



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 1-505-925-2432 or visit <http://unmmg.org/unmhealth>. 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](http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf) or call 1-505-925-2432 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	For the UNM Health and Extended Network <u>providers</u> : \$600 Individual/\$1,200 Family For <u>Out-of-Network Providers</u> : \$1,800 Individual/\$3,600 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your deductible?</b>	Yes. Certain <u>preventive care</u> , services that charge a <u>copay</u> , and <u>emergency room services</u> are covered before you meet your deductible.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> , but a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	For the UNM Health Network and Extended Network <u>providers</u> : \$3,000 Individual/\$6,000 Family For <u>Out-of-Network</u> : \$7,500 Individual/\$15,000 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the out-of-pocket limit?</b>	<u>Premiums</u> , <u>balanced-billed charges</u> , and healthcare this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://unmmg.org/unmhealth">http://unmmg.org/unmhealth</a> or call 1-505-925-2432 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays. Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a referral to see a specialist?</b>	No. Specialist visits do not require a written PCP referral from the plan if the provider is in the UNM Health network.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services without a <u>referral</u> before you see the <u>specialist</u> if you utilize a UNM Health <u>specialist</u> . The specialist's office may require a referral. A Benefit Determination from the plan is required to see a <u>specialist</u> outside of the UNM Health Network.



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
		UNM Health Network (You will pay the least)	Extended Network (Must be <u>prior authorized</u> )	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <u>provider's</u> office or clinic</b>	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	\$30 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$35 <u>copay</u> /visit; <u>deductible</u> does not apply	\$45 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge; <u>deductible</u> does not apply	No charge; <u>deductible</u> does not apply	Not Covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	No charge; <u>deductible</u> does not apply	No charge; <u>deductible</u> does not apply	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior authorization</u> may be required for imaging.

\*For more information about limitations and exceptions, see the plan or policy document at <http://unmmg.org/unmhealth>.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		<u>UNM Health Network</u> (You will pay the least)	<u>Extended Network</u> (Must be <u>prior authorized</u> )	<u>Out-of-Network Provider</u> (You will pay the most)	
<p><b>If you need drugs to treat your illness or condition</b> More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.expresscripts.com">http://www.expresscripts.com</a>.</p>	Generic drugs	\$10 <u>copay</u> (30-day retail) and \$20 <u>copay</u> (90-day retail and mail order)	\$10 <u>copay</u> (30-day retail) and \$20 <u>copay</u> (90-day retail and mail order)	Responsible for 100% of cost , then reimbursed the contracted rate less applicable <u>copay</u>	<p>Some drugs require prior authorization. Not all drugs are covered or have quantity limitations. For more information call 1-800-232-6549, or go to <a href="http://www.expresscripts.com">www.expresscripts.com</a>.</p>
	Preferred brand drugs	25% <u>coinsurance</u> , min \$35 to max \$70 (30-day retail) and 25% <u>coinsurance</u> , min \$87.50 to max \$175 (90-day retail and mail order)	25% <u>coinsurance</u> , min \$35 to max \$70 (30-day retail) and 25% <u>coinsurance</u> , min \$87.50 to max \$175 (90-day retail and mail order)	Responsible for 100% of cost , then reimbursed the contracted rate less applicable <u>copay</u>	
	Non-preferred brand drugs	25% <u>coinsurance</u> , min \$55 to max \$110 (30-day retail) and 25% <u>coinsurance</u> , min \$137.50 to max \$275 (90-day retail and mail order)	25% <u>coinsurance</u> , min \$55 to max \$110 (30-day retail) and 25% <u>coinsurance</u> , min \$137.50 to max \$275 (90-day retail and mail order)	Responsible for 100% of cost, then reimbursed the contracted rate less applicable <u>copay</u>	
	<u>Specialty drugs</u>	\$20% <u>coinsurance</u> to max \$250/prescription. After \$1,250 plan year out-of-pocket, \$55/prescription	\$20% <u>coinsurance</u> to max \$250/prescription. After \$1,250 plan year out-of-pocket, \$55/prescription	Not covered	

\*For more information about limitations and exceptions, see the plan or policy document at <http://unmmg.org/unmhealth>.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		UNM Health Network (You will pay the least)	Extended Network (Must be <u>prior authorized</u> )	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior authorization</u> may be required.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$150 <u>copay/visit</u> ; <u>deductible</u> does not apply	\$150 <u>copay/visit</u> ; <u>deductible</u> does not apply	\$150 <u>copay/visit</u> ; <u>deductible</u> does not apply	None
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Emergency ground and air. No charge for inter-facility transfer.
	<u>Urgent care</u>	\$75 <u>copay/visit</u> ; <u>deductible</u> does not apply	\$75 <u>copay/visit</u> ; <u>deductible</u> does not apply	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior authorization</u> required.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35 <u>copay/visit</u> ; <u>deductible</u> does not apply	\$45 <u>copay/visit</u> ; <u>deductible</u> does not apply	40% <u>coinsurance</u>	Certain services require <u>prior authorization</u> . See your benefits booklet for more information.
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior authorization</u> required.
If you are pregnant	Office visits	\$25 <u>copay/visit</u> ; <u>deductible</u> does not apply	\$30 <u>copay/visit</u> ; <u>deductible</u> does not apply	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	40% <u>coinsurance</u>	

\*For more information about limitations and exceptions, see the plan or policy document at <http://unmmg.org/unmhealth>.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		UNM Health Network (You will pay the least)	Extended Network (Must be <u>prior authorized</u> )	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior authorization</u> required.
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 100 days per plan year.
	<u>Rehabilitation services</u>	\$35 <u>copay</u> /visit; <u>deductible</u> does not apply	\$45 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	Includes: Physical, Occupational, Speech, Hearing and Autism Therapies limited to 70 visits per plan year combined. Inpatient: <u>Prior authorization</u> required.
	<u>Habilitation services</u>	\$35 <u>copay</u> /visit; <u>deductible</u> does not apply	\$45 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 60 days per plan year.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior authorization may be required.
	<u>Hospice services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior authorization may be required.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	Not covered	Covered under pediatric preventive services.
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	Not covered	None

\*For more information about limitations and exceptions, see the plan or policy document at <http://unmmg.org/unmhealth>.

## Excluded Services & Other Covered Services:

### Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long term care
- 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 (limited to 20 visits per year)
- Chiropractic care
- Hearing aids (for members age 18 and younger—age 21 and younger if still attending High School— max 2 hearing aids every 3 years)
- Non-emergency care when traveling outside of 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 1-505-925-2432, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](http://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](http://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: Blue Cross and Blue Shield of New Mexico (BCBSNM) Appeals Unit at 1-800-205-9926 or visit [www.bcbsnm.com](http://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](http://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](http://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.

————— *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

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$600
■ <u>Specialist copayments</u>	\$35
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$600
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$800
<i>What isn't covered</i>	
Limits or exclusions	60\$
<b>The total Peg would pay is</b>	<b>\$1,560</b>

### Managing Joe's type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$600
■ <u>Specialist copayments coinsurance</u>	\$35
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$10
<u>Copayments</u>	\$1,400
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,470</b>

### Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$600
■ <u>Specialist copayments coinsurance</u>	\$35
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

This **EXAMPLE** event includes services like:

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

<b>Total Example Cost</b>	<b>\$2,000</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$600
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$20
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$820</b>

**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 (505) 272-8255.

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

UNM Office of Equal Opportunity  
609 Buena Vista NE  
Albuquerque, NM 87106

Phone: (505) 277-5251 (voicemail)  
TTY/TDD: (505) 272-8255  
Fax: (505) 277-1356  
Email: oeounm.unm.edu

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  
200 Independence Avenue SW  
Room 509F, HHH Building 1019  
Washington, DC 20201

Phone: 800-368-1019  
TTY/TDD: 800-537-7697  
Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>  
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>

**Language Access Services:**

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-505-272-8255 (TTY: 1-505-272-5399).

Navajo: Dii baa ako ninizin: Dii saad bee yaniltili ti'go Diné Bizaad, saad bee aka'anida'awo'dee', t'aa jiik'eh, ei na holo, koji' hodiilnih 1-505-272-8255 (TTY: 1-505-272-5399)

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-505-272-8255 (TTY: 1-505-272-5399).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-505-272-8255 (TTY: 1-505-272-5399).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-505-272-8255 (TTY: 1-505-272-5399)。

Arabic: والى بكم ال صم هات ف 1505-272-8255. ب رقم ات صل ب الدمجان لك ت توافر ال لغوية المساعدة خدمات ف إن ال لغة، أذكر ت تحدث ك نت إذا: ملحوظة 1-505-272-8255

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-505-272-8255 (TTY: 1-505-272-5399)번으로 전화해 주십시오.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-505-272-8255 (TTY: 1-505-272-5399).

Japanese: 注意事項：本語を話される場合、無料の言語支援をご利用いただけます。1-505-272-8255 (TTY: 1-505-272-5399) まで、お電話にてご連絡ください。

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-505-272-8255 (ATS: 1-505-272-5399).

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-505-272-8255 (TTY: 1-505-272-5399).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-505-272-8255 (телетайп: 1-505-272-5399).

Hindi: ध्यान दः यद आप हदी बोलते ह तो आपके िलए मुफ्त मभाषा सहायता सेवाएं उपलब्ध ह। 1-505-272-8255 (TTY: 1-505-272-5399) पर कॉल कर

Farsi: ب گ برید د تماس ب ا ب ا شد می ف راهم 1-505-272-8255 (TTY: 1-505-272-2399) شما ب رای رای گمان ب صورت زبانی ت سه یلات ک نید، می گ ف تگوف فار سسی زبانی ب ه اگر ت وجه:

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-505-272-8255 (TTY: 1-505-272-5399).