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?	**$2,000** Individual / **$4,000** Family	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, network pediatric dental and vision care up to the age of 19, network mental health/substance abuse/chemical dependency services, network home health, network hospice, 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?	**$6,000** Individual / **$12,000** Family	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, penalties for failure to obtain pre-certification 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?	**Yes.** Call PHCS at 1-866-306-1882 to locate an In-Network Provider.	This plan uses a provider network. Services received from a non-participating provider, are not covered unless emergent or urgent. 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.

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	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	$30 copay per provider per day	Not Covered	**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**: PCP $30/Specialist $50 copay **(Services performed in the office setting are considered under the office copay. There is one copay for all services combined during the same visit).** **Chiropractic & Acupuncture:** **Participating Provider**: 30% coinsurance after deductible **(Limited to 20 visits per calendar year)**
	Specialist visit	$50 copay per provider per day	Not Covered	
	Preventive care/screening/ immunization	No Charge	Not Covered	Benefits are available for evidence based items or services that have in effect a rating "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF). (http://www.uspreventiveservicestaskforce.org. 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)	Outpatient Lab/X-ray: $30 copay per provider per day Outpatient Diagnostic Testing: 30% coinsurance after deductible	Not Covered	**Independent Lab:** $30 copay per provider per day **(Includes biomarker testing for diagnostic, treatment, management and monitoring).**
	Imaging (CT/PET scans, MRIs)	30% coinsurance after deductible	Not Covered	Authorization must be obtained. (excludes bone density studies)

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.elixirsolutions.com .	Generic drugs	Retail: $10 copay Mail Order: $30 copay		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. **Outpatient Prescription Drugs Retail and Specialty Pharmacies:** (Up to a 34-day supply or 30-day supply for Specialty Drugs). **Outpatient Prescription Drugs Performance 90 Pharmacies and Mail Order:** (Up to a 90-day supply).
	Preferred brand drugs	Retail: $35 copay Mail Order: $105 copay		
	Non-preferred brand drugs	Retail: $70 copay Mail Order: $210 copay		
	Specialty drugs	Retail:30% up to $400/script Mail Order: N/A		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance after deductible	Not Covered	Authorization must be obtained.
	Physician/surgeon fees	30% coinsurance after deductible	Not Covered	None
If you need immediate medical attention	Emergency room care	$50 copay		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. *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. *Note: There is no charge for testing and treatment for COVID-19.*
	Emergency medical transportation	30% coinsurance after deductible	30% coinsurance after deductible	Transportation limited to the nearest hospital or skilled nursing facility that can provide the necessary medical treatment. Authorization must be obtained for non-emergency transport.
	Urgent care	$50 copay per provider per day	$50 copay per provider per day	Copayment covers the services performed in the urgent care setting. All combined services rendered during the urgent care visit are covered under one copayment.

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 have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance after deductible	Not Covered	Authorization must be obtained.
	Physician/surgeon Fees	30% coinsurance after deductible	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: No Charge	Not Covered	Authorization must be obtained for psychiatric or substance abuse treatment requiring intensive outpatient, residential, or partial outpatient programs.
	Inpatient services	No Charge	Not Covered	Authorization must be obtained.
If you are pregnant	Office visits	No Charge	Not Covered	Cost sharing does not apply for certain Network prenatal/preventive services required by PPACA. Depending on the type of services, a copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	30% coinsurance after deductible	Not Covered	
	Childbirth/delivery facility services	30% coinsurance after deductible	Not Covered	Authorization must be obtained for inpatient stays longer than 48 hours for vaginal delivery or 96 hours for cesarean delivery.

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 help recovering or have other special health needs	Home health care	No Charge	Not Covered	Authorization must be obtained. Limited to 100 visits per calendar year. (Additional visits may be approved based on medical necessity).
If you need help recovering or have other special health needs "cont.d"	Rehabilitation services	$30 copay per provider per day	Not Covered	**PT/OT/ST:** $30 copay per provider per day **Massage Therapy will be allowed by a PT/OT or covered medical doctor with appropriate diagnosis.** Authorization must be obtained after 13 visits.
	Habilitation services	$30 copay per provider per day	Not Covered	**ABA Therapy and Cognitive Rehab:** No Charge
	Skilled nursing care	30% coinsurance after deductible	Not Covered	Authorization must be obtained. Limited to 100 days per calendar year.
	Durable medical equipment	30% coinsurance after deductible	Not Covered	Authorization must be obtained. Batteries are limited for wheelchair only.
	Hospice services	No Charge	Not Covered	Authorization must be obtained.
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Birth up to 19 years of age Limited to one eye exam every 12 months.
	Children's glasses	No Charge	Not Covered	Limited to one pair of eyeglasses every 12 months. replacement lenses and minor repairs to glasses
	Children's dental check-up	No Charge	Not Covered	Birth up to 19 years of age. Limited to one exam, cleaning & polishing every 12 months

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 agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is available by calling the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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: 866-306-1882. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

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** **$2,000**
- **Specialist copay** **$50**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

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	$2,000
Copayments	$0
Coinsurance	$3,240
What isn't covered	
Limits or exclusions	$40
The total Peg would pay is	**$5,280**

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

- **The plan's overall deductible** **$2,000**
- **Specialist copay** **$50**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **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*)

Total Example Cost	**$7,460**

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
The total Joe would pay is	**$5,180**

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

- **The plan's overall deductible** **$2,000**
- **Specialist copay** **$50**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **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*)

Total Example Cost	**$2,000**

In this example, Mia would pay:

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

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