Care Connect Gold Essential

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.mynmhc.org. 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 deductible?	$2,000 Individual / $4,000 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 the deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes; preventive care and services where a copay is listed.	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 https://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?	$7,900 Individual / $15,800 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 limit until the overall family out of pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, 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.mynmhc.org or call 1-855-769-6642** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out of network provider, and you might receive a bill from a provider from 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
		Network Provider (You will pay the least)	Out-of-Network 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	$25 copayment/visit; deductible does not apply	Not Covered	None
	Specialist visit	$50 copayment/visit; deductible does not apply	Not Covered	None
	Preventive care/screening/ immunization	No Charge; deductible does not apply	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	$10/lab; $50/x-ray; deductible does not apply	Not Covered	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance; deductible 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 prescription drug coverage is available at www.mynmhc.org	Generic drugs	$25 retail; deductible does not apply	Not Covered	Covers up to a 30-day retail supply. Mail-order not covered. NMHC offers $0 copayment medications for select drugs from in-network participating pharmacies. To view a complete listing of these drugs refer to the NMHC formulary.
	Preferred brand drugs	$75 retail; deductible does not apply	Not Covered	
	Non-preferred brand drugs	$150 retail; deductible does not apply	Not Covered	
	Preferred speciality drugs	40% coinsurance	Not Covered	Covers up to a 30-day retail supply. Failure to obtain Prior Approval may result in denial of coverage.
	Non-preferred specialty drugs	50% coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not Covered	Failure to obtain Prior Approval may result in denial of coverage.
	Physician/surgeon fees	30% coinsurance	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	Emergency room care	$500 copayment/visit; deductible does not apply	$500 copayment/visit; deductible does not apply	copayment waived if admitted to hospital
	Emergency medical transportation	30% coinsurance	30% coinsurance	None
	Urgent Care Center	$50 copayment/visit; deductible does not apply	$50 copayment/visit; deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not Covered	Failure to obtain Prior Approval may result in a denial of coverage.
	Physician/surgeon fees	30% coinsurance	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	$25 copayment/visit; deductible does not apply	Not Covered	Failure to obtain Prior Approval may result in a denial of coverage.
	Inpatient services	30% coinsurance	Not Covered	
If you are pregnant	Office visits	$50 copayment/visit; deductible does not apply	Not Covered	Up to a maximum of $300 copayment/pregnancy
	Childbirth/delivery professional services	30% coinsurance	Not Covered	Home birth not covered
	Childbirth/delivery facility services	30% coinsurance	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	Home health care	30% coinsurance	Not Covered	Coverage is limited to 100 visits per calendar year.
	Rehabilitation services	$50 copayment/visit; deductible does not apply	Not Covered	Failure to obtain Prior Approval may result in a denial of coverage.
	Habilitation services	$50 copayment/visit; deductible does not apply	Not Covered	Failure to obtain Prior Approval may result in a denial of coverage.
	Skilled nursing care	30% coinsurance	Not Covered	Coverage is limited to 60 days/visits per calendar year.
	Durable medical equipment	30% coinsurance	Not Covered	Failure to obtain Prior Approval may result in a denial of coverage. The Plan covers hearing aids and the evaluation for the fitting of Hearing Aids only for Dependent children up to age eighteen (18), or up to age twenty-one (21) if still attending high school.
	Hospice services	30% coinsurance	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; deductible does not apply	50% coinsurance; deductible does not apply	Coverage is limited to one exam per calendar year.
	Children's glasses	No Charge; deductible does not apply	50% coinsurance; deductible does not apply	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.)

- Abortion Services (except in cases of rape, incest, or when the life of the mother is endangered)
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids (Adult)
- Home Births
- Infertility treatment (except for diagnosis and medically indicated treatments for physical conditions causing infertility)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Weight loss programs (Unless for Medically necessary treatment for morbid obesity)

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

- Acupuncture (Max of 20 visits / year)
- Bariatric surgery
- Chiropractic care (Max of 20 visits / year)
- Routine foot care (diabetics only)

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. You may also contact the Office of the Superintendent of Insurance (OSI) at 1-855-427-5674. 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 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: New Mexico Health Connections 1-855-769-6642.

You may also contact the Office of the Superintendent of Insurance at 505-827-4601.

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)

The plan's overall deductible	$2,000
Specialist Copayment	$50
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$13,623

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$1,220
Coinsurance	$2,688
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,968**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,000
Specialist Copayment	$50
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$7,755

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,210
Copayments	$2,210
Coinsurance	$518
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$3,993**

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

The plan's overall deductible	$2,000
Specialist Copayment	$50
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$2,896

In this example, Mia would pay:

Cost Sharing	
Deductibles	$580
Copayments	$1,900
Coinsurance	$248
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,728**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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Language Assistance Services
Servicios de acceso al idioma

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'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 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).

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

The following is a statement describing nondiscrimination for NMHC 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 NMHC 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: NMHC 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 NMHC 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 NMHC 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: NMHC 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