new mexico health connections : **Choice Connect Gold PPO** **Coverage Period: 1/1/2017– 12/31/2017**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual, Individual + Spouse, Family| **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.mynmhc.org or by calling (855) 7MY-NMHC.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For In-Network Providers $500 individual/$1,000 family. For Out-of-Network Providers $1,000 individual/$2,000 family. Doesn't apply to preventive care or services where a copay is listed.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No. There are no other specific deductibles.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For In-Network Providers $7,150 individual/$14,300 family For Out-of-Network Providers $14,300 person/$28,600 family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed 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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.mynmhc.org or call (855) 7MY-NMHC** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	50% after deductible	——————none——————
	Specialist visit	$40 copay/visit	50% after deductible	
	Other practitioner office visit	$40 copay/visit for chiropractic and acupuncture	50% after deductible for chiropractic and acupuncture	Coverage is limited to 20 visit/calendar year for each type of provider unless for rehabilitative or habilitative purposes.
	Preventive care/screening/immunization	No Charge	50% after deductible	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	50% after deductible	——————none——————
	Imaging (CT/PET scans, MRIs)	$350 copay/test	50% after deductible	Failure to obtain Prior Approval may result in a denial of coverage.
If you need drugs to treat your illness or condition More information about **prescription**	Generic drugs	$10 retail; $30 mail order/prescription	50% after deductible	Covers up to a 30-day retail supply. Mail-order 90- day supply, in-network only.
	Preferred brand drugs	$30 retail; $90 mail order/prescription	50% after deductible	
	Non-preferred brand drugs	$60 retail; $180 mail order/prescription	50% after deductible	

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
drug coverage is available at www.mynmhc.org.	Specialty drugs	30% up to a maximum of $250/perscription	50% after deductible	Covers up to a 30-day supply, retail. Failure to obtain Prior Approval may result in a denial of coverage.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% after deductible	50% after deductible	Failure to obtain Prior Approval may result in a denial of coverage.
	Physician/surgeon fees	30% after deductible.	50% after deductible	
If you need immediate medical attention	Emergency room services	$350 copay/visit	$350 copay/visit	Copay waived if admitted to hospital.
	Emergency medical transportation	$100 copay/trip	$100 copay/trip	————————none————————
	Urgent care	$50 copay/visit	$50 copay/visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% after deductible	50% after deductible	Failure to obtain Prior Approval may result in a denial of coverage.
	Physician/surgeon fee	30% after deductible	50% after deductible	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No Charge	50% after deductible	Failure to obtain Prior Approval may result in a denial of coverage.
	Mental/Behavioral health inpatient services	30% after deductible	50% after deductible	
	Substance use disorder outpatient services	No Charge	50% after deductible	
	Substance use disorder inpatient services	30% after deductible	50% after deductible	
If you are pregnant	Prenatal and postnatal care	$40 copay/visit	50% after deductible	Up to a maximum of $300 copay/pregnancy.
	Delivery and all inpatient services	30% after deductible	50% after deductible	Home birth not covered.
If you need help recovering or have other special health needs	Home health care	No charge after deductible	50% after deductible	Coverage is limited to 100 visits per plan year.
	Rehabilitation services	$20 copay/visit	50% after deductible	Failure to obtain Prior Approval may result in a denial of coverage.
	Habilitation services	$20 copay/visit	50% after deductible	Failure to obtain Prior Approval may result in a denial of coverage.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Skilled nursing care	30% after deductible	50% after deductible	Coverage is limited to 60 days/visits per plan year.
	Durable medical equipment	30% after deductible	50% after deductible	Failure to obtain Prior Approval may result in a denial of coverage.
	Hospice service	No Charge	50% after deductible	
If your child needs dental or eye care	Eye exam	No Charge	50% of billed charges	Coverage is limited to one exam per calendar year.
	Glasses	No Charge	50% of billed charges	Coverage is limited to one pair of lenses and frames per calendar year.
	Dental check-up	Not Covered	Not Covered	Pediatric dental coverage can be purchased separately as a stand-alone policy.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Home Birth
- Private-duty nursing
- Dental Care (Adult and Child)
- Long Term Care

  Routine Eye Care (Adult)
- Hearing aids (Adult)
- Non-emergency care when traveling outside the U.S
- Weight Loss Programs (Unless for Medically necessary treatment for morbid obesity)

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (Max of 20 visits/year)
- Bariatric surgery
- Chiropractic care (Max of 20 visits/year)
- Infertility Treatment
- Routine Foot Care (diabetics only)
- Termination of pregnancy

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-7MY-NMHC. You may also contact your state insurance department, 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.

Your Complaint and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **complaint**, sometimes called a **grievance**. For questions about your rights, this notice, or assistance, you can contact New Mexico Health Connections at (855) 7MY-NMHC. In addition to speaking to one of our Customer Care Representatives by phone, you can also express your Concerns by walk-in interview or arranged appointment at the address below.

New Mexico Health Connections
2440 Louisiana Blvd. NE, Suite 601
Albuquerque, NM 87110

You may also submit your Concerns in writing to the above noted address. You may also contact the OSI by mail to the Office of the Superintendent of Insurance, P.O. Box 1689, Santa Fe, New Mexico 87504-1689; or Email to mhcb.grievance@state.nm.us. You may fax to the OSI, ATTN: Superintendent at (505) 827-4734; or Complete an on-line Complaint Form available at http://www.osi.state.nm.us.

Does This Coverage Provide Minimal Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does This Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits to a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

English If you, or someone you're helping, has questions about Be Well NM, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-855-769-6642.

Spanish Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Be Well NM, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-855-769-6642.

Navajo Dii kwe'é atah nílínígíí Be Well NM haada yit' éego bína'ídíłkidgo éí doodago háida bíká anilyeedígíí t'áadoo le'é yína'ídíłkidgo beehaz'áanii hóló díí t'áá hazaadk'ehjí háká a'doowołgo bee haz' a doo baah ílínígóó. Ata' halne'ígíí koji' bich'i' hodíílnih 1-855-769-6642

Vietnamese Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Be Well NM, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-855-769-6642.

German Falls Sie oder jemand, dem Sie helfen, Fragen zum Be Well NM haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-855-769-6642 an.

Chinese 如果您，或是您正在協助的對象，有關於[插入項目的名稱 Be Well NM方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話在此插入數字 1-855-769-6642。

Arabic شما حق دریافت کمک و اطلاعات به زبان خود را بدون هیچ هزینه داشته باشد. برای صحبت با یک مترجم، 6642-769-855-1 تماس بگیرید Be Well NM، اگر شما یا کسی شما کمک است، سوال در مورد

Korean 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Be Well NM 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-855-769-6642 로 전화하십시오.

Tagalog Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Be Well NM, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-855-769-6642.

Japanese ご本人様、またはお客様の身の回りの方でも、Be Well NM についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-855-769-6642 までお電話ください。

French Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Be Well NM, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-855-769-6642.

Italian Se tu o qualcuno che stai aiutando avete domande su Be Well NM, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-855-769-6642.

Russian Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Be Well NM, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-855-769-6642.

Hindi यदि आपके ,या आप द्वारा सहायता ककए जा रहे ककसी व्यक्तत के Be Well NM के बारे में प्रश्न हैं ,तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। ककसी िुभाषषए से बात करने के लिए , 1-855-769-6642 पर कॉि करें।

Persian-Farsi

اگر شما یا کسی شما کمک است، سوال در مورد Be Well NM، تماس بگیرید 6642-769-855-1. برای صحبت با یک مترجم، بدون هیچ هزینه داشته باشد. شما حق دریافت کمک و اطلاعات به زبان خود را.

Thai หากคุณ หรือคนที่คุณกาลังช่วยเหลือมีคาถามเกี่ยวกับ Be Well NM คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 1-855-769-6642

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,310
- **Patient pays** $2,230

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$510
Copays	$230
Coinsurance	$1,340
Limits or exclusions	$150
Total	**$2,230**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

Amount owed to providers: $5,400

- **Plan pays** $3,820
- **Patient pays** $1,580

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$510
Copays	$680
Coinsurance	$310
Limits or exclusions	$80
Total	**$1,580**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.