
 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 1-877-210-8339 or visit www.truehealthnewmexico.com/aps. 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 ? | In Network: \$500 single/ \$1,000 two-party/ \$1,250 family. Doesn't apply to preventive care or services where a copay is listed. | 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 ? | For participating providers \$4,000 single/\$8,000 two-party/ \$12,000 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 limit until the overall family out of pocket limit has been met. The prescription drug plan has a separate out-of-pocket limit. |
| What is not included in the out-of-pocket limit ? | Premium , balance billing charges, and health care this plan doesn't cover. In addition, certain specialty drugs are considered non-essential health benefits under the Affordable Care Act (ACA), and fall outside the out-of-pocket limits. | Even though you pay these expenses, they don't count toward the out of pocket limit . |

| Important Questions | Answers | Why This Matters: |
|--|---|---|
| Will you pay less if you use a network provider ? | Yes. See www.truehealthnewmexico.com or call 1-877-210-8339 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 | \$20 copayment /visit; deductible does not apply | Not Covered | Doctor on Demand Virtual Visits: No Charge |
| | 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) | \$20 copayment /day | Not Covered | None |
| | Imaging (CT/PET scans, MRIs) | Free-standing Imaging Center: \$120 copayment /day; Other Facilities: 20% coinsurance after the deductible | Not Covered | Prior Approval is required. 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) | |
| <p>If you need drugs to treat your illness or condition More information about prescription drug coverage is available at Express Scripts: 1-866-563-9297</p> | Generic drugs | Retail (up to 34-day supply): 20% coinsurance , min \$10/rx, max \$25/rx; Home delivery/Walgreens (up to 90-day supply): \$25 copayment /rx | Not covered | <p>Prescription drug benefits are administered for Albuquerque Public Schools by Express Scripts. Insulin and Diabetic Supplies: \$0 copayment</p> <p>Maintenance medications: A maximum of two 30-day fills of maintenance medications are allowed at a retail pharmacy. Then, maintenance medications require a 90-day fill through Express Scripts home delivery or at a Walgreens pharmacy.</p> <p>Insulin or a Medically Necessary alternative will not exceed \$0 for a 30-day supply. Amounts will not apply to the plan dollar limits when using a drug manufacture coupon/copay card on covered drugs.</p> <p>Certain prescription drugs for the treatment of mental illness, behavioral health, or substance abuse disorders will be covered at No Charge to you, when obtained from a participating pharmacy. Contact Express Scripts for more information.</p> |
| | Preferred brand drugs | Retail (up to 34-day supply): 30% coinsurance , min \$35/rx, max \$65/rx; Home delivery/Walgreens (up to 90-day supply): \$70 copayment /rx | Not covered | |
| | Non-preferred brand drugs | Retail (up to 34-day supply): 40% coinsurance , min \$70/rx, max \$140/rx; Home delivery/Walgreens (up to 90-day supply): \$150 copayment /rx | Not covered | |
| | Preferred speciality drugs | Generic: \$70 copayment /rx; Preferred brand: \$100 copayment /rx; Non-preferred brand: \$150 copayment /rx | 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 have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance ; deductible applies | Not Covered | Prior Approval is required. Failure to obtain Prior Approval may result in denial of coverage. |
| | Physician/surgeon fees | 20% coinsurance ; deductible applies | Not Covered | Prior Approval is required. Failure to obtain Prior Approval may result in denial of coverage. |
| If you need immediate medical attention | Emergency room care | \$350 copayment /visit; deductible does not apply | \$350 copayment /visit; deductible does not apply | Emergency room copay waived if admitted to the hospital. |
| | Emergency medical transportation | 20% coinsurance ; deductible applies | 20% coinsurance ; deductible applies | No charge for anything related to COVID-19 screening, testing, or medical treatment. |
| | Urgent Care Center | \$50 copayment ; deductible does not apply | \$50 copayment ; deductible does not apply | Balance billing is not allowed for out-of-network care. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance ; deductible applies | Not Covered | Prior Approval is required. Failure to obtain Prior Approval may result in a denial of coverage. |
| | Physician/surgeon fees | 20% coinsurance ; deductible applies | Not Covered | Prior Approval is required. 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; deductible does not apply | Not Covered | Virtual or Telehealth: No Charge. Prior Approval is required for inpatient services. Failure to obtain Prior Approval may result in a denial of coverage. |
| | Inpatient services | No Charge; deductible does not apply | Not Covered | |
| If you are pregnant | Office visits | \$50 copayment /visit- initial visit only, then No Charge. deductible does not apply | Not Covered | Copay only due for first pre-natal visit |
| | Childbirth/delivery professional services | 20% coinsurance ; deductible applies | Not Covered | Home Births Not Covered |
| | Childbirth/delivery facility services | 20% coinsurance ; deductible applies | Not Covered | Home Births 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 | \$50 copayment /visit; deductible does not apply | Not Covered | None |
| | Rehabilitation services | \$20 copayment /visit up to \$320 annual maximum; deductible does not apply | Not Covered | Cardiac/Pulmonary: \$0/visit. Prior Approval is required. Coverage is limited to 60 days/visits per calendar year. |
| | Habilitation services | \$20 copayment /visit up to \$320 annual maximum; deductible does not apply | Not Covered | Prior Approval is required. Coverage is limited to 60 days/visits per calendar year. |
| | Skilled nursing care | 20% coinsurance ; deductible applies | Not Covered | Includes inpatient physical rehabilitation. Coverage is limited to 60 days/visits per calendar year. Prior Approval is required. |
| | Durable medical equipment | 20% coinsurance ; deductible does not apply | Not Covered | Prior authorization is required or benefits may be denied. |
| | Hospice services | 20% coinsurance ; deductible applies | Not Covered | None |
| If your child needs dental or eye care | Children's eye exam | Not Covered Under Medical Plan | Not Covered | None |
| | Children's glasses | Not Covered Under Medical Plan | Not Covered | None |
| | Children's dental check-up | Not Covered Under Medical Plan | Not Covered | None |

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](#).)

- | | | |
|------------------------|--|--|
| • Bariatric surgery | • Home Births | • Private-duty nursing |
| • Cosmetic surgery | • Long-term care | • Routine eye care (Adult) |
| • Dental care | • Non-emergency care when traveling outside New Mexico | • Routine foot care (unless you are diabetic) |
| • Hearing aids (Adult) | • Non-emergency care when traveling outside the U.S. | • 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 (maximum 25 visits/year) | • Hearing aids (Child) | • Infertility treatment (Limitations apply) |
| • Chiropractic care (maximum 25 visits/year) | | |

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: True Health New Mexico at 1-877-210-8339, 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. 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: True Health New Mexico 1-877-210-8339. 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.

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

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 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 | \$500 | ■ The plan's overall deductible | \$500 | ■ The plan's overall deductible | \$500 |
| ■ Specialist Copayment | \$50 | ■ Specialist Copayment | \$50 | ■ Specialist Copayment | \$50 |
| ■ Hospital (facility) coinsurance | 20% | ■ Hospital (facility) coinsurance | 20% | ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% | ■ Other coinsurance | 20% | ■ Other coinsurance | 20% |
| <p>This EXAMPLE event includes services like: 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>This EXAMPLE event includes services like: 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>This EXAMPLE event includes services like: 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> | |
| Total Example Cost | \$12,700 | Total Example Cost | \$5,600 | Total Example Cost | \$2,800 |
| In this example, Peg would pay: | | In this example, Joe would pay: | | In this example, Mia would pay: | |
| <i>Cost Sharing</i> | | <i>Cost Sharing</i> | | <i>Cost Sharing</i> | |
| Deductibles | \$500 | Deductibles | \$0 | Deductibles | \$500 |
| Copayments | \$50 | Copayments | \$190 | Copayments | \$530 |
| Coinsurance | \$2,400 | Coinsurance | \$300 | Coinsurance | \$140 |
| <i>What isn't covered</i> | | <i>What isn't covered</i> | | <i>What isn't covered</i> | |
| Limits or exclusions | \$30 | Limits or exclusions | \$60 | Limits or exclusions | \$0 |
| The total Peg would pay is | \$2,980 | The total Joe would pay is | \$550 | The total Mia would pay is | \$1170 |

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

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|------------------|--|
| English | ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-210-8339 (TTY: 711). |
| Spanish | ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-210-8339 (TTY: 711). |
| Navajo | Díí baa akó nínízin: Díí saad bee yánilti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, koji' hódílnih 1-877-210-8339 (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 1-877-210-8339 (TTY: 711). |
| German | ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-210-8339 (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 1-877-210-8339 (TTY : 711)。 |
| Arabic | ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-210-8339 (رقم هاتف الصم والبكم: 711). |
| Korean | 주의 : 한국어를 말할 때 무료로 언어 지원 서비스를 이용할 수 있습니다. 1-877-210-8339 (TTY: 711) 로 전화하십시오. |
| Tagalog-Filipino | PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-210-8339 (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。1-877-210-8339 (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 1-877-210-8339 (ATS: 711). |
| Italian | ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-210-8339 (TTY: 711). |
| Russian | ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-210-8339 (телетайп: 711). |
| Hindi | सावधानी: यदि आप अंग्रेजी बोलते हैं, तो भाषा सहायता सेवाएं नि:शुल्क, आपके लिए उपलब्ध हैं। 1-877-210-8339 पर कॉल करें (टीटीवी: 711)। |
| Farsi | توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-877-210-8339 (TTY: 711) تماس بگیرید. |
| Thai | ความสนใจ: หากคุณพูดภาษาไทยมีบริการให้ความช่วยเหลือด้านภาษาฟรี โทร 1-877-210-8339 (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, creed or religion, sexual orientation, 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 1-844-508-4677, 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 report a complaint to: True Health New Mexico Compliance Hotline, <https://www.lighthouse-services.com/brighthousegroup>. Phone (toll-free): 1-855-208-3766 (English), 1-800-216-1288 (Spanish). Email: Reports@Lighthouse-Services.com. Fax: 1-215-689-3885.

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 credo o la religión, la orientación sexual, 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 1-844-508-4677, 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 reportar una queja a: *True Health New Mexico* Compliance Hotline, <https://www.lighthouse-services.com/brighthousegroup>. Teléfono (gratis): 1-855-208-3766 (inglés), 1-800-216-1288 (español). Correo electrónico: Reports@Lighthouse-Services.com. Fax: 1-215-689-3885.

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