## Ambetter from Western Sky Community Care
## Elite Silver: 73% AV Level Silver Plan



**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/2023-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 individual / $0 family. | See the Common Medical Events chart below for your cost for services this plan covers. |
| **Are there services covered before you meet your deductible?** | Yes, except for Preferred Brand (Tier 2), Non-Preferred Brand (Tier 3), and Specialty drugs (Tier 4). | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | Yes, $1,500 individual / $3,000 family for prescription drug coverage. There are no other specific deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | For network providers: $7,250 individual / $14,500 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 the Bronze\|Silver\|Gold NM network at https://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 | $30 Copay / visit | Not covered | Unlimited Virtual Care Visits received from Ambetter Telehealth covered at No Charge, providers covered in full. |
| | Specialist visit | $60 Copay / visit | Not covered | Covered No Limit. |
| | 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) | $40 Copay / test for laboratory & professional services<br>50% Coinsurance for x-ray & diagnostic imaging<br>50% Coinsurance for laboratory & professional services and x-ray & diagnostic imaging at other places of service | Not covered | Prior authorization may be required. Covered No Limit. Other places of service may include Hospital, Emergency Room, or Outpatient Facility.<br><br>Failure to obtain prior authorization for any service that requires prior authorization may result in reduction of benefits. See your policy for more details. |
| | Imaging (CT/PET scans, MRIs) | 50% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at **https://ambetter.westernskycommunitycare.com/2023formulary**. | Generic drugs (Tier 1) | Preferred Generic Retail: $5 Copay / prescription<br>Generic Retail: $30 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 3x retail cost sharing amount. Insulin or medically necessary alternative will not exceed a total of twenty-five dollars ($25.00) per thirty-day supply. Note: Certain prescription drugs for preventive care, the treatment of mental illness, behavioral health, or substance abuse disorders will be covered at No Charge to you, when obtained from a participating |
| | Preferred brand drugs (Tier 2) | Retail: 45% Coinsurance; subject to Rx drug deductible | Not covered | |
| | Non-preferred brand drugs (Tier 3) | Retail: 50% Coinsurance; subject to Rx drug deductible | 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) | |
| | | | | pharmacy. See your plan's covered drug list for details. |
| | Specialty drugs (Tier 4) | Retail: 50% Coinsurance; subject to Rx drug deductible | 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 twenty-five dollars ($25.00) per thirty-day supply. Note: Certain prescription drugs for preventive care, the treatment of mental illness, behavioral health, or substance abuse disorders will be covered at No Charge to you, when obtained from a participating pharmacy. See your plan's covered drug list for details. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 50% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| | Physician/surgeon fees | 50% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| **If you need immediate medical attention** | Emergency room care | 50% Coinsurance | 50% 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 | 50% Coinsurance | 50% Coinsurance; deductible does not apply | Covered No Limit. Note: Prior authorization is not required for emergency transport. Non-emergent transport requires prior authorization. If you receive service from an out-of-network ground/water ambulance provider, you may be subject to balance billing. |
| | Urgent care | $50 Copay / visit | $50 Copay / visit; deductible does not apply | Covered No Limit. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 50% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |

| 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) | |
| | Physician/surgeon fees | 50% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | No charge | Not covered | Prior authorization may be required. Covered No Limit. (Primary care provider (PCP) and other practitioner visits do not require prior authorization). |
| | Inpatient services | No charge | Not covered | Prior authorization may be required. Covered No Limit. |
| **If you are pregnant** | Office visits | $30 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 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 | 50% 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 | 50% Coinsurance | Not covered | |
| **If you need help recovering or have other special health needs** | Home health care | 50% Coinsurance | Not covered | Prior authorization may be required. Limited to 100 days per year. |
| | Rehabilitation services | Outpatient: $30 Copay / visit Inpatient: 50% Coinsurance | Not covered | Outpatient: Prior authorization may be required. Covered No Limit. Inpatient: Prior authorization may be required. Covered No Limit. |
| | Habilitation services | Outpatient: $30 Copay Inpatient: | Not covered | Outpatient: Prior authorization may be required. Covered No Limit. |

| 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) | |
| | | 50% Coinsurance | | Inpatient: Prior authorization may be required. Covered No Limit. |
| | Skilled nursing care | 50% Coinsurance | Not covered | Prior authorization may be required. Limited to 60 days per year. |
| | Durable medical equipment | 50% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| | Hospice services | 50% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. Respite Care services are only available as part of hospice care for a period not to exceed 5 continuous days for every 60 days of hospice. No more than two respite care stays will be available during a hospice benefit period. |
| **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 (Adult)
- 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).)
- Long-Term Care (Long Term Acute Care is a covered benefit. Long Term Nursing Care/ Custodial Care is not a covered benefit.)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Weight loss programs (Dietary evaluations and counseling for the medical management of morbid obesity and obesity. Prescription drugs medically necessary for the treatment of obesity and morbid obesity are also covered.)

**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. Note: Acupuncture limits do not apply when services are provided for habilitative or rehabilitative purposes.)
- Bariatric surgery (Only covered if medically necessary treatment for morbid obesity.)
- Chiropractic care (Limited to 20 visits per year. Note: Chiropractic limits do not apply when services are provided for habilitative or rehabilitative purposes.)
- Hearing aids (Limited to 1 hearing aid per ear every 3 years.)
- Routine foot care

**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.; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272); or Office of Personnel Management Multi-State Plan Program at https://www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review/. 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.beWellnm.com or call (833) 862-3935.

**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 on how 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 (833) 415-0566

**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?** **Not Applicable**.
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, kwiijigo 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.***

*For more information about limitations and exceptions, see plan or policy document at https://api.centene.com/eoc/2023/39006NM001.pdf.

## 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 | $60 |
| Hospital (facility) coinsurance | 50% |
| Other coinsurance | 50% |

**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 * | $10 |
| Copayments | $500 |
| Coinsurance | $4,400 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$4,970** |

### 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 | $60 |
| Hospital (facility) coinsurance | 50% |
| Other coinsurance | 50% |

**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** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles * | $1,500 |
| Copayments | $600 |
| Coinsurance | $1,400 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$3,520** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copayment | $60 |
| Hospital (facility) coinsurance | 50% |
| Other coinsurance | 50% |

**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** |

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles * | $10 |
| Copayments | $300 |
| Coinsurance | $900 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,210** |

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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

**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 711).

**Navajo:** Din4 k'ehj7 y1n7[ti'go ata' hane' n1 h0l= d00 naaltsoos t'11 Din4 k'ehj7 bee bik'e'ashch%go nich'8' 1dooln7i[go bee haz'3 a[d0' 1ko d77 t'11 1t'4 t'11 j77k'e k0t'4ego nich'8' 22'1t'4. Koj8' h0lne' 1-833-945-2029 (TTY 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 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 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 711)。

**Arabic:** إذا كان لديك أو لدى شخص تساعده 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 711)

**Korean:** 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Western Sky Community Care에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는1-833-945-2029 (TTY 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 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 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 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 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 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 711) पर कॉल करें।

**Persian:** دارید، از این حق برخوردارید که کمک و اطلاعاتAmbetter from Western Sky Community Careاگر شما، یا کسي که به او کمک مي کنید سؤالي در مورد تماس بگیرید. 1-833-945-2029 (TTY 711)را بصورت رایگان به زبان خود دریافت کنید. براي صحبت کردن با مترجم با شماره

**Thai:** หากท่านหรือผู้ที่ท่านให้ความช่วยเหลืออยู่ในขณะนี้มีคำถามเกี่ยวกับ Ambetter from Western Sky Community Care ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่าน โดยไม่เสียค่าใช้จ่ายใด ๆ ทั้งสิ้น หากต้องการใช้บริการล่าม กรุณาโทรศัพท์ติดต่อที่หมายเลข 1-833-945-2029 (TTY 711).

AMB20-NM-C-00190

## 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 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, PO Box 10341 Van Nuys CA 91410, at 1-833-945-2029 (TTY 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
Sante Fe, NM 87501
Toll Free (844) 255-9210
Phone: (505) 490-4060
Fax: (505) 490-4883