Care Connect HDHP Bronze

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 1-866-668-9002 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?	$6,900 Individual / $13,800 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	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?	$6,900 Individual / $13,800 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 1-866-668-9002** 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	No charge after deductible	Not Covered	None
	Specialist visit	No charge after deductible	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)	No charge after deductible	Not Covered	None
	Imaging (CT/PET scans, MRIs)	No charge after deductible	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	No charge after deductible	Not Covered	Covers up to a 30-day supply retail or through mail order.
	Preferred brand drugs	No charge after deductible	Not Covered	
	Non-preferred brand drugs	No charge after deductible	Not Covered	
	Preferred specialty drugs	No charge after deductible	Not Covered	Covers up to a 30-day supply retail. Mail order not covered. Failure to obtain Prior Approval may result in denial of coverage.
	Non-preferred specialty drugs	No charge after deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	Not Covered	Failure to obtain Prior Approval may result in denial of coverage.
	Physician/surgeon fees	No charge after deductible	Not Covered	Failure to obtain Prior Approval may result in denial of coverage.
If you need immediate medical attention	Emergency room care	No charge after deductible	No charge after deductible	None
	Emergency medical transportation	No charge after deductible	No charge after deductible	None
	Urgent Care Center	No charge after deductible	No charge after deductible	None

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 have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	Not Covered	Failure to obtain Prior Approval may result in a denial of coverage, unless for emergency.
	Physician/surgeon fees	No charge after deductible	Not Covered	Failure to obtain Prior Approval may result in a denial of coverage, unless for emergency.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge after deductible	Not Covered	Failure to obtain Prior Approval may result in a denial of coverage.
	Inpatient services	No charge after deductible	Not Covered	
If you are pregnant	Office visits	No charge after deductible	Not Covered	None
	Childbirth/delivery professional services	No charge after deductible	Not Covered	Home birth not covered
	Childbirth/delivery facility services	No charge after deductible	Not Covered	Home birth not covered
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	No charge after deductible	Not Covered	Failure to obtain Prior Approval may result in a denial of coverage.
	Habilitation services	No charge after deductible	Not Covered	Failure to obtain Prior Approval may result in a denial of coverage.
	Skilled nursing care	No charge after deductible	Not Covered	Coverage is limited to 60 days/visits per calendar year.
	Durable medical equipment	No charge after deductible	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	No charge after deductible	Not Covered	Failure to obtain Prior Approval may result in a 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 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 after deductible	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 (unless for rehabilitative or habilitative purposes) (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, unless for rehabilitative or habilitative purposes.)
- Bariatric surgery
- Chiropractic care (Max of 20 visits /year, unless for rehabilitative or habilitative purposes.)
- 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 1-866-668-9002.

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** **$6,900**
- **Specialist Copayment** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$6,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,960**

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

- **The plan's overall deductible** **$6,900**
- **Specialist Copayment** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

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	**$7,000**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$6,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$6,955**

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

- **The plan's overall deductible** **$6.900**
- **Specialist Copayment** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

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	**$1,900**

In this example, Mia would pay:

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

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