charge Intensive Outpatient Program: 40% coinsurance	Not Covered	Prior Approval required for psychiatric or substance abuse treatment requiring intensive outpatient, residential, or partial outpatient programs.
	Inpatient services	40% coinsurance	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 (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you are pregnant	Office visits	No Charge	Not Covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, deductible and coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	40% coinsurance	Not Covered	
	Childbirth/delivery facility services	40% coinsurance	Not Covered	
If you need help recovering or have other special health needs	Home health care	40% coinsurance	Not Covered	Prior Approval required. Limited to 100 visits/calendar year.
	Rehabilitation services	40% coinsurance	Not Covered	Prior Approval required for physical, occupational and speech therapies.
	Habilitation services	40% coinsurance	Not Covered	
	Skilled nursing care	40% coinsurance	Not Covered	Prior Approval required. Limited to 60 days/calendar year.
	Durable medical equipment	40% coinsurance	Not Covered	Prior Approval required.
	Hospice services	40% coinsurance	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 (You will pay the least)	Non-Participating Provider (You will pay the most)	
If your child needs dental or eye care	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
- Dental Care (Adult)
- Long-Term Care
- Private-Duty Nursing
- Routine Eye Care (Adult)
- 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)
- Bariatric Surgery
- Chiropractic Care (Max. 20 visits/year)
- Hearing Aids (For members up to age 21)
- Infertility Treatment (Treat medical conditions causing infertility)
- Non-emergency care when traveling outside the U.S.
- Weight loss programs (Health education and counseling)

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.

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，□□打□个号□ (800) 290-1368.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 290-1368.

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	$5,000
Primary care copayment	$35
Hospital (facility) coinsurance	40%
Other coinsurance	40%

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)*

Total Example Cost	$12,840

In this example, Peg would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$720
Coinsurance	$1,630
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$7,410

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

The plan's overall deductible	$5,000
Specialist copayment	$55
Hospital (facility) coinsurance	40%
Other coinsurance	40%

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	$7,460

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,730
Copayments	$1,800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,730

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

The plan's overall deductible	$5,000
Specialist copayment	$55
Hospital (facility) coinsurance	40%
Other coinsurance	40%

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	$2,010

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,050
Copayments	$210
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,260

The plan would be responsible for the other costs of these EXAMPLE covered services.