new mexico health connections : **Care Connect $750 HMO** **Coverage Period: 1/1/2016 – 12/31/2016**

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

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?	$750 individual/$1,500 family Doesn't apply to preventive care or services where a copay is listed.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. If a service lists a copay amount ($ per visit, per test, per prescription, per surgery, per trip, per admit) the deductible does not apply to that service.
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 participating providers $6,000 individual/$12,000 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	$25 copay/visit	Not Covered	——————none——————
	Specialist visit	$50 copay/visit	Not Covered	——————none——————
	Other practitioner office visit	$60 copay/visit for chiropractic and acupuncture	Not Covered	Coverage is limited to a $1,500 annual maximum each.
	Preventive care/screening/immunization	No charge	Not Covered	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not Covered	——————none——————
	Imaging (CT/PET scans, MRIs)	$250 copay/test	Not Covered	Failure to obtain Prior Approval may result in a denial of coverage.
If you need drugs to treat your illness or condition	Generic drugs	$15 retail; $45 mail order/prescription	Not Covered	Covers up to a 30-day retail supply; 90-day mail order supply
	Preferred brand drugs	$45 retail; $135 mail order/prescription	Not Covered	Covers up to a 30-day retail supply; 90-day mail order supply

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
More information about **prescription drug coverage** is available at www.mynmhc.org.	Non-preferred brand drugs	$75 retail; $225 mail order/prescription	Not Covered	Covers up to a 30-day retail supply; 90-day mail order supply
	Specialty drugs	$150 /prescription, retail or mail order	Not Covered	Covers up to a 30-day supply, retail or mail order. Failure to obtain Prior Approval may result in a denial of coverage.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% after deductible	Not Covered	Failure to obtain Prior Approval may result in a denial of coverage.
	Physician/surgeon fees	No additional charge. Covered under Facility Fee copay.	Not Covered	Failure to obtain Prior Approval may result in a denial of coverage.
If you need immediate medical attention	Emergency room services	$250 copay/visit	$250 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	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,000 copay/admit	Not Covered	Failure to obtain Prior Approval may result in a denial of coverage.
	Physician/surgeon fee	No additional charge. Covered under Facility Fee copay.	Not Covered	Failure to obtain Prior Approval may result in a denial of coverage.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge for the first 3 visits, then $25 copay/visit	Not Covered	Failure to obtain Prior Approval may result in a denial of coverage.
	Mental/Behavioral health inpatient services	$1,000 copay/admit	Not Covered	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
	Substance use disorder outpatient services	No charge for the first 3 visits, then $25 copay/visit	Not Covered	Failure to obtain Prior Approval may result in a denial of coverage.
	Substance use disorder inpatient services	$1,000 copay/admit	Not Covered	Failure to obtain Prior Approval may result in a denial of coverage.
If you are pregnant	Prenatal and postnatal care	$25 copay, first visit only	Not Covered	——————none——————
	Delivery and all inpatient services	$1,000 copay/admit	Not Covered	——————none——————
If you need help recovering or have other special health needs	Home health care	No Charge after deductible	Not Covered	Coverage is limited to 100 visits per calendar year.
	Rehabilitation services	$60 copay/visit	Not Covered	Failure to obtain Prior Approval may result in a denial of coverage.
	Habilitation services	$60 copay/visit	Not Covered	Failure to obtain Prior Approval may result in a denial of coverage.
	Skilled nursing care	$1,000 copay/admit	Not Covered	Coverage is limited to 60 days/visits per calendar year.
	Durable medical equipment	20% after deductible	Not Covered	Failure to obtain Prior Approval may result in a denial of coverage.
	Hospice service	No Charge	Not Covered	Coverage is limited to $10,000 per member, per lifetime.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Coverage is limited to one exam per calendar year.
	Glasses	Not Covered	Not Covered	Coverage is limited to one pair of lenses and frames per calendar year.
	Dental check-up	Not Covered	Not Covered	——————none——————

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
- Dental Care (Adult or Child)
- Hearing aids (Adult)
- Long Term Care
- Non-emergency care when traveling outside the U.S
- Private-duty nursing
- Routine Eye Care (Adult)

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
- Bariatric surgery
- Chiropractic care
- Infertility Treatment
- Routine Foot Care (diabetics only)
- Weight Loss Programs

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:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-769-6642.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 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** $5,410
- **Patient pays** $2,130

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	$750
Copays	$1,230
Coinsurance	$0
Limits or exclusions	$150
Total	**$2,130**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,560
- **Patient pays** $1,840

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	$750
Copays	$800
Coinsurance	$210
Limits or exclusions	$80
Total	**$1,840**

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.