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 866-306-1882 or visit 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.dol.gov/ebsa/healthreform or call 866-306-1882 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**Per Calendar Year:** **$500**/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.** Preventive care, Pre-admission testing, Home Health, and Hospice, is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But 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**: **$3,300**/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 that 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 network provider?	**No.**	This Plan does not have a network. Benefits under this Plan will pay as secondary to Medicare based on the allowable amount indicated on the Medicare Explanation of Benefits. Additionally, certain claims may be covered based on the Pool's determination of Medical Necessity. This plan uses a provider network. If you receive services from an out-of-network facility, you may receive a bill from the facility for the difference between the facility 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.

a  All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance after deductible	**Office Surgery and related services/Allergy Injections and Serum/Therapeutic Injections/ Allergy Testing/X-ray/Lab/Diagnostic Testing/All other office related services:** **Participating Provider**: 20% coinsurance after deductible
	Specialist visit	20% coinsurance after deductible	**Acupuncture:** **Participating Provider**: 20% coinsurance after deductible **12 visits in 90 days; an additional 8 visits may be allowed if improvement.** **(Limited to 20 visits per calendar year)**
	Preventive care/screening/ immunization	No Charge	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	None

Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.elixirsolutions.com	Generic drugs	The policy will coordinate, as a secondary payer, prescription drug benefits with your Medicare Part D insurance carrier.	The policy pays secondary to Medicare. You must be enrolled in Medicare Part A, Part B and Part D to receive outpatient prescription drug benefits from this policy. Prescriptions must be filled at a participating pharmacy in accordance with the member's Medicare Part D plan.
	Preferred brand drugs		
	Non-preferred brand drugs		
	Specialty drugs		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	None
	Physician/surgeon fees	20% coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	20% coinsurance after deductible	None
	Emergency medical transportation	20% coinsurance after deductible	Transportation limited to the nearest hospital or skilled nursing facility that can provide the necessary medical treatment.
	Urgent care	20% coinsurance after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	Authorization must be obtained for services not covered by Medicare.
	Physician/surgeon Fees	20% coinsurance after deductible	None

Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	None
	Inpatient services	No Charge	Authorization must be obtained for services not covered by Medicare.
If you are pregnant	Office visits	20% coinsurance after deductible	Cost sharing does not apply for certain Network prenatal/preventive services required by PPACA. Depending on the type of services, deductible/coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% coinsurance after deductible	
	Childbirth/delivery facility services	20% coinsurance after deductible	Authorization must be obtained for services not covered by Medicare

Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	No Charge	Authorization must be obtained. Limited to 100 visits per calendar year.
	Rehabilitation services	20% coinsurance after deductible	**PT/OT/ST:** 20% coinsurance after deductible
	Habilitation services	20% coinsurance after deductible	**ABA Therapy and Cognitive Rehab:** No Charge
If you need help recovering or have other special health needs "cont.d"	Skilled nursing care	20% coinsurance after deductible	Authorization must be obtained for services not covered by Medicare. Limited to 100 days per calendar year.
	Durable medical equipment	20% coinsurance after deductible	None
	Hospice services	No Charge	Authorization must be obtained for inpatient stays.
If your child needs dental or eye care	Children's eye exam	No Charge	Birth up to 19 years of age. Limited to one eye exam every 12 months.
	Children's glasses	No Charge	Limited to one pair of eyeglasses every 12 months. replacement lenses and minor repairs to glasses
	Children's dental check-up	No Charge	Birth up to 19 years of age. Limited to one exam, cleaning & polishing every calendar year

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 (Limited to 20 visits per calendar year) • Bariatric Surgery • Chiropractic Care ~~(Limited to 20 visits per calendar year)~~	• Hearing aids • 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 the 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 866-306-1882.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 866-306-1882.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 866-306-1882.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 866-306-1882.

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**
- **Specialist copay** **$0**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Specialist 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	$500
Copayments	$0
Coinsurance	$2,460
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,000**

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 copay** **$0**
- **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)*

Total Example Cost	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$1,380
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,940**

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

- **The plan's overall deductible** **$500**
- **Specialist copay** **$0**
- **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)*

Total Example Cost	**$2,000**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$890**

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