New Mexico Medical Insurance Pool "When no one else will help, we're there"

NM Medical Insurance Pool

Coverage for: Individual | **Plan Type: Medicare Carveout**

Medicare Carve-out ($500 Deductible)

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 1-800-290-1368 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 1-800-290-1368 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, 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 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: $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?	Deductible, prescription drugs, 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 network provider?	No.	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-network 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 network provider might use a non-network 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	Providers	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	Acupuncture treatment and chiropractic care are limited to 20 visits each/calendar year.
	Specialist visit	20% coinsurance	
	Preventive care/screening/ immunization	No Charge	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)	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.medtrakrx.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 MedTrak Pharmacy Services pharmacy with your NMMIP ID card.
	Formulary drugs		
	Non-Formulary drugs		
	Specialty Drugs		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	None
	Physician/surgeon fees	20% coinsurance	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	Providers	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency room care	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	Transportation limited to the nearest hospital or skilled nursing facility that can provide the necessary medical treatment.
	Urgent care	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Prior Approval required.
	Physician/surgeon fees	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	None
	Inpatient services	20% coinsurance	Prior Approval required.
If you are pregnant	Office visits	No Charge	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	20% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Limited to 100 visits/calendar year.
	Rehabilitation services	20% coinsurance	Includes physical, occupational and speech therapies in an office or outpatient setting.
	Habilitation services	20% coinsurance	Limited to 100 days/calendar year.
	Skilled nursing care	20% coinsurance	Limited to 60 days/calendar year. Prior Approval required.
	Durable medical equipment	20% coinsurance	None.
	Hospice services	20% coinsurance	Inpatient stays: Prior Approval required.
If your child needs dental or eye care	Children's eye exam	No Charge – birth to 19 years	Limited to one exam/calendar year.
	Children's glasses	No Charge – birth to 19 years	Limited to one pair of glasses every 12 months, replacement lenses and minor repairs to glasses.

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	Providers	Limitations, Exceptions, & Other Important Information
	Children's dental check-up	No Charge – birth 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，请拨打这个号码 (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	$500
Primary care copayment	$0
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)*

Total Example Cost	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$40
Coinsurance	$2,520
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,120**

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	$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	$770
Coinsurance	$590
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,920**

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

The plan's overall deductible	$500
Specialist copayment	$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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$390
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.