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 1-877-994-2583 or visit www.bcbsnm.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 www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-877-994-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Preferred Provider: $500 Individual / $1,000 Two-Person / $1,500 Family Non-Preferred Provider: $2,800 Individual / $5,600 Two-Person / $8,400 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 deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Office visits that charge a copay, prescription drugs, and preventive care are covered before you meet your deductible.	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 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?	Preferred Provider: $3,500 Individual / $7,000 Two-Person / $10,500 Family Non-Preferred Provider: $7,000 Individual / $14,000 Two-Person / $21,000 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 limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balanced-billed charges, penalty amounts, and healthcare 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.bcbsnm.com or call 1-877-994-2583 for a list of Preferred 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 for 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
		Preferred Provider (You will pay the least)	Non-Preferred 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	$30 copay/visit; deductible does not apply	50% coinsurance	None
	Specialist visit	$55 copay/visit; deductible does not apply	50% coinsurance	None
	Preventive care/screening/immunization	No Charge; deductible does not apply	50% coinsurance; deductible does not apply	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance up to max $200/test	50% coinsurance	Requires preauthorization.
If you need drugs to treat your illness or condition More information about **Prescription drug coverage** is available at www.express-scripts.com	Generic drugs	Not Applicable	Not Applicable	See your Express Scripts Prescription drug plan information for details.
	Preferred brand drugs	Not Applicable	Not Applicable	
	Non-Preferred brand drugs	Not Applicable	Not Applicable	
	Specialty drugs	Not Applicable	Not Applicable	

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsnm.com

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Non-emergency observation is $500 per visit after deductible.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$250 copay/visit	$250 copay/visit	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	Non-Preferred or non-emergency air transfer is 50% coinsurance.
	Urgent care	$50 copay/visit	$50 copay/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,000 copay/admission	50% coinsurance	Preauthorization required; $300 penalty if not preauthorized for Non-Preferred.
	Physician/surgeon fees	No Charge	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/visit; deductible does not apply	50% coinsurance	Intensive outpatient program (IOP) is $55 copay per visit. Residential treatment center (RTC) is limited to 60 days per plan year. Inpatient, IOP, RTC, and partial hospitalization require preauthorization; $300 penalty if not preauthorized for Non-Preferred. Inpatient physician services are No Charge after deductible.
	Inpatient services	$1,000 copay/admission	50% coinsurance	

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you are pregnant	Office visits	$30 copay/visit; deductible does not apply	50% coinsurance	Copay charged for initial visit only. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	$30 copay PPP $55 copay specialist; deductible does not apply	50% coinsurance	
	Childbirth/delivery facility services	$1,000 copay/admission	50% coinsurance	Preauthorization required; $300 penalty if not preauthorized for Non-Preferred. Inpatient physician services are No Charge after deductible.
If you need help recovering or have other special health needs	Home health care	$55 copay/visit; deductible does not apply	50% coinsurance	Limited to 100 visits per plan year.
	Rehabilitation services	$55 copay/visit; deductible does not apply	50% coinsurance	Includes physical, occupational, and speech therapies (office/outpatient).
	Habilitation services	$55 copay/visit; deductible does not apply	50% coinsurance	
	Skilled nursing care	$1,000 copay/admission	50% coinsurance	Preauthorization required for inpatient physical rehabilitation; $300 penalty if not preauthorized for Non-Preferred. Related professional services are No Charge after deductible.
	Durable medical equipment	25% coinsurance	40% coinsurance	Precertification required for equipment over $1,000 or long-term rentals.
	Hospice services	No Charge; deductible does not apply	50% coinsurance	None

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsnm.com

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	If vision coverage purchased, see your vision plan information.
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	If dental coverage purchased, see your dental plan information.

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.)

- Cosmetic surgery
- Dental care (Adult, routine dental)
- Infertility treatment (unless for medical condition causing the infertility)
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (unless you are diabetic)
- Weight loss programs

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

- Acupuncture (max 25 visits/year combined with chiropractic care)
- Bariatric surgery
- Chiropractic care (max 25 visits/year combined with acupuncture)
- Coverage provided outside the United States. See www.bcbsnm.com
- Hearing aids (Adults and children, limited to $2,500 per ear, per 3 year period from date of purchase)
- Non-emergency care when traveling outside the U.S.

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 1-877-994-2583, 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.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsnm.com

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: Blue Cross and Blue Shield of New Mexico (BCBSNM) Appeals Unit at 1-800-205-9926 or visit www.bcbsnm.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the New Mexico Superintendent of Insurance toll-free at 1-855-427-5674 or www.osi.state.nm.us.

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 the 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:
Spanish (Español): Para obtener asistencia en Español, llame al 1-877-994-2583.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-994-2583.
Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 1-877-994-2583.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-994-2583.

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	**$500**
Specialist *copayments*	**$55**
Hospital (facility) *copayments*	**$1,000**
Other *coinsurance*	**20%**

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	**$12,700**

In this example, Peg would pay:

Cost sharing	
Deductibles	$500
Copayments	$1,100
Coinsurance	$600
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	**$2,300**

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

The plan's overall deductible	**$500**
Specialist *copayments*	**$55**
Hospital (facility) *copayments*	**$1,000**
Other *coinsurance*	**20%**

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	**$7,400**

In this example, Joe would pay:

Cost sharing	
Deductibles	$500
Copayments	$400
Coinsurance	$300
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$5,500**

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

The plan's overall deductible	**$500**
Specialist *copayments*	**$55**
Hospital (facility) *copayments*	**$1,000**
Other *coinsurance*	**20%**

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	**$2,000**

In this example, Mia would pay:

Cost sharing	
Deductibles	$500
Copayments	$600
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

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

BlueCross BlueShield of New Mexico

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost.
To speak to an interpreter, call the customer service number on the back of your member card. If you are not a member, or don't have a card, call 855-710-6984.

العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث إلى مترجم فوري، اتصل على رقم خدمة العملاء المذكور على ظهر بطاقة عضويتك. فإن لم تكن عضوًا، أو كنت لا تملك بطاقة، فاتصل على 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請致電印在您的會員卡背面的客戶服務電話號碼。如果您不是會員, 或沒有會員卡, 請致電 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, composez le numéro du service client indiqué au verso de votre carte de membre. Si vous n'êtes pas membre ou si vous n'avez pas de carte, veuillez composer le 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Kundenservicenummer auf der Rückseite Ihrer Mitgliedskarte an. Falls Sie kein Mitglied sind oder keine Mitgliedskarte besitzen, rufen Sie bitte 855-710-6984 an.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए, अपने सदस्य कार्ड के पीछे दिए गए ग्राहक सेवा नंबर पर कॉल करें। यदि आप सदस्य नहीं हैं, या आपके पास कार्ड नहीं है, तो 855-710-6984 पर कॉल करें।
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il servizio clienti al numero riportato sul lato posteriore della tua tessera di socio. Se non sei socio o non possiedi una tessera, puoi chiamare il numero 855-710-6984.
日本語 Japanese	ご本人様、またはお客様の身の回りの方でも、ご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、メンバーカードの裏のカスタマーサービス番号までお電話ください。メンバーでない場合またはカードをお持ちでない場合は 855-710-6984 までお電話ください。
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 회원 카드 뒷면에 있는고객 서비스 번호로 전화하십시오. 회원이 아니시거나 카드가 없으시면 855-710-6984 으로 전화주십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídílkidgo, ts'ídá bee ná ahóóti'i' t'áá níik'e níká a'doolwoł. Ata' halne'í bich'į' hadeesdzih nínízingo éí kwe'é da'íníishgi áká anídaalwo'ígíí bich'į' hodíílnih, bee nééhózinii bine'dęę' bikáá'. Kojí atah naaltsoos ná hadít'éégóó éí doodago bee nééhózinígíí ádingo koji' hodíílnih 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با خدمات مشتری به شماره ای که در پشت کارت عضویت شما درج شده است تماس بگیرید. اگر عضو نیستید، یا کارت عضویت ندارید، با شماره 855-710-6984 تماس حاصل نمایید.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы поговорить с переводчиком, позвоните в отдел обслуживания клиентов по телефону, указанному на обратной стороне вашей карточки участника. Если вы не являетесь участником или у вас нет карточки, позвоните по телефону 855-710-6984.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete comuníquese con el número del Servicio al Cliente que figura en el reverso de su tarjeta de miembro. Si usted no es miembro o no posee una tarjeta, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa numero ng serbisyo para sa kustomer sa likod ng iyong kard ng miyembro. Kung ikaw ay hindi isang miyembro, o kaya ay walang kard, tumawag sa 855-710-6984.
ไทย Thai	หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีข้อสงสัยใด ๆ คุณมีสิทธิที่จะได้รับความช่วยเหลือ และข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่ามโดยติดต่อฝ่ายบริการลูกค้าที่หมายเลขตามที่ระบุด้านหลังบัตรสมาชิก หากไม่ใช่สมาชิกหรือไม่มีบัตร กรุณาติดต่อที่หมายเลข 855-710-6984
Tiếng Việt Vietnamese	Nếu quý vị hoặc người mà quý vị giúp đỡ có bất kỳ câu hỏi nào, quý vị có quyền được hỗ trợ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, gọi số dịch vụ khách hàng nằm ở phía sau thẻ hội viên của quý vị. Nếu quý vị không phải là hội viên hoặc không có thẻ, gọi số 855-710-6984.

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator	Phone: 855-664-7270 (voicemail)
300 E. Randolph St.	TTY/TDD: 855-661-6965
35th Floor	Fax: 855-661-6960
Chicago, Illinois 60601	Email: CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services	Phone: 800-368-1019
200 Independence Avenue SW	TTY/TDD: 800-537-7697
Room 509F, HHH Building 1019	Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Washington, DC 20201	Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

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Important Questions	Answers	Why This Matters:
What is the overall deductible?	$350 Individual / $675 Two-Person / $1,000 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 deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Office visits that charge a copay, prescription drugs, and preventive care are covered before you meet your deductible.	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 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?	$3,500 Individual / $7,000 Two-Person / $10,500 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 limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balanced-billed charges, penalty amounts, and healthcare 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.bcbsnm.com or call 1-877-994-2583 for a list of Preferred 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 for 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
		Preferred Provider (You will pay the least)	Non-Preferred 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 copay/visit; deductible does not apply	Not Covered	None
	Specialist visit	$45 copay/visit; deductible does not apply	Not Covered	None
	Preventive care/screening/immunization	No Charge; deductible does not apply	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not Covered	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance up to max $200/test	Not Covered	Requires preauthorization.
If you need drugs to treat your illness or condition More information about **Prescription drug coverage** is available at www.express-scripts.com.	Generic drugs	Not Applicable	Not Applicable	See your Express Scripts Prescription drug plan information for details.
	Preferred brand drugs	Not Applicable	Not Applicable	
	Non-Preferred brand drugs	Not Applicable	Not Applicable	
	Specialty drugs	Not Applicable	Not Applicable	

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsnm.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not Covered	Non-emergency observation is $250 per visit after deductible.
	Physician/surgeon fees	No Charge; deductible does not apply	Not Covered	None
If you need immediate medical attention	Emergency room care	$250 copay/visit	$250 copay/visit	None
	Emergency medical transportation	$30 copay ground $100 copay air	$30 copay ground $100 copay air	Requires preauthorization.
	Urgent care	$50 copay/visit	Not Covered	Call 1-800-810-BLUE (2583) if you are outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/admission	Not Covered	Requires preauthorization.
	Physician/surgeon fees	No Charge; deductible does not apply	Not Covered	Requires preauthorization.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit; deductible does not apply	Not Covered	Intensive outpatient program (IOP) is $50 copay per visit. Residential treatment center (RTC) is limited to 60 days per plan year. Inpatient, IOP, RTC, and partial hospitalization require preauthorization. Inpatient physician services are No Charge after deductible.
	Inpatient services	$500 copay/admission	Not Covered	

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsnm.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you are pregnant	Office visits	$25 copay/visit; deductible does not apply	Not Covered	Copay charged for initial visit only. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	$25 copay PPP $45 copay specialist; deductible does not apply	Not Covered	
	Childbirth/delivery facility services	$500 copay/admission	Not Covered	Preauthorization required. Inpatient physician services are No Charge after deductible.
If you need help recovering or have other special health needs	Home health care	$45 copay/physician visit No Charge for nurse visit; deductible does not apply	Not Covered	None
	Rehabilitation services	$45 copay/visit; deductible does not apply	Not Covered	Includes physical, occupational, and speech therapies (office/outpatient).
	Habilitation services	$45 copay/visit; deductible does not apply	Not Covered	
	Skilled nursing care	$500 copay/admission	Not Covered	Preauthorization required for inpatient physical rehabilitation. Related professional services are No Charge after deductible
	Durable medical equipment	20% coinsurance	Not Covered	None
	Hospice services	No Charge; deductible does not apply	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	If vision coverage purchased, see your vision plan information.
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	If dental coverage purchased, see your dental plan information.

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.)

- Cosmetic surgery
- Dental care (Adult, routine dental)
- Infertility treatment (unless for medical condition causing the infertility)
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (unless you are diabetic)
- Weight loss programs

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

- Acupuncture (max 25 visits/year combined with chiropractic care)
- Bariatric surgery
- Chiropractic care (max 25 visits/year combined with acupuncture)
- Hearing aids (Adults and children, limited to $2,500 per ear, per 3 year period from date of purchase)
- Non-emergency care when traveling outside the U.S.

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 1-877-994-2583, 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.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsnm.com.

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: Blue Cross and Blue Shield of New Mexico (BCBSNM) Appeals Unit at 1-800-205-9926 or visit www.bcbsnm.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the New Mexico Superintendent of Insurance toll-free at 1-855-427-5674 or www.osi.state.nm.us.

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 the 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:
Spanish (Español): Para obtener asistencia en Español, llame al 1-877-994-2583.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-994-2583.
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-877-994-2583.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-994-2583.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsnm.com.

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	$350
Specialist *copayments*	$45
Hospital (facility) *copayments*	$500
Other *coinsurance*	20%

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	**$12,700**

In this example, Peg would pay:

Cost sharing	
Deductibles	$350
Copayments	$600
Coinsurance	$100
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	**$1,150**

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

The plan's overall deductible	$350
Specialist *copayments*	$45
Hospital (facility) *copayments*	$500
Other *coinsurance*	20%

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	**$7,400**

In this example, Joe would pay:

Cost sharing	
Deductibles	$350
Copayments	$300
Coinsurance	$300
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$5,250**

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

The plan's overall deductible	$350
Specialist *copayments*	$45
Hospital (facility) *copayments*	$500
Other *coinsurance*	20%

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	**$2,000**

In this example, Mia would pay:

Cost sharing	
Deductibles	$300
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$900**

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

BlueCross BlueShield of New Mexico

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost.
To speak to an interpreter, call the customer service number on the back of your member card. If you are not a member, or don't have a card, call 855-710-6984.

العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث إلى مترجم فوري، اتصل على رقم خدمة العملاء المذكور على ظهر بطاقة عضويتك. فإن لم تكن عضوًا، أو كنت لا تملك بطاقة، فاتصل على 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請致電印在您的會員卡背面的客戶服務電話號碼。如果您不是會員, 或沒有會員卡, 請致電 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, composez le numéro du service client indiqué au verso de votre carte de membre. Si vous n'êtes pas membre ou si vous n'avez pas de carte, veuillez composer le 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Kundenservicenummer auf der Rückseite Ihrer Mitgliedskarte an. Falls Sie kein Mitglied sind oder keine Mitgliedskarte besitzen, rufen Sie bitte 855-710-6984 an.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए, अपने सदस्य कार्ड के पीछे दिए गए ग्राहक सेवा नंबर पर कॉल करें। यदि आप सदस्य नहीं हैं, या आपके पास कार्ड नहीं है, तो 855-710-6984 पर कॉल करें।
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il servizio clienti al numero riportato sul lato posteriore della tua tessera di socio. Se non sei socio o non possiedi una tessera, puoi chiamare il numero 855-710-6984.
日本語 Japanese	ご本人様、またはお客様の身の回りの方でも、ご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、メンバーカードの裏のカスタマーサービス番号までお電話ください。メンバーでない場合またはカードをお持ちでない場合は 855-710-6984 までお電話ください。
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 회원 카드 뒷면에 있는고객 서비스 번호로 전화하십시오. 회원이 아니시거나 카드가 없으시면 855-710-6984 으로 전화주십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídílkidgo, ts'ídá bee ná ahóóti'i' t'áá níik'e níká a'doolwoł. Ata' halne'í bich'į' hadeesdzih nínízingo éí kwe'é da'íníishgi áká anídaalwo'ígíí bich'į' hodíílnih, bee nééhózinii bine'dęę' bikáá'. Kojí atah naaltsoos ná hadít'éégóó éí doodago bee nééhózinígíí ádingo koji' hodíílnih 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با خدمات مشتری به شماره ای که در پشت کارت عضویت شما درج شده است تماس بگیرید. اگر عضو نیستید، یا کارت عضویت ندارید، با شماره 855-710-6984 تماس حاصل نمایید.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы поговорить с переводчиком, позвоните в отдел обслуживания клиентов по телефону, указанному на обратной стороне вашей карточки участника. Если вы не являетесь участником или у вас нет карточки, позвоните по телефону 855-710-6984.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete comuníquese con el número del Servicio al Cliente que figura en el reverso de su tarjeta de miembro. Si usted no es miembro o no posee una tarjeta, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa numero ng serbisyo para sa kustomer sa likod ng iyong kard ng miyembro. Kung ikaw ay hindi isang miyembro, o kaya ay walang kard, tumawag sa 855-710-6984.
ไทย Thai	หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีข้อสงสัยใด ๆ คุณมีสิทธิที่จะได้รับความช่วยเหลือ และข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่ามโดยติดต่อฝ่ายบริการลูกค้าที่หมายเลขตามที่ระบุด้านหลังบัตรสมาชิก หากไม่ใช่สมาชิกหรือไม่มีบัตร กรุณาติดต่อที่หมายเลข 855-710-6984
Tiếng Việt Vietnamese	Nếu quý vị hoặc người mà quý vị giúp đỡ có bất kỳ câu hỏi nào, quý vị có quyền được hỗ trợ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, gọi số dịch vụ khách hàng nằm ở phía sau thẻ hội viên của quý vị. Nếu quý vị không phải là hội viên hoặc không có thẻ, gọi số 855-710-6984.

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator	Phone:	855-664-7270 (voicemail)
300 E. Randolph St.	TTY/TDD:	855-661-6965
35th Floor	Fax:	855-661-6960
Chicago, Illinois 60601	Email:	CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building 1019	Complaint Portal:	https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Washington, DC 20201	Complaint Forms:	http://www.hhs.gov/ocr/office/file/index.html

PRESBYTERIAN **State of New Mexico Fam**

Coverage for: Individual or 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 1-888-275-7737 or visit www.phs.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 http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-888-275-7737 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$350** Individual/ **$675** Two-person/ **$1,000** Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. preventive care is covered before you meet your deductible.	This plan covers some items and services even if you havent yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive care without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/sbc-glossary/#preventive-care.
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?	**$3,500** Single/**$7,000** Two-person/**$10,500** Family.	The out of pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, health care this plan doesn't cover, and penalty amounts.	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.phs.org or call 1-888-275-7737** for a list of participating 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 for the difference between the provider's charge and what your plan pays (balance billing).
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
		In-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. Video visit - No charge	Not covered	Deductible does not apply.
	Specialist visit	$45 copayment/visit	Not covered	Deductible does not apply.
	Preventive care/screening/immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered	Coverage is limited up to a maximum of $200 per test/day. Prior authorization may be required.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at phs.org/formsanddocuments	Generic drugs (Tier 1)	Not covered	Not covered	Administered by Express Scripts - contact at 1-800-743-1720.
	Preferred brand drugs (Tier 2)	Not covered	Not covered	
	Non-preferred brand drugs (Tier 3)	Not covered	Not covered	
	Specialty drugs (Tier 4)	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	----------None----------
	Physician/surgeon fees	20% coinsurance	Not covered	Facility claim only
If you need immediate medical attention	Emergency room care	$250 copayment/visit	$250 copayment /visit	Waived if admitted into a hospital, then hospital copayment applies.
	Emergency medical transportation	$30 copayment/trip ground; $100 copayment/trip air	$30 copayment/trip ground; $100 copayment/trip air	----------None----------
	Urgent care	$50 copayment/visit	$50 copayment/visit	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copayment/admission	Not covered	Prior authorization may be required.
	Physician/surgeon fees	No change	Not covered	Prior authorization may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copayment/visit	Not covered	----------None----------
	Inpatient services	$500 copayment/admission	Not covered	Prior authorization may be required.
If you are pregnant	Office visits	$25 copayment initial visit only	Not covered.	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	No charge	Not covered	----------None----------
	Childbirth/delivery facility services	$500 copayment/pregnancy	Not covered	----------None----------
If you need help recovering or have other special health needs	Home health care	$45 copayment/physician services	Not covered	No charge for nursing services.Deductible does not apply. Prior authorization may be required.
	Rehabilitation services	Inpatient: $500 copayment/admission; Outpatient: $45 copayment/visit	Not covered	Office visit. Deductible does not apply. Prior authorization may be required.
	Habilitation services	$45 copayment/visit	Not covered	----------None----------
	Skilled nursing care	$500 copayment/admission	Not covered	Admission copayment waived if readmitted within 15 days. Prior authorization may be required.
	Durable medical equipment	20% coinsurance	Not covered	Prior authorization may be required.
	Hospice services	No charge	Not covered	Deductible does not apply. Prior authorization may be required.
If your child needs dental or eye care	Children's eye exam	20% coinsurance	Not covered	----------None----------
	Children's glasses	20% coinsurance	Not covered	Prior authorization may be required.
	Children's dental check-up	Not covered	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.)

- Cosmetic Surgery
- Dental Care (Adult)
- Dental check-up (Child)
- Eye exam (Child)
- Glasses (Child)
- Infertility Treatment
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Private-Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

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

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 appeal. 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, you may contact the Office of the Superintendent of Insurance Managed Health Care Bureau at 1-855-427-5674 or by email at mhcb.grievance@state.nm.us.

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 Standard, you may be eligible for a premium tax credits to help you pay for a plan through the Marketplace.

Language Access Services:

Para obtener asistencia en Español, llame al 1-888-275-7737.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-275-7737.

如果需要中文的帮助，请拨打这个号码 1-888-275-7737.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-275-7737.

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	$350
Specialist	$45
Hospital (Facility)	$500
Other	No Charge

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	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$350
Copayments	$50
Coinsurance	$209
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$669

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

The plan's overall deductible	$350
Specialist	$45
Hospital (Facility)	$500
Other	No Charge

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	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$107
Copayments	$290
Coinsurance	$27
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$479

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

The plan's overall deductible	$350
Specialist	$45
Hospital (Facility)	$500
Other	No Charge

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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$53
Copayments	$405
Coinsurance	$13
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$472

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

Notice of Nondiscrimination and Accessibility

Discrimination is Against the Law

Presbyterian Healthcare Services complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Presbyterian Healthcare Services does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Presbyterian Healthcare Services:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Presbyterian Customer Service Center at 505- 923-5420, 1-855-592-7737, TTY: 711.

If you believe that Presbyterian Healthcare Services has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance. You can file a grievance in person, or by mail, fax, or email. If you need help filing a grievance, the Privacy Officer and Civil Rights Coordinator is available to help you.

Presbyterian Privacy Officer and Civil Rights Coordinator
P.O. Box 27489
Albuquerque, NM 87125

Phone: 1-866-977-3021, TTY: 711
Fax: 505-923-5124
Email: info@phs.org

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201

Phone: 1-800-368-1019, 1-800-537-7697 (TDD)
Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

PRESBYTERIAN

Multi-Language Interpreter Services

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 505-923-5420, 1-855-592-7737 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 505-923-5420, 1-855-592-7737 (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 505-923-5420, 1-855-592-7737 (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 505-923-5420, 1-855-592-7737 (TTY: 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 505-923-5420, 1-855-592-7737 (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 505-923-5420, 1-855-592-7737 (TTY: 711)。
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (TTY:711), 505-923-5420 1-855-592-7737 رقم هاتف الصم والبكم.
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 505-923-5420, 1-855-592-7737 (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 505-923-5420, 1-855-592-7737 (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。505-923-5420, 1-855-592-7737 (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 505-923-5420, 1-855-592-7737 (ATS: 711).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 505-923-5420, 1-855-592-7737 (TTY: 711).
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 505-923-5420, 1-855-592-7737 (телетайп: 711).
Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 505-923-5420, 1-855-592-7737 (TTY: 711) पर कॉल करें।
Farsi	توجه: اگر به زبان انگلیسی صحبت می کنید، سرویس های دستیار زبان به صورت رایگان در اختیارتان قرار می گیرند. با شماره 505-923-5420، 1-855-592-7737 (TTY: 711) تماس بگیرید.
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 505-923-5420, 1-855-592-7737 (TTY: 711).

PRESBYTERIAN

PresRN

Presbyterian Health Plan members have access to PresRN, a nurse advice line available to you 24 hours a day, 7 days a week, including holidays. There is no charge to call our experienced registered nurses (RN) for answers to your questions and health concerns. As always, if you are having a medical emergency, please call 911.

What is PresRN?

PresRN is an easy way to speak with a Presbyterian nurse if you are not feeling well and do not know what to do. Just call the phone number for your health plan and one of our qualified nurses will listen to your health concerns and give you the answers that you need to care for you and your family. Our Presbyterian nurses are happy to answer general health questions when you are healthy too.

- Phone: 505-923-5570 or 1-866-221-9679

Your benefit at a glance

EXPRESS SCRIPTS®

Express Scripts Prescription Drug Benefit

For The State of New Mexico – January to December 2018

	Retail (30-day supply)	Mail Order (90-day supply)
Out of Pocket	$3,500 single / $10,500 family (accumulated with Medical OOP towards annual max)	
Deductible**	$50 Individual / $100 Family only on Non-Generics (applies to Medical annual OOP Max)	
Generic	$6	$17
Brand (Preferred)	30% ($35 min / $95 max)	$120
Brand (Non-Preferred)	40% ($60 min / $130 max)	$155
Specialty Medications (30 day supply) - must move to mail order after 2 fills at retail	$60 Generic $85 Preferred Brand $125 Non-preferred Brand	$60 Generic $85 Preferred Brand $125 Non-preferred Brand

***** Deductible - For Single/Individual coverage**, a one-time $50 deductible will be charged on the first fill of a non-generic medication at retail or mail order. The $50 deductible will apply toward the total medical OOP maximum. Once that $50 deductible is met, there will be no further deductible charged on any individual claim for the remainder of the plan year.*

*** **Deductible - For Family coverage, or single + child(ren),** a one-time $100 deductible will be charged on the first fill of a non-generic medication at retail or mail order. The $100 deductible will apply toward the total medical OOP maximum. Once that $100 deductible is met, there will be no further deductible charged on any individual claim for the remainder of the plan year.*

******Product Selection Cost -** If you obtain a brand-name drug when a generic equivalent is available, you are responsible for the generic copayment plus the cost difference between the brand-name drug and the generic drug.*

Saving with Home Delivery

Use Express Scripts home delivery pharmacy to fill your maintenance medications (those prescription drugs you take regularly to treat an ongoing condition). We deliver up to a 90-day supply to you with free standard shipping. Three retail fills are allowed on maintenance medications before your copay will increase to the mail order copays shown above (for a 30 day supply).

Saving with Generics

FDA-approved generics are as safe and effective as their brand-name counterparts. If you're taking a brand-name drug, talk to your doctor and ask whether a less expensive generic drug could treat your condition. If your doctor agrees, ask your doctor to write a new prescription for the generic that you can fill through your prescription benefit.

Home Delivery… it's quick and easy

call us and we will contact your doctor to get a new 90-day prescription or have your doctor fax it to us.

Manage your prescription online and on the go	Register at express-scripts.com	Download the Express Scripts Mobile App
Receive Prescription Reminders	✓	✓
Search for lower cost options using My Rx Choices	✓	✓
Receive Prescription and Drug Interaction Alerts	✓	✓
Show your virtual ID card at a retail pharmacy		✓
Contact a pharmacist	✓	
Check your coverage, claims and balances	✓	
Print claim forms, order forms and fax forms	✓	

DELTA DENTAL®

State of New Mexico Dental Plan
Administered by Delta Dental of New Mexico

Network Information

In-Network Providers in New Mexico: PPONew Mexico

The State of New Mexico Dental Plan features the PPONew Mexico network, a preferred Provider network with more than 2,200 access points in New Mexico.[1] This network is designed to offer members savings based on Provider discounts (Maximum Approved Fees) while giving access to general Providers and specialists in every category. In addition, Benefit levels are enhanced when you select a PPONew Mexico Provider.

In-Network Providers in Other States: Delta Dental PPO℠

Outside of New Mexico, the Delta Dental PPO network is considered in-network. Delta Dental PPO is a national preferred Provider network with more than 282,000 office locations nationwide.[2]

Reduce your out-of-pocket costs by always selecting an in-network Provider. By selecting Participating Providers, you are only responsible for your Coinsurance and Deductible, if applicable, at the time you receive services. No balance billing applies and your Provider will file claims on your behalf.

Choosing an In-Network Provider

Delta Dental has multiple Provider networks, and not every Provider participates in every network. When asking a Provider if he or she participates with Delta Dental, make sure to specify the PPONew Mexico Provider network (or Delta Dental PPO, if outside New Mexico). You can search for Providers on www.deltadentalnm.com under the "Find a Dentist" link, or in the Delta Dental mobile app.

Out-of-Network Providers

Out-of-network Providers have not agreed to the Provider fee maximums applicable under the dental Plan. Your out-of-pocket costs can be much higher because you may be balance billed for the difference up to the full amount charged by the Provider. Further, you may have to pay the full amount at the time you receive services and submit a claim for reimbursement. Reduced Benefit levels apply to out-of-network services.

Specified Medical Conditions

The State of New Mexico Plan covers routine cleanings twice per year. For members with periodontal disease and some specific at-risk health conditions, additional cleanings or topical fluoride treatment are available. The patient should talk with his or her Provider about treatment.

Quick Bite: Pre-Treatment Estimates—Be in the Know

Are you anticipating a potentially costly procedure such as a crown or root canal? Request a Pre-Treatment Estimate prior to scheduling dental services to get an estimate of what your share of the cost will be. Talk with your Provider and ask him/her to submit a Pre-Treatment Estimate. Delta Dental will respond in writing to you and your Provider. Be a wise consumer and avoid potential additional expenses by taking advantage of this free service.

Contact

Phone: (505) 855-7111 or toll-free (877) 395-9420
Email: customerservice@deltadentalnm.com
Web: www.deltadentalnm.com
Mobile App: Download the Delta Dental mobile app on the App Store (Apple) or Google Play (Android)

Access 24/7

Delta Dental's automated voice response system is available 24/7 to help you with topics such as Benefit/eligibility verification, requesting an ID card, Provider directories (fax, voice, or email), and checking claim/Pre-Treatment Estimate status.

1. Network data for PPONew Mexico. Delta Dental of New Mexico. Accessed September 20, 2017.
2. "Delta Dental by the Numbers." Delta Dental Plans Association. Web. Accessed September 20, 2017. www.deltadental.com/Public/Company/stats2.jsp

PPONew Mexico Network – 2018 – *Dental Plan Administered by Delta Dental of New Mexico*		
Benefit Category	***In Network:***	***Out of Network:****
Diagnostic and Preventive Services		
Oral Exams (two routine per calendar year)	Plan Pays 100% You Pay 0%	Plan Pays 100% You Pay 0%*
Routine or Periodontal Cleanings (two per calendar year or up to two additional for specified at-risk medical conditions)		
Radiographic Images (full mouth: once every five years; bitewings: twice in a calendar year)		
Topical Fluoride (through age 18, twice per calendar year)		
Emergency Treatment for Relief of Pain		
Sealants (through age 15, permanent molars only, three year limitation)		
Space Maintainers (through age 18, five year limitation)		
Basic Services		
Amalgam or Composite Fillings	Plan Pays 100% You Pay 20%	Plan Pays 55% You Pay 45%*
Stainless Steel Crowns (primary teeth only)		
Oral Surgery (maxillofacial surgical procedures of the oral cavity, including extractions)		
Endodontics (pulp therapy and root canal filling)		
Periodontics (non-surgical and surgical treatment of gum disease)		
Repairs to Crowns, Implants, Onlays, Bridges, and Partial or Complete Dentures		
Adjustments to Partial or Complete Dentures		
General Anesthesia (intravenous sedation and general anesthesia, when Dentally Necessary and administered by a licensed Provider for a covered oral surgery procedure)		
Major Services		
Prosthodontic procedures for construction of fixed bridges, partials, or complete dentures	Plan Pays 60% You Pay 40%	Plan Pays 35% You Pay 65%*
Implants (specified services, including repairs, and related prosthodontics, subject to clinical review/approval)		
Onlays, Crowns, and Cast Restorations (when teeth cannot be restored with amalgam or composite resin restorations)		
Orthodontic Services		
Children up to 18th birthday	Plan Pays 75% up to a $2,000 lifetime maximum You Pay 25%*	
Adults, 18 and over	Plan Pays 60% up to a $1,750 lifetime maximum You Pay 40%*	
Deductibles and Maximums		
Calendar Year Deductible—Jan. 1 – Dec. 31. (Does not apply to Diagnostic and Preventive Services or Orthodontic Services)	You Pay $50 per Enrolled Person $150 per Family	
Calendar Year Maximum—Jan. 1 – Dec. 31. (Excludes expenses for Orthodontic Services)	Plan Pays up to $1,750 per Enrolled Person	

**Selecting a Non-Participating Provider may result in higher out-of-pocket expenses, even when there is no change in Benefit level between in-network and out-of-network Benefits. Non-Participating Providers do not accept Delta Dental's Maximum Approved Fees as payment in full. You will be financially responsible for balance billed amounts, or amounts that exceed the Non-Participating Provider's reimbursement.*

This Benefit comparison has been prepared as a general description to highlight some of the Benefits available under your dental Plan. It does not reflect all Benefits, limitations, and exclusions, or provide complete coverage information. Delta Dental will provide complete coverage descriptions when you enroll.

The State of New Mexico

DAVIS VISION
EYECARE REFRAMED℠

Welcome to Davis Vision!

We are pleased to provide you with information on your vision benefit to help you care for your vision and eye health - a key part of overall health and wellness!

If you are not currently enrolled, please visit our member site at davisvision.com or call 1.877.923.2847 to locate providers or for additional information.

Using your benefits is easy! Just log on to our Member site at davisvision.com and click "Find a Provider," or call us at 1.800.999.5431.

Make an appointment. Tell your provider you are a Davis Vision member with coverage through The State of New Mexico. Provide your member ID number, name and date of birth, and do the same for your covered dependents seeking vision services. Your provider will take care of the rest!

Your Davis Vision Premier Plan Benefits

100% OF YOUR CALLS & CLAIMS ARE PROUDLY ADMINISTERED IN THE USA

Benefit	Frequency Once every -	In-network Copay	In-network Coverage
Eye Examination	12 months	$10	Covered in full. *Includes dilation when professionally indicated.*
Spectacle Lenses	12 months	$15	Clear plastic lenses in any single vision, bifocal, trifocal or lenticular prescription. Covered in full. (See below for additional lens options and coatings.)
Frame	24 months	$0	**Covered in Full Frames:** Any Fashion, Designer or Premier level frame from Davis Vision's Collection[2] (retail value, up to $190). **OR, Frame Allowance:** $150 toward any frame from provider plus 20% off any balance.[1] No copay required. **OR, Visionworks Frame Allowance:** $200 allowance plus 20% off any balance toward any frame from a Visionworks family of store locations.[5] No copay required.
Contact Lens Evaluation, Fitting & Follow Up Care	12 months	$0	**Davis Vision Collection Contacts:** Covered in full. **Non Collection Contacts[3]:** $60 allowance plus 15% off balance[1].
Contact Lenses (in lieu of eyeglasses)	12 months	$0	**Covered in Full Contacts:** From Davis Vision's Collection[2], up to: Planned Replacement: Four boxes/multi-packs* Disposable: Eight boxes/multi-packs* **OR, Contact Lens Allowance:** $150 allowance toward any contacts from provider's supply plus 15% off balance.[1] No copay required. **OR, Visually Required Contacts:** Covered in full with prior approval. **Number of contact lens boxes may vary based on manufacturer's packaging.*

Significant savings on optional frames, lens types and coatings! Member Price

Davis Vision Collection Frames: Fashion | Designer | Premier	$0 | $0 | $0
Tinting of Plastic Lenses	$0
Oversize Lenses	$0
Scratch-Resistant Coating	$0
Ultraviolet Coating	$12
Anti-Reflective Coating: Standard | Premium | Ultra	$35 | $48 | $60
Polycarbonate Lenses	$0[4]-$30
High-Index Lenses	$55
Progressive Lenses: Standard | Premium | Ultra	$50 | $90 | $140
Polarized Lenses	$75
Photochromic Lenses (i.e. Transitions®, etc.)[6]	$65
Scratch Protection Plan: Single Vision | Multifocal Lenses	$20 | $40

[1] *Additional discounts not applicable at Walmart, Sam's Club or Costco locations*
[2] *The Davis Vision Collection is available at most participating independent provider locations.*
[3] *Including, but not limited to toric, multifocal and gas permeable contact lenses.*
[4] *For dependent children, monocular patients and patients with prescriptions of +/- 6.00 diopters or greater.*
[5] *Enhanced frame allowance available at all Visionworks Locations nationwide.*
[6] *Transitions™ is a registered trademark of Transitions Optical Inc.*

Please note: Your provider reserves the right to not dispense materials until all applicable member costs, fees and copayments have been collected. Contact lenses: Routine eye examinations do not include professional services for contact lens evaluations. Any applicable fees above the evaluation and fitting allowance are the responsibility of the member. If contact lenses are selected and fitted, they may not be exchanged for eyeglasses. Progressive lenses: If you are unable to adapt to progressive addition lenses you have purchased, conventional bifocals will be supplied at no additional cost; however, your copayment is nonrefundable. May not be combined with other discounts or offers. Please be advised these lens options and copayments apply to in-network benefits.

Frequently Asked Questions

How can I contact Member Services?
Call 1.800.999.5431 for automated help 24/7. Live help is also available seven days a week: Monday-Friday, 8 a.m.-11 p.m. | Saturday, 9 a.m.-4 p.m. | Sunday, 12 p.m.-4 p.m. (Eastern Time). (TTY services: 1.800.523.2847.)

What frames are in Davis Vision's Collection?
Our Collection offers a great selection of fashionable and designer frames, most of which are covered in full. No wonder 8 out of 10 members select a Collection frame. Log on to our member Web site at davisvision.com and take a look!

When will I receive my eyewear?
Your eyewear will be delivered to your network provider generally within five business days of order receipt. Special prescriptions, lens coatings, provider frames or out-of-stock frames may delay the standard turnaround time.

Do I need a claim form?
Claim forms are only required if you visit an out-of-network provider. Claim forms are available on our member Web site.

Can I split my benefits?
You may split your benefits by receiving your eye examination and eyeglasses or contact lenses on different dates or through different provider locations. To maximize your benefit value we recommend that all services be obtained from a network provider.

Can I use an out-of-network provider?
Yes; however, you receive the greatest value by staying in-network. If you go out-of-network, pay the provider at the time of service, then submit a claim to Davis Vision for reimbursement, up to the following amounts: eye exam - $40 | single vision lenses - $40 | bifocal - $60 | trifocal - $80 | lenticular - $100 | frame - $50 | elective contacts - $105 | visually required contacts - $225.

Are there any exclusions to the vision benefits?
Your vision plan does not cover medical treatment of eye disease or injury; vision therapy; special lens designs or coatings, other than those described herein; replacement of lost eyewear; non-prescription (plano) lenses; contact lenses and eyeglasses in the same benefit cycle; services not performed by licensed personnel; two pair of eyeglasses in lieu of bifocals.

DAVIS VISION EXTRAS!

One Year Breakage Warranty Repair or replacement of your plan covered spectacle lenses, Collection frame or frame from a network retail location where the Collection is not displayed.

Greater Benefits Access a higher frame allowance by visiting a Visionworks family of store locations[7].

Additional Savings At most participating network locations, members receive up to 20% off additional eyeglasses, sunglasses and items not covered by the benefit and 10% off disposable contact lenses.[8]

Mail Order Contact Lenses Replacement contacts (after initial benefit) through www.DavisVisionContacts.com mail-order service ensures easy, convenient, purchasing online and quick, direct shipping to your door. Log on to our member Web site for details.

Laser Vision Correction Up to 25% discount off participating provider's U&C or 5% off advertised special (whichever is lower). Log on to our member Web site for details and to locate a provider.

Low Vision Services Comprehensive low vision evaluation once every five years and low vision aids up to the plan maximum. Covers up to four follow-up visits in five years.

Eye Health & Wellness Log on and learn more about your eyes, health and wellness; common eye conditions that can impair vision; and what you can do to ensure healthy eyes and a healthier life.

For more details... about your vision benefits, patient rights and responsibilities, or more information about Davis Vision, please log on to our member Web site or contact us at 1.800.999.5431.

Davis Vision has made every effort to correctly summarize your vision plan features herein. In the event of a conflict between this information and your organization's contract with Davis Vision, the terms of the contract will prevail.

[7] Enhanced frame allowance available at all Visionworks Locations nationwide.

[8] Additional discounts not applicable at Walmart, Sam's Club or Costco locations.

Lea County Group Number: 30072336

Your Vision Benefits Summary

Get the best in eye care and eyewear with LEA COUNTY GOVERNMENT and VSP® Vision Care.

Using your VSP benefit is easy.

- **Create an account at vsp.com.** Once your plan is effective, review your benefit information.
- **Find an eye care provider who's right for you.** The decision is yours to make—choose a VSP doctor, a participating retail chain, or any out-of-network provider. To find a VSP provider, visit **vsp.com** or call **800.877.7195**.
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on **vsp.com**.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP provider.

Best Eye Care

You'll get the highest level of care, including a WellVision Exam®– the most comprehensive exam designed to detect eye and health conditions. Plus, when you see a VSP provider, you'll get the most out of your benefit, have lower out-of-pocket costs, and your satisfaction is guaranteed.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like bebe®, Calvin Klein, Cole Haan, Flexon®, Lacoste, Nike, Nine West, and more[1]. Visit **vsp.com** to find a Premier Program location that carries these brands. Prefer to shop online? Check out all of the brands at **Eyeconic.com**, VSP's online eyewear store.

Plan Information

VSP Coverage Effective Date: 01/01/2017
VSP Provider Network: VSP Signature

LEA COUNTY GOVERNMENT and VSP provide you with an affordable eyecare plan.

Benefit	Description	Copay
Your Coverage with a VSP Provider		
WellVision Exam	• Focuses on your eyes and overall wellness • Every calendar year	$10
Prescription Glasses		$20
Frame	• $130 allowance for a wide selection of frames • $150 allowance for featured frame brands • 20% savings on the amount over your allowance • $70 Costco® frame allowance • Every other calendar year	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • Every calendar year	Included in Prescription Glasses
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 35-40% on other lens enhancements • Every calendar year	$50 $80 - $90 $120 - $160
Contacts (instead of glasses)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every calendar year	Up to $60
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam. **Retinal Screening** • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities	

Your Coverage with Out-of-Network Providers

Visit **vsp.com** for details, if you plan to see a provider other than a VSP network provider.

Exam	up to $50	Lined Trifocal Lenses	up to $100
Frame	up to $70	Progressive Lenses	up to $75
Single Vision Lenses	up to $50	Contacts	up to $105
Lined Bifocal Lenses	up to $75		

Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location.

Visit vsp.com or call 800.877.7195 for more details on your vision coverage and exclusive savings and promotions for VSP members.

[1]Brands/Promotion subject to change.

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