Dear Student:

Under the Affordable Care Act, all health insurers and group health plans are required to provide consumers with a Summary of Benefits and Coverage (SBC). The SBC is a summary of the benefits and health coverage offered by the University of New Mexico Student Health Plan. Minimum Essential Coverage (MEC) certification is in process.

Attached is the SBC for the University of New Mexico Student Health Plan covering plans purchased between 07/01/18 – 08/19/19. In accordance with the University of New Mexico, coverage may be purchased for varying periods of time. The coverage periods for University of New Mexico are listed below:

<table>
<thead>
<tr>
<th>Coverage Period</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall*</td>
<td>08/20/18 - 01/13/19</td>
</tr>
<tr>
<td>Spring</td>
<td>01/14/19 – 08/18/19</td>
</tr>
<tr>
<td>Summer</td>
<td>06/03/18 – 08/18/19</td>
</tr>
</tbody>
</table>

*MD & Pharmacy coverage begins 07/01/18

If you have any questions regarding your coverage or the length of time you purchased, please contact UNM Team Health at 844-866-2224.
**Important Questions** | **Answers** | **Why This Matters:**
--- | --- | ---
What is the overall deductible? | Student Health & Counseling Center (SHAC) provider $0 Individual / N/A Family UNM Health & PPO providers (combined) $250 Individual / $500 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. Services 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/](http://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? | Student Health & Counseling Center (SHAC), UNM Health & PPO providers (combined) $6,350 Individual / $12,700 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, preauthorization penalties, 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 [https://unm.myahpcare.com](https://unm.myahpcare.com) or call 1-844-866-2224 for a list of network providers. | You pay the least if you use a provider in SHAC. You pay more if you use a provider in-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.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>SHAC Provider (You will pay the least) $5 copay/visit; deductible does not apply</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>In-Network Provider (must be preauthorized) $15 copay/visit; deductible does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>Out-of-Network Provider (You will pay the most) $25 copay/visit; deductible does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs</td>
<td>20% coinsurance</td>
<td>Out-of-Network is reimbursed at the In-Network allowable less applicable copay.</td>
</tr>
<tr>
<td>More information about <strong>prescription drug coverage</strong> is available at <a href="http://www.bcbsnm.com">www.bcbsnm.com</a>.</td>
<td>Preferred brand drugs</td>
<td>20% coinsurance</td>
<td>Retail available up to 90 day supply, with 1 copay per 30 days. Mail order is not covered.</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>20% coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [https://unm.myahpcare.com](https://unm.myahpcare.com).*
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</thead>
<tbody>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>Not Covered</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Not Covered</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>Not Covered</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>Not Covered</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>Not Covered</td>
<td>$15 copay/visit; deductible does not apply</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>Not Covered</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Not Covered</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>Cost sharing does not apply</td>
<td>Includes office, home, outpatient, and Intensive Outpatient Program (IOP) services; plus inpatient and partial hospitalization. IOP, inpatient and partial hospitalization require preauthorization.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>Not Covered</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>Not Covered</td>
<td>$15 copay/visit; deductible does not apply</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>Not Covered</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>Not Covered</td>
<td>20% coinsurance</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [https://unm.myahpcare.com](https://unm.myahpcare.com).
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>SHAC Provider (You will pay the least)</td>
<td>In-Network Provider (must be preauthorized)</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td><strong>Home health care</strong> Not Covered</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Rehabilitation services</strong> 20% coinsurance</td>
<td>50% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Habilitation services</strong> 20% coinsurance</td>
<td>50% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Skilled nursing care</strong> Not Covered</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Durable medical equipment</strong> Not Covered</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Hospice services</strong> Not Covered</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td><strong>Children’s eye exam</strong> Not Covered</td>
<td>No Charge; deductible does not apply</td>
<td>No Charge; deductible does not apply</td>
</tr>
<tr>
<td></td>
<td><strong>Children’s glasses</strong> Not Covered</td>
<td>No Charge; deductible does not apply</td>
<td>No Charge; deductible does not apply</td>
</tr>
<tr>
<td></td>
<td><strong>Children’s dental check-up</strong> Not Covered</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
</tbody>
</table>

**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 (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 (1 visit per day)
- Chiropractic care (30 visits per year)
- Hearing aids
- Non-emergency care when traveling outside the U.S.

* For more information about limitations and exceptions, see the plan or policy document at [https://unm.myahpcare.com](https://unm.myahpcare.com).
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 1-844-866-2224. You may also contact your state insurance department at 1-855-427-5674. 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 toll free at 1-855-427-5674 or visit 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:
Navajo (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwiijigo holne’ 1-877-498-7652.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.
The plan would be responsible for the other costs of these EXAMPLE covered services.

### 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.

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**Peg is Having a Baby** *(9 months of in-network pre-natal care and a hospital delivery)*

- The plan’s overall deductible: $250
- Specialist copayment: $10
- Hospital (facility) coinsurance: 20%
- 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)*

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$12,800</th>
</tr>
</thead>
</table>

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

- The plan’s overall deductible: $250
- Specialist copayment: $10
- Hospital (facility) coinsurance: 20%
- 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)*

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$7,400</th>
</tr>
</thead>
</table>

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

- The plan’s overall deductible: $250
- Specialist copayment: $10
- Hospital (facility) coinsurance: 20%
- 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)*

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$1,900</th>
</tr>
</thead>
</table>

---

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>$250</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td></td>
</tr>
<tr>
<td>Copayments</td>
<td>$60</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,400</td>
</tr>
</tbody>
</table>

What isn’t covered:

- Limits or exclusions: $60

The total Peg would pay is $2,770

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>$250</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td></td>
</tr>
<tr>
<td>Copayments</td>
<td>$600</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$300</td>
</tr>
</tbody>
</table>

What isn’t covered:

- Limits or exclusions: $60

The total Joe would pay is $1,210

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>$250</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td></td>
</tr>
<tr>
<td>Copayments</td>
<td>$30</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$300</td>
</tr>
</tbody>
</table>

What isn’t covered:

- Limits or exclusions: $0

The total Mia would pay is $580

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<table>
<thead>
<tr>
<th>Arabic</th>
<th>العربية</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chinese</td>
<td>简明中文</td>
</tr>
<tr>
<td>French</td>
<td>Français</td>
</tr>
<tr>
<td>German</td>
<td>Deutsch</td>
</tr>
<tr>
<td>Gujarati</td>
<td>ગુજરાતી</td>
</tr>
<tr>
<td>Hindi</td>
<td>हिंदी</td>
</tr>
<tr>
<td>Japanese</td>
<td>日本語</td>
</tr>
<tr>
<td>Korean</td>
<td>한국어</td>
</tr>
<tr>
<td>Lao</td>
<td>ເລາומה</td>
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<tr>
<td>Navajo</td>
<td>Diné</td>
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<td>Persian</td>
<td>فارسی</td>
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<td>Russian</td>
<td>Русский</td>
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<tr>
<td>Spanish</td>
<td>Español</td>
</tr>
<tr>
<td>Tagalog</td>
<td>Tagalog</td>
</tr>
<tr>
<td>Urdu</td>
<td>اردو</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>Tiếng Việt</td>
</tr>
</tbody>
</table>

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.
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.

<table>
<thead>
<tr>
<th>Office of Civil Rights Coordinator</th>
<th>Phone:</th>
<th>855-664-7270 (voicemail)</th>
</tr>
</thead>
<tbody>
<tr>
<td>300 E. Randolph St.</td>
<td>TTY/TDD:</td>
<td>855-661-6965</td>
</tr>
<tr>
<td>35th Floor</td>
<td>Fax:</td>
<td>855-661-6960</td>
</tr>
<tr>
<td>Chicago, Illinois 60601</td>
<td>Email:</td>
<td><a href="mailto:CivilRightsCoordinator@hcsc.net">CivilRightsCoordinator@hcsc.net</a></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>U.S. Dept. of Health &amp; Human Services</th>
<th>Phone:</th>
<th>800-368-1019</th>
</tr>
</thead>
<tbody>
<tr>
<td>200 Independence Avenue SW</td>
<td>TTY/TDD:</td>
<td>800-537-7697</td>
</tr>
<tr>
<td>Room 509F, HHH Building 1019</td>
<td>Complaint Portal:</td>
<td><a href="https://ocrportal.hhs.gov/ocr/portal/lobby.jsf">https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</a></td>
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