



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 1-877-994-2583 or at www.bcbsnm.com. 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 1-877-994-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Blue Preferred: \$500 Individual/\$1,000 Two-Person/\$1,500 Family Preferred provider : \$700 Individual/\$1,400 Two-Person/\$2,100 Family Non-preferred provider : \$3,000 Individual/\$6,000 Two-Person/\$9,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible?	Yes. Some services that charge a copay , and certain preventive care 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 www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Blue Preferred: \$4,000 Individual/\$8,000 Two-Person/\$12,000 Family Preferred provider : \$5,600 Individual/\$11,200 Two-Person/\$16,800 Family Non-preferred provider : \$9,000 Individual/\$18,000 Two-Person/\$27,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums , penalty amounts, 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?	Yes. See www.bcbsnm.com/SONM or call 1-877-994-2583 for a list of preferred providers .	You pay the least if you use a provider in Blue Preferred. You pay more if you use a provider in-network . You will pay the most if you use an out-of-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 an out-of-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 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
		Blue Preferred (You will pay the Least)	Preferred Provider (You will pay more)	Non-preferred 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	\$40 copay /visit; deductible does not apply	\$50 copay /visit; deductible does not apply	50% coinsurance	None
	Specialist visit	\$60 copay /visit; deductible does not apply	\$70 copay /visit; deductible does not apply	50% coinsurance	None
	Preventive care/screening/immunization	No Charge; deductible does not apply	No Charge; deductible does not apply	50% coinsurance	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)	30% coinsurance	40% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	25% coinsurance up to max \$300/test	35% coinsurance up to max \$300/test	50% coinsurance	Preauthorization may be required; see your benefit booklet* for details. Gynecological or obstetrical ultrasounds do not require preauthorization .
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com or 1-877-744-5313	Generic drugs	Not Applicable	Not Applicable	Not Applicable	See your CVS Prescription drug plan information for details.
	Preferred brand drugs	Not Applicable	Not Applicable	Not Applicable	
	Non-preferred brand drugs	Not Applicable	Not Applicable	Not Applicable	
	Specialty drugs	Not Applicable	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	35% coinsurance	50% coinsurance	None
	Physician/surgeon fees	20% coinsurance	30% coinsurance	50% coinsurance	None

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.bcbsnm.com/SONM.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Blue Preferred (You will pay the Least)	Preferred Provider (You will pay more)	Non-preferred Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	\$325 copay /visit	\$325 copay /visit	\$325 copay /visit	Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	Non-emergency air transfer is 20%/30%/50% coinsurance . Non-emergency air ambulance requires a prior-authorization.
	Urgent care	\$65 copay /visit	\$75 copay /visit	\$75 copay /visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$1,250 copay /admission	\$1,750 copay /admission	50% coinsurance	Requires preauthorization .
	Physician/surgeon fees	No Charge after deductible	No Charge after deductible	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge; deductible does not apply	No Charge; deductible does not apply	50% coinsurance	Preauthorization may be required; see your benefit booklet* for detail.
	Inpatient services	No Charge; deductible does not apply	No Charge; deductible does not apply	50% coinsurance	
If you are pregnant	Office visits	\$40 PCP/\$60 SPC copay /visit; deductible does not apply	\$50 PCP/\$70 SPC copay /visit; deductible does not apply	50% coinsurance	Copay charged for initial visit only. Cost sharing does not apply for preventive services . Depending on the type of services, a copayment , coinsurance , or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No Charge after deductible	No Charge after deductible	50% coinsurance	
	Childbirth/delivery facility services	\$1,000 copay /admission	\$1,400 copay /admission	50% coinsurance	

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.bcbsnm.com/SONM.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Blue Preferred (You will pay the Least)	Preferred Provider (You will pay more)	Non-preferred Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	\$55 copay /visit; deductible does not apply	\$65 copay /visit; deductible does not apply	50% coinsurance	Limited to 100 visits per year.
	Rehabilitation services	\$40 copay /therapist visit; deductible does not apply	\$50 copay /therapist visit; deductible does not apply	50% coinsurance	Includes physical, occupational, and speech therapies (office/outpatient). Preauthorization may be required. No benefit maximum.
	Habilitation services	\$40 copay /therapist visit; deductible does not apply	\$50 copay /therapist visit; deductible does not apply	50% coinsurance	
	Skilled nursing care	\$1,250 copay /admission	\$1,750 copay /admission	50% coinsurance	Includes inpatient physical rehabilitation. Requires preauthorization .
	Durable medical equipment	25% coinsurance	35% coinsurance	45% coinsurance	None
	Hospice services	No Charge; deductible does not apply	No Charge; deductible does not apply	50% coinsurance	No Charge for home hospice.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	If vision coverage purchased, see your vision plan information.
	Children's glasses	Not Covered	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	Not Covered	If dental coverage purchased, see your dental plan information.

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, routine dental)
- Infertility treatment (unless for medical condition causing the infertility)
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (unless you are diabetic)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Acupuncture (25 visits per year)
- Bariatric surgery
- Chiropractic care (25 visits per year)
- Hearing aids (Children up to age 21 no benefit maximum, Adults 22 years and above limited to \$2,500 per hearing-impaired ear, per 3 years period from date of purchase)
- Non-emergency care when traveling outside the U.S.

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.bcbsnm.com/SONM.

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: the [plan](#) at 1-877-994-2583, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 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](#) or the New Mexico State-Based Exchange BeWellnm at www.BeWellnm.com. 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: Blue Cross and Blue Shield of New Mexico (BCBSNM) [Appeals](#) Unit at 1-800-205-9926 or visit www.bcbsnm.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. 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

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

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 1-877-994-2583.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-994-2583.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-877-994-2583.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-994-2583.

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 copayment](#) \$60
- Hospital (facility) [copayment](#) \$1,250
- 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	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$1,300
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$70
The total Peg would pay is	\$2,270

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](#) \$60
- Hospital (facility) [copayment](#) \$1,250
- 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	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$400
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$3,500
The total Joe would pay is	\$4,500

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$60
- Hospital (facility) [copayment](#) \$1,250
- 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	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$700
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Mia would pay is	\$1,410



BlueCross BlueShield of New Mexico

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To speak to an interpreter, call the customer service number on the back of your member card. If you are not a member, or don't have a card, call 855-710-6984.

العربية Arabic	إن كان لديك أو لدى شخص تساعد أسئلة، فذلك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث إلى مترجم فوري، اتصل على رقم خدمة العملاء المذكور على ظهر بطاقة عضويتك. فإن لم تكن عضوًا، أو كنت لا تملك بطاقة، فاتصل على 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請致電印在您的會員卡背面的客戶服務電話號碼。如果您不是會員, 或沒有會員卡, 請致電 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, composez le numéro du service client indiqué au verso de votre carte de membre. Si vous n'êtes pas membre ou si vous n'avez pas de carte, veuillez composer le 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Kundenservicenummer auf der Rückseite Ihrer Mitgliedskarte an. Falls Sie kein Mitglied sind oder keine Mitgliedskarte besitzen, rufen Sie bitte 855-710-6984 an.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए, अपने सदस्य कार्ड के पीछे दिए गए ग्राहक सेवा नंबर पर कॉल करें। यदि आप सदस्य नहीं हैं, या आपके पास कार्ड नहीं है, तो 855-710-6984 पर कॉल करें।
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il servizio clienti al numero riportato sul lato posteriore della tua tessera di socio. Se non sei socio o non possiedi una tessera, puoi chiamare il numero 855-710-6984.
日本語 Japanese	ご本人様、またはお客様の方の身の回りの方でも、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、情報を入力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、メンバーカードの裏のカスタマーサービス番号までお電話ください。メンバーでない場合またはカードをお持ちでない場合は 855-710-6984 までお電話ください。
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 회원 카드 뒷면에 있는 고객 서비스 번호로 전화하십시오. 회원이 아니시거나 카드가 없으시면 855-710-6984 으로 전화하십시오.
Diné Navajo	T'áá ni, éi doodago la'da biká anánilwo'ígíí, na' idílkidgo, ts'idá bee ná ahóótí'í' t'áá níik'e níká a'doolwol. Ata' halne'í bich'í' hadeesdzih ninizingo éi kwe'é da'iniishgi áká anidaalwo'ígíí bich'í' hodiilnih, bee nééhózinii bine'déé' bikáá'. Kojí atah naaltsoos ná hadít'éégóó éi doodago bee nééhózinígíí ádingo kojí' hodiilnih 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با خدمات مشتری به شماره ای که در پشت کارت عضویت شما درج شده است تماس بگیرید. اگر عضو نیستید، یا کارت عضویت ندارید، با شماره 855-710-6984 تماس حاصل نمایید.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы поговорить с переводчиком, позвоните в отдел обслуживания клиентов по телефону, указанному на обратной стороне вашей карточки участника. Если вы не являетесь участником или у вас нет карточки, позвоните по телефону 855-710-6984.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete comuníquese con el número del Servicio al Cliente que figura en el reverso de su tarjeta de miembro. Si usted no es miembro o no posee una tarjeta, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa numero ng serbisyong para sa kustomer sa likod ng iyong kard ng miyembro. Kung ikaw ay hindi isang miyembro, o kaya ay walang kard, tumawag sa 855-710-6984.
ไทย Thai	หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีข้อสงสัยใด ๆ คุณมีสิทธิที่จะได้รับความช่วยเหลือ และข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่ามโดยติดต่อฝ่ายบริการลูกค้าที่หมายเลขตามที่ระบุด้านหลังบัตรสมาชิก หากไม่ใช่สมาชิกหรือไม่มีบัตร กรุณาติดต่อที่หมายเลข 855-710-6984
Tiếng Việt Vietnamese	Nếu quý vị hoặc người mà quý vị giúp đỡ có bất kỳ câu hỏi nào, quý vị có quyền được hỗ trợ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, gọi số dịch vụ khách hàng nằm ở phía sau thẻ hội viên của quý vị. Nếu quý vị không phải là hội viên hoặc không có thẻ, gọi số 855-710-6984.

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a [grievance](#).

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, IL 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>