

 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 1-855-769-6642 or visit [www.truehealthnewmexico.com](http://www.truehealthnewmexico.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 <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf> or call 1-855-756-4448 to request a copy.

| Important Questions   | Answers   | Why This Matters:   |
|---|---|---|
| What is the overall <a href="#">deductible</a> ?                                | \$4,000 Individual / \$8,000 Family.  | Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of the <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .  |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes; preventive care and services where a copay is listed.  | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain preventive services without cost-sharing and before you meet your <a href="#">deductible</a> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>                                       |
| Are there other <a href="#">deductibles</a> for specific services?              | No.   | You don't have to meet <a href="#">deductibles</a> for specific services.   |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$7,150 Individual / \$14,300 Family  | The <a href="#">out of pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out of pocket limit</a> until the overall family <a href="#">out of pocket limit</a> has been met.  |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premium</a> , <a href="#">balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.                   | Even though you pay these expenses, they don't count toward the <a href="#">out of pocket limit</a> .   |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.truehealthnewmexico.com">www.truehealthnewmexico.com</a> or call 1-855-769-6642 for a list of network providers. | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an out of network provider, and you might receive a bill from a <a href="#">provider</a> from the difference between the provider's charge and what your <a href="#">plan</a> 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 <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No.   | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .  |



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  |
|--|--|---|--|---|
|  |  | Network Provider<br>(You will pay the least)                            | Out-of-Network Provider<br>(You will pay the most) |   |
| If you visit a health care <a href="#">provider's</a> office or clinic   | Primary care visit to treat an injury or illness       | 50% <a href="#">coinsurance</a>   | Not Covered  | None  |
|  | <a href="#">Specialist</a> visit                       | 50% <a href="#">coinsurance</a>   | Not Covered  | None  |
|  | <a href="#">Preventive care/screening/immunization</a> | No Charge; <a href="#">deductible</a> does not apply                    | Not Covered  | None  |
| If you have a test   | <a href="#">Diagnostic test</a> (x-ray, blood work)    | 50% <a href="#">coinsurance</a>   | Not Covered  | None  |
|  | Imaging (CT/PET scans, MRIs)                           | 50% <a href="#">coinsurance</a>   | Not Covered  | Failure to obtain Prior Approval may result in a denial of coverage.  |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.truehealthnewmexico.com">www.truehealthnewmexico.com</a> | Generic drugs (Tier 1)                                 | 50% <a href="#">coinsurance</a> for retail and mail order prescriptions | Not Covered  | Covers up to a 30-day retail supply. 90-day mail order supply, in-network only.<br>True Health New Mexico offers \$0 copayment medications for select drugs from in-network participating pharmacies.<br>To view a complete listing of these drugs refer to True Health New Mexico formulary. |
|  | Preferred brand drugs (Tier 2)                         | 50% <a href="#">coinsurance</a> for retail and mail order prescriptions | Not Covered  |   |
|  | Non-preferred brand drugs (Tier 3)                     | 50% <a href="#">coinsurance</a> for retail and mail order prescriptions | Not Covered  |   |
|  | <a href="#">Specialty drugs</a> (Tier 4)               | 50% <a href="#">coinsurance</a> for retail and mail order prescriptions | Not Covered  |   |
| If you have outpatient surgery   | Facility fee (e.g., ambulatory surgery center)         | 50% <a href="#">coinsurance</a>   | Not Covered  | Failure to obtain Prior Approval may result in denial of coverage.  |
|  | Physician/surgeon fees                                 | 50% <a href="#">coinsurance</a>   | Not Covered  | Failure to obtain Prior Approval may result in denial of coverage.  |
| If you need immediate medical attention  | <a href="#">Emergency room care</a>                    | 50% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>                    | <a href="#">copayment</a> waived if admitted to hospital  |
|  | <a href="#">Emergency medical transportation</a>       | 50% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>                    | None  |
|  | <a href="#">Urgent Care Center</a>                     | 50% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>                    | None  |

| Common Medical Event  | Services You May Need                     | What You Will Pay                                    |  | Limitations, Exceptions, & Other Important Information                        |
|---|---|--|--|---|
|   |   | Network Provider<br>(You will pay the least)         | Out-of-Network Provider<br>(You will pay the most) |   |
| If you have a hospital stay   | Facility fee (e.g., hospital room)        | 50% <a href="#">coinsurance</a>                      | Not Covered  | Failure to obtain Prior Approval may result in a denial of coverage.          |
|   | Physician/surgeon fees                    | 50% <a href="#">coinsurance</a>                      | Not Covered  | Failure to obtain Prior Approval may result in a denial of coverage.          |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | No Charge; <a href="#">deductible</a> does not apply | Not Covered  | Failure to obtain Prior Approval may result in a denial of coverage.          |
|   | Inpatient services                        | 50% <a href="#">coinsurance</a>                      | Not Covered  |   |
| If you are pregnant   | Office visits                             | 50% <a href="#">coinsurance</a>                      | Not Covered  |   |
|   | Childbirth/delivery professional services | 50% <a href="#">coinsurance</a>                      | Not Covered  | Home birth not covered  |
|   | Childbirth/delivery facility services     | 50% <a href="#">coinsurance</a>                      | Not Covered  | Home birth not covered  |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>          | 50% <a href="#">coinsurance</a>                      | Not Covered  | Coverage is limited to 100 visits per calendar year.                          |
|   | <a href="#">Rehabilitation services</a>   | 50% <a href="#">coinsurance</a>                      | Not Covered  | Failure to obtain Prior Approval may result in a denial of coverage.          |
|   | <a href="#">Habilitation services</a>     | 50% <a href="#">coinsurance</a>                      | Not Covered  | Failure to obtain Prior Approval may result in a denial of coverage.          |
|   | <a href="#">Skilled nursing care</a>      | 50% <a href="#">coinsurance</a>                      | Not Covered  | Coverage is limited to 60 days/visits per calendar year.                      |
|   | <a href="#">Durable medical equipment</a> | 50% <a href="#">coinsurance</a>                      | Not Covered  | Failure to obtain Prior Approval may result in a denial of coverage.          |
|   | <a href="#">Hospice services</a>          | No Charge; <a href="#">deductible</a> does not apply | Not Covered  | Failure to obtain Prior Approval may result in a denial of coverage.          |
| If your child needs dental or eye care                                    | Children's eye exam                       | No Charge; <a href="#">deductible</a> does not apply | 50% of billed charges <a href="#">coinsurance</a>  | Coverage is limited to one exam per calendar year.                            |
|   | Children's glasses                        | No Charge; <a href="#">deductible</a> does not apply | 50% of billed charges <a href="#">coinsurance</a>  | Coverage is limited to one pair of lenses and frames per calendar year.       |
|   | Children's dental check-up                | Not Covered  | Not Covered  | Pediatric dental coverage can be purchased separately as a standalone policy. |

## 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](#).)

- |   |   |  |
|---|---|--|
| <ul style="list-style-type: none"><li>• Cosmetic surgery</li><li>• Dental care (Adult)</li><li>• Hearing aids (Adult)</li><li>• Home Births</li></ul> | <ul style="list-style-type: none"><li>• Infertility treatment (except for diagnosis and medically indicated treatments for physical conditions causing infertility)</li><li>• Long term care</li><li>• Non-emergency care when traveling outside the U.S.</li></ul> | <ul style="list-style-type: none"><li>• Private duty nursing</li><li>• Routine eye care (Adult)</li><li>• Weight loss programs (Unless for medically necessary treatment for morbid obesity)</li></ul> |
|---|---|--|

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

- |   |   |  |
|---|---|--|
| <ul style="list-style-type: none"><li>• Abortion Services</li><li>• Acupuncture (Max of 20 visits / year)</li></ul> | <ul style="list-style-type: none"><li>• Bariatric surgery</li><li>• Chiropractic care (Max of 20 visits / year)</li></ul> | <ul style="list-style-type: none"><li>• Routine foot care (diabetics only)</li></ul> |
|---|---|--|

**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 1-855-808-3568 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](http://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](http://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: True Health New Mexico 1-855-769-6642.

You may also contact the Office of the Superintendent of Insurance at 505-827-4734.

### 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:

See Multi-Language insert at the end of this document.

—————*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<br>(9 months of in-network pre-natal care and a hospital delivery)   |                 | Managing Joe's type 2 Diabetes<br>(a year of routine in-network care of a well-controlled condition)  |                | Mia's Simple Fracture<br>(in-network emergency room visit and follow up care)   |                |
|---|-----------------|---|----------------|---|----------------|
| ■ The plan's overall deductible   | \$4,000         | ■ The plan's overall deductible   | \$4,000        | ■ The plan's overall deductible   | \$4,000        |
| ■ Specialist Copayment  | 50%             | ■ Specialist Copayment  | 50%            | ■ Specialist Copayment  | 50%            |
| ■ Hospital (facility) coinsurance   | 50%             | ■ Hospital (facility) coinsurance   | 50%            | ■ Hospital (facility) coinsurance   | 50%            |
| ■ Other coinsurance   | 50%             | ■ Other coinsurance   | 50%            | ■ Other coinsurance   | 50%            |
| <p><b>This EXAMPLE event includes services like:</b><br/>                     Specialist office visits (<i>prenatal care</i>)<br/>                     Childbirth/Delivery Professional Services<br/>                     Childbirth/Delivery Facility Services<br/>                     Diagnostic tests (<i>ultrasounds and blood work</i>)<br/>                     Specialist visit (<i>anesthesia</i>)</p> |                 | <p><b>This EXAMPLE event includes services like:</b><br/>                     Primary care physician office visits (<i>including disease education</i>)<br/>                     Diagnostic tests (<i>blood work</i>)<br/>                     Prescription drugs<br/>                     Durable medical equipment (<i>glucose meter</i>)</p> |                | <p><b>This EXAMPLE event includes services like:</b><br/>                     Emergency room care (<i>including medical supplies</i>)<br/>                     Diagnostic test (<i>x-ray</i>)<br/>                     Durable medical equipment (<i>crutches</i>)<br/>                     Rehabilitation services (<i>physical therapy</i>)</p> |                |
| <b>Total Example Cost</b>   | <b>\$12,700</b> | <b>Total Example Cost</b>   | <b>\$7,400</b> | <b>Total Example Cost</b>   | <b>\$1,900</b> |
| <b>In this example, Peg would pay:</b>  |                 | <b>In this example, Joe would pay:</b>  |                | <b>In this example, Mia would pay:</b>  |                |
| <i>Cost Sharing</i>   |                 | <i>Cost Sharing</i>   |                | <i>Cost Sharing</i>   |                |
| Deductibles   | \$1,700         | Deductibles   | \$2,700        | Deductibles   | \$700          |
| Copayments  | \$0             | Copayments  | \$0            | Copayments  | \$0            |
| Coinsurance   | \$5,400         | Coinsurance   | \$2,700        | Coinsurance   | \$700          |
| <i>What isn't covered</i>   |                 | <i>What isn't covered</i>   |                | <i>What isn't covered</i>   |                |
| Limits or exclusions  | \$60            | Limits or exclusions  | \$1,800        | Limits or exclusions  | \$0            |
| <b>The total Peg would pay is</b>   | <b>\$7,200</b>  | <b>The total Joe would pay is</b>   | <b>\$7,200</b> | <b>The total Mia would pay is</b>   | <b>\$1,400</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

|                  |  |
|------------------|--|
| English          | ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-769-6642 (TTY: 711).                             |
| Spanish          | ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-769-6642 (TTY: 711).                            |
| Navajo           | D77 baa ak0 n7n7zin: D77 saad bee y1n7[ti'go Diné Bizaad, saad bee 1k1'1n7da'1wo'd66', t'11 jiiik'eh, 47 n1 h0l=, koj8' h0d77lnih 1-855-769-6642 (TTY: 711).     |
| Vietnamese       | CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-769-6642 (TTY: 711).   |
| German           | ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-769-6642 (TTY: 711).                |
| Chinese          | 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-769-6642 (TTY: 711)。  |
| Arabic           | ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-769-6642 (رقم هاتف الصم والبكم: 711).                            |
| Korean           | 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-769-6642 (TTY: 711) 번으로 전화해 주십시오.   |
| Tagalog-Filipino | PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-769-6642 (TTY: 711).          |
| Japanese         | 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-769-6642 (TTY: 711) まで、お電話にてご連絡ください。   |
| French           | ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-769-6642 (ATS: 711).                      |
| Italian          | ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-769-6642 (TTY: 711). |
| Russian          | ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-769-6642 (телетайп: 711).                                 |
| Hindi            | ☒☒☒☒न दें: य ☒☒ आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-769-6642 (TTY: 711) पर कॉल करें।                                   |
| Farsi            | توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-855-769-6642 (TTY: 711) تماس بگیرید.                              |
| Thai             | เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-769-6642 (TTY: 711).   |



## Notice of Non-Discrimination and Accessibility *Aviso de no discriminación y accesibilidad*

The following is a statement describing nondiscrimination for True Health New Mexico and the services it provides to its clients and members.

- We do not discriminate on the basis of race, color, national origin, age, disability, or gender in our health programs or activities.
- We provide help free of charge to people with disabilities or whose primary language is not English. To ask for a document in another format such as large print, or to get language help such as a qualified interpreter, please call True Health New Mexico Customer Service at 1-855-769-6642, Monday through Friday, 8:00 a.m. to 5:00 p.m. TTY: 1-800-659-8331.
- If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can send a complaint to: True Health New Mexico Compliance Hotline, 2440 Louisiana Blvd. NE, Suite 601, Albuquerque, NM 87110. Phone: 1-855-882-3904. Fax: 1-866-231-1344.

You also have the right to file a complaint directly with the U.S. Dept. of Health and Human Services online, by phone, or by mail:

- Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.
- Phone: Toll-free: 1-800-368-1019, TDD: 1-800-537-7697
- Mail: U.S. Dept. of Health & Human Services, 200 Independence Ave. SW, Room 509F, HHH Bldg., Washington, DC 20201

### **Aviso de no discriminación y accesibilidad**

A continuación presentamos una declaración que resume la norma de no discriminación de *True Health New Mexico* y los servicios que prestamos a nuestros clientes y asegurados.

- No discriminamos por la raza, el color, el origen nacional, la edad, las discapacidades o el sexo en nuestras actividades o programas de salud.
- Ayudamos gratuitamente a las personas que tienen discapacidades o cuyo idioma nativo no es el inglés. Para pedir un documento en otro formato, como en letra grande, o para recibir la ayuda de un intérprete calificado, favor de llamar al Centro de Atención al Cliente de *True Health New Mexico* al 1-855-769-6642, para los servicios TTY llame al 1-800-659-8331, de lunes a viernes, de las 8:00 de la mañana a las 5:00 de la tarde.
- Si usted cree que no hemos prestado estos servicios o que le hemos discriminado de alguna otra manera por su raza, color, origen nacional, edad, discapacidad o sexo, puede enviar una queja a: *True Health New Mexico* Compliance Hotline, 2440 Louisiana Blvd. NE, Suite 601, Albuquerque, NM 87110. Teléfono: 1-855-882-3904. Fax: 1-866-231-1344.

Además tiene derecho a presentar una queja directamente al Departamento de Salud y Servicios Humanos de los EE. UU. [*U.S. Dept. of Health and Human Services*] ya sea en línea, por teléfono o por correo:

- En línea: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Los formularios de queja están a su disposición en: <http://www.hhs.gov/ocr/office/file/index.html>.
- Por teléfono: Línea telefónica gratis: 1-800-368-1019, TDD: 1-800-537-7697
- Por correo: U.S. Dept. of Health & Human Services, 200 Independence Ave. SW, Room 509F, HHH Bldg., Washington, DC 20201