



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, visit <https://Ambetter.WesternSkyCommunityCare.com/2021-brochures.html>, or call 1-833-945-2029 (TTY 711). 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.healthcare.gov/sbc-glossary> or call 1-833-945-2029 (TTY 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0	See the Common Medical Events chart below for your cost for services this plan covers.
Are there services covered before you meet your deductible ?	There is no deductible .	There is no 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 network providers : \$2,850 individual / \$5,700 family. Not applicable for out-of-network providers .	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 , balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See http://ambetter.westernskycommunitycare.com/findadoc or call 1-833-945-2029 (TTY 711) 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 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
		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	\$10 Copay / visit	Not covered	Virtual Visits from Ambetter Health covered at \$0, providers covered in full.
	Specialist visit	\$35 Copay / visit	Not covered	----None----
	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)	\$30 Copay / test for laboratory outpatient & professional services; 40% Coinsurance for x-ray and diagnostic imaging	Not covered	Prior authorization may be required. Covered no limit. Prior authorization not required for gynecological or obstetrical diagnostic ultrasounds. Failure to obtain prior authorization for any service that requires prior authorization may result in reduction of benefits. Testing and delivery of health care services for COVID-19 are cost-share free. See your policy for more details.
	Imaging (CT/PET scans, MRIs)	40% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://Ambetter.WesternSkyCommunityCare.com/2021formulary .	Generic drugs (Tier 1)	Retail: \$10 Copay / prescription	Not covered	Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail cost sharing amount. Insulin or medically necessary alternative will not exceed a total of \$25.00 per 30-day supply.
	Preferred brand drugs (Tier 2)	Retail: \$40 Copay / prescription	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail cost sharing amount. Insulin or medically necessary alternative will not exceed a total of \$25.00 per 30-day supply.
	Non-preferred brand drugs (Tier 3)	Retail: 50% Coinsurance	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)	
	Specialty drugs (Tier 4)	Retail: 50% Coinsurance	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 30 days through mail order. Insulin or medically necessary alternative will not exceed a total of \$25.00 per 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	40% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If you need immediate medical attention	Emergency room care	40% Coinsurance	40% Coinsurance ; deductible does not apply	For emergency care received out-of-network, you should not be balance-billed by the provider, if you are, please contact Member Services.
	Emergency medical transportation	40% Coinsurance	40% Coinsurance ; deductible does not apply	For emergency care received out-of-network, you should not be balance-billed by the provider, if you are, please contact Member Services.
	Urgent care	\$10 Copay / visit	\$10 Copay / visit; deductible does not apply	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	40% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	40% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 Copay / Office Visit; 40% Coinsurance for all other outpatient services	Not covered	Prior authorization may be required. Covered No Limit. (PCP and other practitioner visits do not require prior authorization).
	Inpatient services	40% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If you are pregnant	Office visits	\$10 Copay / visit	Not covered	Prior authorization not required for deliveries within the standard timeframe per federal regulation, but may be required for other services. Cost sharing does not apply for

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)	
				preventive services , such as routine pre-natal and post-natal screenings. Depending on the type of services, coinsurance , deductible or copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	40% Coinsurance	Not covered	Prior authorization may be required. Cost sharing does not apply for preventive services . Depending on the type of services, copayment , coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	40% Coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	40% Coinsurance	Not covered	Prior authorization may be required. Limited to 100 visits per year.
	Rehabilitation services	\$10 Copay / visit	Not covered	Prior authorization may be required. Covered No Limit.
	Habilitation services	\$10 Copay / visit	Not covered	Prior authorization may be required. Covered No Limit.
	Skilled nursing care	40% Coinsurance	Not covered	Prior authorization may be required. Limited to 60 days per year.
	Durable medical equipment	40% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Hospice services	40% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to 1 visit per year.
	Children's glasses	No charge	Not covered	Limited to 1 item per year.
	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](#).)

- Abortion (Except in cases of rape, incest, or when the life of the mother is endangered)
- Cosmetic surgery
- Dental care
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Weight loss programs

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

- Acupuncture (Limited to 20 visits per year.)
- Bariatric surgery (Only covered if [medically necessary](#) treatment for morbid obesity.)
- Chiropractic care (Limited to 20 visits per year.)
- Hearing aids (Limited to 1 hearing aid per ear every 3 years.)
- Infertility treatment (Limited to services for [diagnostic tests](#) to find the cause of infertility. Services to treat the underlying medical conditions that cause infertility are covered (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency).)
- Routine foot care (Coverage is limited to diabetes care only.)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Ambetter from Western Sky Community Care at 1-833-945-2029 (TTY 711); Office of Superintendent of Insurance, PO Box 1689, Santa Fe, NM 87504-1689, Phone No. (855) 427-5674 Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Office of Superintendent of Insurance, PO Box 1689, Santa Fe, NM 87504-1689, Phone No. (855) 427-5674 Additionally, a consumer assistance program can help you file your [appeal](#). Contact (855) 427-5674

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:

Spanish (Español): Para obtener asistencia en Español, llame al 1-833-945-2029 (TTY 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-945-2029 (TTY 711).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-833-945-2029 (TTY 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-833-945-2029 (TTY 711).

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	\$0
■ Specialist copayment	\$35
■ Hospital (facility) coinsurance	40%
■ Other coinsurance	40%

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$400
Coinsurance	\$2,400
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,860

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$35
■ Hospital (facility) coinsurance	40%
■ Other coinsurance	40%

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	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$900
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,220

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$35
■ Hospital (facility) coinsurance	40%
■ Other coinsurance	40%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic tests](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$800
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,000

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter from Western Sky Community Care, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-833-945-2029 (TTY/TDD 711)
Navajo:	Diné k'chji yánilti'go ata' hanc' ná hóló dóó naaltsoos t'áá Diné k'chji bee bik'e'ashchijigo nich'i' ádoonililgo bee haz'á aldó' áko díi t'áá át'e t'áá jiik'e kót'éego nich'i' ąą'át'ě. Koji' hólne' 1-833-945-2029 (TTY/TDD 711)
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Western Sky Community Care, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-833-945-2029 (TTY/TDD 711).
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Western Sky Community Care hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-833-945-2029 (TTY/TDD 711) an.
Chinese:	如果您, 或是您正在協助的對象, 有關於 Ambetter from Western Sky Community Care 方面的問題, 您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話, 請撥電話 1-833-945-2029 (TTY/TDD 711)。
Arabic:	إذا كان لديك أو لدى شخص تساعد أسئلة حول Ambetter from Western Sky Community Care ، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-833-945-2029 (TTY/TDD 711)
orean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Western Sky Community Care 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-833-945-2029 (TTY/TDD 711) 로 전화하십시오.
Tagalog:	Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Ambetter from Western Sky Community Care, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-833-945-2029 (TTY/TDD 711).
Japanese:	Ambetter from Western Sky Community Care について何かご質問がございましたらご連絡ください。ご希望の言語によるサポートや情報を無料でご提供いたします。通訳が必要な場合は、1-833-945-2029 (TTY/TDD 711)までお電話ください。
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Western Sky Community Care, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-833-945-2029 (TTY/TDD 711)
Italian:	Se lei, o una persona che lei sta aiutando, avesse domande su Ambetter from Western Sky Community Care, ha diritto a usufruire gratuitamente di assistenza e informazioni nella sua lingua. Per parlare con un interprete, chiami l'1-833-945-2029 (TTY/TDD 711).
Russian:	: В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Western Sky Community Care вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-833-945-2029 (TTY/TDD 711).
Hindi:	आप या जिसकी आप मदद कर रहे हैं उनके, Ambetter from Western Sky Community Care के बारे में कोई सवाल हों, तो आपको बिना किसी खर्च के अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। किसी दुभाषिये से बात करने के लिए 1-833-945-2029 (TTY/TDD 711) पर कॉल करें।
Persian:	دارید، از این حق برخوردارید که کمک و اطلاعات Ambetter from Western Sky Community Care را به کسی که به او کمک می کنید سؤالی در مورد تماس بگیرید. 1-833-945-2029 (TTY/TDD 711) را بصورت رایگان به زبان خود دریافت کنید. برای صحبت کردن با مترجم با شماره
Thai:	หากท่านหรือผู้ที่ท่านให้ความช่วยเหลืออยู่ในขณะนี้มีความเกี่ยวข้องกับ Ambetter from Western Sky Community Care ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่าน โดยไม่เสียค่าใช้จ่ายใด ๆ ทั้งสิ้น หากต้องการใช้บริการล่าม กรุณาโทรศัพท์ติดต่อที่หมายเลข 1-833-945-2029 (TTY/TDD 711).

Statement of Non-Discrimination

Ambetter from Western Sky Community Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Ambetter from Western Sky Community Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Ambetter from Western Sky Community Care:

- 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 Ambetter from Western Sky Community Care at 1-833-945-2029 (TTY/TDD 711)

If you believe that Ambetter from Western Sky Community Care 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 with: Ambetter from Western Sky Community Care, Attn: Appeals and Grievances 12515-8 Research Blvd, Ste. 400 Austin, TX 78759, at 1-833-945-2029 (TTY/TDD 711), Fax 1-833-886-7956. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ambetter from Western Sky Community Care is available to help you. 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, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Managed Health Care Bureau
Office of Superintendent of Insurance
1120 Paseo De Peralta, Santa Fe, NM 87501
Tel: 1-505-827-3811
Toll Free: 1-855-427-5674
www.osi.state.nm.us

To complete the online Consumer Complaint Form or to download the form in English or in Spanish, visit <https://www.nmag.gov/consumer-complaint-instructions.aspx>.
State of New Mexico Office of the Attorney General
408 Galisteo Street
Villagra Building
Santa Fe, NM 87501
Toll Free (844) 255-9210
Phone: (505) 490-4060
Fax: (505) 490-4883