


**\$2,000 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> \$2,000/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>What is the Family <a href="#">deductible Savings Provision</a>?</b>	If three (3) or more qualified family members enroll in individual Pool Policies with the same <a href="#">deductible</a> amount, then reduced <a href="#">deductible</a> limits may apply.	The entire Family meets an annual <a href="#">deductible</a> when the total <a href="#">deductible</a> amount for all family members reaches two times the individual <a href="#">deductible</a> amount chosen. Note: If an Enrollee's individual <a href="#">deductible</a> is met, no more charges incurred by that Enrollee may be used to satisfy the Family Deductible.
<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> \$6,000/individual.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services.
<b>What is the Family <a href="#">out-of-pocket Savings Provision</a>?</b>	If three (3) or more qualified family members enroll for Pool Policies with the same <a href="#">out-of-pocket</a> amount, then reduced <a href="#">out-of-pocket</a> limits may apply.	The entire Family meets an annual <a href="#">out-of-pocket</a> limit when the total <a href="#">out-of-pocket</a> amount for all family members reaches two times the individual <a href="#">out-of-pocket</a> limit. Note: If an Enrollee's individual <a href="#">out-of-pocket</a> limit is met, no more charges incurred by that Enrollee may be used to satisfy the Family <a href="#">out-of-pocket</a> .
<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> .

<p><b>Will you pay less if you use a <a href="#">participating provider</a>?</b></p>	<p>Yes. : PHCS network.. 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></p>	<p>This <a href="#">plan</a> uses a <a href="#">provider network</a>. <u>Services received from an <a href="#">non-participating provider</a>, are not covered unless emergent or urgent. If you receive services from an <a href="#">out-of-network facility</a>, you may receive a bill from the <a href="#">facility</a> for the difference between the <a href="#">facility</a> charge and what your <a href="#">plan</a> pays (<a href="#">balance billing</a>).</u> 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.</p> <p>*This plan provides certain protections under the New Mexico Surprise Billing Act in the event you receive services from an Out-of-Network provider. Please refer to the NMMIP Policy Booklet: Provider Choices, for more information.</p>
<p><b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b></p>	<p>No. You don't need a referral to see a <a href="#">specialist</a>.</p>	<p>You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a>.</p>



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	\$30 <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 30% <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	\$50 <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> : \$30 <a href="#">copay</a> /visit <a href="#">X-ray</a> : \$30 <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)	30% <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.elixirsolutions.com">www.elixirsolutions.com</a>	Generic drugs	Acute: \$10 <a href="#">copay</a> /prescription 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. <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.</p> <p>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.</p>
	Formulary drugs	Acute: \$35 <a href="#">copay</a> /prescription Maintenance: \$105 <a href="#">copay</a> /prescription		

	Non-Formulary drugs	Acute: \$70 <a href="#">copay</a> /prescription Maintenance: \$210 <a href="#">copay</a> / prescription		<p>Experimental &amp; investigational drugs are not covered.</p> <p>Note: New Mexico HB292 allows a cap on copays and out-of-pocket expenses for insulin or medically necessary alternative at \$25 per prescription for a 30-day supply.</p>
	Specialty Drugs	30% <a href="#">coinsurance</a> , up to \$400/prescription	Not Covered	

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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 have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	30% <a href="#">coinsurance</a>	Not Covered	Prior Approval required.
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	Not Covered	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$350 <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> <p>*This plan provides certain protections under the New Mexico Surprise Billing Act in the event you receive services from an Out-of-Network provider. Please refer to the NMMIP Policy Booklet: Provider Choices, for more information.</p> <p><i>Note: There is no charge for testing and treatment for COVID-19.</i></p>
	<a href="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a>	30% <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>	\$50 <a href="#">copay</a> /visit	\$50 <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> .
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	30% <a href="#">coinsurance</a>	Not Covered	Prior Approval required.
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	Not Covered	None

<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	<u>Non-Intensive Outpatient (Office Visit):</u> No Charge  <u>Intensive Outpatient Program:</u> No Charge	Not Covered	Prior Approval required for psychiatric or substance abuse treatment requiring intensive outpatient, residential, or partial outpatient programs.
	Inpatient services	No Charge	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	<p><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).</p> <p><i>Note: Gynecological and obstetrical ultrasounds do not require prior authorization.</i></p>
	Childbirth/delivery professional services	30% <a href="#">coinsurance</a>	Not Covered	
	Childbirth/delivery facility services	30% <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>	No Charge	Not Covered	Prior Approval required. Limited to 100 visits/calendar year.
	<a href="#">Rehabilitation services</a>	\$30 copay/visit	Not Covered	Prior Approval required for physical, occupational and speech therapies.
	<a href="#">Habilitation services</a>	\$30 copay/visit	Not Covered	
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a>	Not Covered	Prior Approval required. Limited to 100 days/calendar year.
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a>	Not Covered	Prior Approval required.
	<a href="#">Hospice services</a>	30% <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)	
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](#).)**

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|---|--|---|
| <ul style="list-style-type: none"> <li>• Cosmetic Surgery</li> <li>• Dental Care (Adult)</li> </ul> | <ul style="list-style-type: none"> <li>• Long-Term Care</li> <li>• Private-Duty Nursing</li> </ul> | <ul style="list-style-type: none"> <li>• Routine Eye Care (Adult)</li> <li>• Routine Foot Care (Unless you are diabetic)</li> </ul> |
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**Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your [plan](#) document.)**

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|---|---|--|
| <ul style="list-style-type: none"> <li>• Acupuncture (Max. 20 visits/year)</li> <li>• Bariatric Surgery</li> <li>• Chiropractic Care (Max. 20 visits/year)</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing Aids (For members up to age 21)</li> <li>• Infertility Treatment (Treat medical conditions causing infertility)</li> </ul> | <ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Weight loss programs (Health education and counseling)</li> </ul> |
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**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.*

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## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000
■ <a href="#">Primary care copayment</a>	\$30
■ <a href="#">Hospital (facility) coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

#### 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>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments – Prenatal Office Visits	\$0
Coinsurance	\$3,240
What isn't covered	
Limits or exclusions	\$40
<b>The total Peg would pay is</b>	<b>\$5,280</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000
■ <a href="#">Specialist copayment</a>	\$50
■ <a href="#">Hospital (facility) coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

#### 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>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$1,500
Coinsurance	\$1,620
What isn't covered	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$5,180</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000
■ <a href="#">Specialist copayment</a>	\$50
■ <a href="#">Hospital (facility) coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

#### 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>\$2,000</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$150
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,150</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services