




# Healthy Connect \$750

Coverage for: Individual, Individual + Spouse, Family | Plan Type: HMO

 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-Glossary508-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> ?	\$750 Individual / \$1,500 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> ?	\$6,000 Individual / \$12,000 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 (You will pay the least)	Out-of-Network Provider (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	\$20 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply	Not Covered	None
	<a href="#">Specialist</a> visit	\$50 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply	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)	No Charge; <a href="#">deductible</a> does not apply	Not Covered	None
	Imaging (CT/PET scans, MRIs)	\$300 <a href="#">copayment</a> /test; <a href="#">deductible</a> does not apply	Not Covered	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 <a href="#">prescription drug coverage</a> is available at <a href="http://www.truehealthnewmexico.com">www.truehealthnewmexico.com</a>	Generic drugs	\$15 retail; \$45 mail order/prescription; <a href="#">deductible</a> does not apply	Not Covered	Covers up to a 30-day retail supply. 90-day mail order supply, in-network only.
	Preferred brand drugs	\$45 retail; \$135 mail order/prescription; <a href="#">deductible</a> does not apply	Not Covered	THNM offers \$0 <a href="#">copayment</a> medications for select drugs from in-network participating pharmacies. To view a complete listing of these drugs refer to the THNM formulary.
	Non-preferred brand drugs	\$75 retail; \$225 mail order/prescription; <a href="#">deductible</a> does not apply	Not Covered	
	Preferred speciality drugs	\$400/prescription; <a href="#">deductible</a> does not apply	Not Covered	Covers up to a 30-day retail supply. Failure to obtain Prior Approval may result in a denial of coverage.
	Non-preferred specialty drugs	50% <a href="#">coinsurance</a>	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <a href="#">coinsurance</a>	Not Covered	Failure to obtain Prior Approval may result in denial of coverage.
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	Not Covered	Failure to obtain Prior Approval may result in denial of coverage.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$350 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply	\$350 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply	<a href="#">copayment</a> waived if admitted to hospital
	<a href="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a>	Not Covered	None
	<a href="#">Urgent Care Center</a>	\$50 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply	\$50 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$1,500 <a href="#">copayment</a> /admission; <a href="#">deductible</a> does not apply	Not Covered	Failure to obtain Prior Approval may result in a denial of coverage.
	Physician/surgeon fees	No charge; covered in Facility fee; <a href="#">deductible</a> does not apply	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	
	Inpatient services	\$1,500 <a href="#">copayment</a> /admission; <a href="#">deductible</a> does not apply	Not Covered	Failure to obtain Prior Approval may result in a denial of coverage.
If you are pregnant	Office visits	\$50 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply	Not Covered	Up to a maximum of \$300 <a href="#">copayment</a> /pregnancy
	Childbirth/delivery professional services	No charge; covered in Facility fee; <a href="#">deductible</a> does not apply	Not Covered	Home birth not covered
	Childbirth/delivery facility services	\$1,500 <a href="#">copayment</a> /admission; <a href="#">deductible</a> does not apply	Not Covered	Home birth not covered

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	30% <a href="#">coinsurance</a>	Not Covered	Coverage is limited to 100 visits per plan year.
	<a href="#">Rehabilitation services</a>	\$20 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply	Not Covered	Failure to obtain Prior Approval may result in a denial of coverage.
	<a href="#">Habilitation services</a>	\$20 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply	Not Covered	Failure to obtain Prior Approval may result in a denial of coverage.
	<a href="#">Skilled nursing care</a>	\$1,500 <a href="#">copayment</a> /admission; <a href="#">deductible</a> does not apply	Not Covered	Coverage is limited to 60 days/visits per plan year.
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a>	Not Covered	Failure to obtain Prior Approval may result in a denial of coverage.
	<a href="#">Hospice services</a>	30% <a href="#">coinsurance</a>	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	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<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 con</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 <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Abortion Services</li> <li>• Acupuncture (Max of 25 visits / year)</li> </ul>	<ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Chiropractic care (Max of 25 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, U.S Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](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 U.S. Department of Labor's Benefits Security Administration at 1-866-444-EBSA (3272) or visit [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

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 (9 months of in-network pre-natal care and a hospital delivery)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$750	■ The plan's overall deductible	\$750	■ The plan's overall deductible	\$750
■ Specialist Copayment	\$50	■ Specialist Copayment	\$50	■ Specialist Copayment	\$50
■ Hospital (facility) coinsurance	\$1,500	■ Hospital (facility) coinsurance	\$1,500	■ Hospital (facility) coinsurance	\$1,500
■ Other coinsurance	30%	■ Other coinsurance	30%	■ Other coinsurance	30%
<p><b>This EXAMPLE event includes services like:</b>                      Specialist office visits (<i>prenatal care</i>)                      Childbirth/Delivery Professional Services                      Childbirth/Delivery Facility Services                      Diagnostic tests (<i>ultrasounds and blood work</i>)                      Specialist visit (<i>anesthesia</i>)</p>		<p><b>This EXAMPLE event includes services like:</b>                      Primary care physician office visits (<i>including disease education</i>)                      Diagnostic tests (<i>blood work</i>)                      Prescription drugs                      Durable medical equipment (<i>glucose meter</i>)</p>		<p><b>This EXAMPLE event includes services like:</b>                      Emergency room care (<i>including medical supplies</i>)                      Diagnostic test (<i>x-ray</i>)                      Durable medical equipment (<i>crutches</i>)                      Rehabilitation services (<i>physical therapy</i>)</p>	
<b>Total Example Cost</b>	<b>\$12,840</b>	<b>Total Example Cost</b>	<b>\$7,460</b>	<b>Total Example Cost</b>	<b>\$2,700</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	\$0	Deductibles	\$750	Deductibles	\$550
Copayments	\$2,750	Copayments	\$1,310	Copayments	\$1,700
Coinsurance	\$0	Coinsurance	\$520	Coinsurance	\$240
<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	\$60	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$2,810</b>	<b>The total Joe would pay is</b>	<b>\$2,640</b>	<b>The total Mia would pay is</b>	<b>\$2,490</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	Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, koji' hódíłnih 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	ध्यान दें: यदि 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