


**\$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](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:
<b>What is the overall <a href="#">deductible</a>?</b>	Per calendar year: <a href="#">Participating Providers</a> \$5,000/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.
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	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> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No. There are no other specific <a href="#">deductibles</a> .	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	Per calendar year: <a href="#">Participating Providers</a> \$7,350/individual.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<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> .
<b>Will you pay less if you use a <a href="#">participating provider</a>?</b>	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.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	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 (You will pay the least)	Non-Participating Provider (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	\$35 <a href="#">copay</a> /visit	Not Covered	<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> .  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.  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.
	<a href="#">Specialist</a> visit	\$55 <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> : \$40 <a href="#">copay</a> /visit <a href="#">X-ray</a> : \$40 <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)	40% <a href="#">coinsurance</a>	Not Covered	
<b>If you need drugs to treat your illness or condition</b> 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 Maintenance: \$30 <a href="#">copay</a> /prescription	Not Covered	<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.  <a href="#">Acute Retail Medications</a> : up to a 34-day supply. <a href="#">Maintenance (Retail and Mail-Order) Medications</a> : up to a 90-day supply. <a href="#">Specialty Medications</a> : 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 <a href="#">copay</a> /prescription Maintenance: \$150 <a href="#">copay</a> /prescription		
	Non-Formulary drugs	Acute: \$100 <a href="#">copay</a> /prescription Maintenance: \$300 <a href="#">copay</a> /prescription		
	Specialty Drugs	30% <a href="#">coinsurance</a> , up to \$400/prescription		
<b>If you have</b>	Facility fee (e.g.,	40% <a href="#">coinsurance</a>	Not Covered	<a href="#">Prior Approval</a> 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)	
outpatient surgery	ambulatory surgery center)			
	Physician/surgeon fees	40% <a href="#">coinsurance</a>	Not Covered	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$400 <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>	40% <a href="#">coinsurance</a>	40% <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>	\$55 <a href="#">copay</a> /visit	\$55 <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)	40% <a href="#">coinsurance</a>	Not Covered	Prior Approval required.
	Physician/surgeon fees	40% <a href="#">coinsurance</a>	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	<p><u>Non-Intensive Outpatient (Office Visit):</u> No Charge</p> <p><u>Intensive Outpatient Program:</u> 40% <a href="#">coinsurance</a></p>	Not Covered	Prior Approval required for psychiatric or substance abuse treatment requiring intensive outpatient, residential, or partial outpatient programs.
	Inpatient services	40% <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 (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>If you are pregnant</b>	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	40% <a href="#">coinsurance</a>	Not Covered	
	Childbirth/delivery facility services	40% <a href="#">coinsurance</a>	Not Covered	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	40% <a href="#">coinsurance</a>	Not Covered	Prior Approval required. Limited to 100 visits/calendar year.
	<a href="#">Rehabilitation services</a>	40% <a href="#">coinsurance</a>	Not Covered	Prior Approval required for physical, occupational and speech therapies.
	<a href="#">Habilitation services</a>	40% <a href="#">coinsurance</a>	Not Covered	
	<a href="#">Skilled nursing care</a>	40% <a href="#">coinsurance</a>	Not Covered	Prior Approval required. Limited to 60 days/calendar year.
	<a href="#">Durable medical equipment</a>	40% <a href="#">coinsurance</a>	Not Covered	Prior Approval required.
	<a href="#">Hospice services</a>	40% <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 (You will pay the least)	Non-Participating Provider (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, kwijigo 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*)

<b>Total Example Cost</b>	<b>\$12,840</b>
---------------------------	-----------------

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

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

**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*)

<b>Total Example Cost</b>	<b>\$7,460</b>
---------------------------	----------------

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

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

**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*)

<b>Total Example Cost</b>	<b>\$2,010</b>
---------------------------	----------------

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

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