This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **UNMHealth.org** or by calling UNM Health at (505) 925-2432.

Important Questions	Answers	Why this Matters:
What is the overall **deductible**?	For UNM Health participating **providers**: **$600** person / **$1,200** family For non-participating **providers**: **$1,800** person / **$3,600** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, July 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other **deductibles** for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an **out-of-pocket limit** on my expenses?	For UNM Health **providers**: **$3,000** person / **$6,000** family For non-participating **providers**: **$7,500** person / **$15,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the **out-of-pocket limit**?	Premiums, balance-billed 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.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a **network** of **providers**?	Yes. See **http://unmhealth.org** for UNM Health providers or for In Network providers call (**505) 925-2432** for a list of participating **providers**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a **specialist**?	Yes.	You can see the **specialist** you choose without permission from this plan if you utilize a UNM Health provider. Otherwise, a Benefit Determination is required for any other provider outside of the UNM Health Network.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If a non-participating **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-participating **provider** hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a UNM Health Provider	Your Cost If You Use a Tier 2 Provider	Your Cost If You Use an Out Of Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or an illness	$25 copay/visit	$30 copay/visit	40% coinsurance	The deductible does not apply to participating providers.
	Specialist visit	$35 copay/visit	$45 copay/visit	40% coinsurance	The deductible does not apply to participating providers.
	Other practitioner office visit	$35 copay/visit	$45 copay/visit	40% coinsurance	The deductible does not apply to participating providers.
	Preventive care/ screening/ immunization	No Charge	No Charge	Not Covered	The deductible does not apply to participating providers.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	No Charge	40% coinsurance	The deductible does not apply to participating providers.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	40% coinsurance	Prior authorizarion may be required
If you need drugs to treat your illness or condition.	Generic drugs	$10 copay (30-day retail) and $20 copay (90-day retail and mail order)	$10 copay (30-day retail) and $20 copay (90-day retail and mail order)	Responsible for 100% of cost , then reimbursed the contracted rate less applicable copay	Some drugs require prior authorization. Not all drugs are covered or have quantity ations. For more information call 1-800-232-6549

Common Medical Event	Services You May Need	Your Cost If You Use a UNM Health Provider	Your Cost If You Use a Tier 2 Provider	Your Cost If You Use an Out Of Network Provider	Limitations & Exceptions
More information about **prescription drug coverage** is available at http://www.express-scripts.com	Preferred brand drugs	25% coinsurance, min $35 to max $70 (30-day retail) and 25% coinsurance, min $87.50 to max $175 (90-day retail and mail order)	25% coinsurance, min $35 to max $70 (30-day retail) and 25% coinsurance, min $87.50 to max $175 (90-day retail and mail order)	Responsible for 100% of cost , then reimbursed the contracted rate less applicable copay	
	Non-preferred brand drugs	25% coinsurance, min $55 to max $110 (30-day retail) and 25% coinsurance, min $137.50 to max $275 (90-day retail and mail order)	25% coinsurance, min $55 to max $110 (30-day retail) and 25% coinsurance, min $137.50 to max $275 (90-day retail and mail order)	Responsible for 100% of cost, then reimbursed the contracted rate less applicable copay	
	Specialty drugs	$20% coinsurance to max $250/prescription. After $1,250 plan year out-of-pocket, $55/prescription	$20% coinsurance to max $250/prescription. After $1,250 plan year out-of-pocket, $55/prescription	Not covered	Must use Accredo. Call 1-866-824-5662
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	40% coinsurance	----------none----------
	Physician/surgeon fees	10% coinsurance	30% coinsurance	40% coinsurance	----------none----------
If you need immediate medical attention	Emergency room services	$150 copay/visit	$150 copay/visit	$150 copay/visit	The deductible does not apply.
	Emergency medical transportation	Applies to In-network benefit	30% coinsurance emergency ground/air	Applies to In-network benefit	No charge for Inter-facility transfer ground and air
	Urgent Care	$75 copay/visit	$75 copay/visit	40% coinsurance	The deductible does not apply to participating providers
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	40% coinsurance	Prior authorization may be required

Common Medical Event	Services You May Need	Your Cost If You Use a UNM Health Provider	Your Cost If You Use a Tier 2 Provider	Your Cost If You Use an Out Of Network Provider	Limitations & Exceptions
	Physician/surgeon fee	10% coinsurance	30% coinsurance	40% coinsurance	Prior authorization may be required
If you have mental or behavioral health, or sub-stance abuse needs	Mental/Behavioral health outpatient services	$35 copay/visit	$45 copay/visit	40% coinsurance	The deductible does not apply to participating providers.
	Mental/Behavioral health inpatient services	10% coinsurance	30% coinsurance	40% coinsurance	Prior authorization may be required
	Substance use disorder outpatient services	$35 copay/visit	$45 copay/visit	40% coinsurance	The deductible does not apply to participating providers.
	Substance use disorder inpatient services	10% coinsurance	30% coinsurance	40% coinsurance	Prior authorization may be required
If you are pregnant	Prenatal and postnatal care	$25 or $35 copay/visit	$30 or $45 copay/visit	40% coinsurance	For routine obstetrical care, the copay is charged for the initial visit only. Copay is not subject to deductible
	Delivery and all inpatient services	10% coinsurance	30% coinsurance	40% coinsurance	Prior authorization may be required for inpatient Hospital stays in excess of 48 hrs. (Vaginal delivery) or 96 hrs. (C-section).
If you need help recovering or have other special needs If you need help or have other special health needs	Home health care	10% coinsurance	30% coinsurance	40% coinsurance	Limited to 100 visits per plan year.
	Rehabilitation services	$35 copay/visit	$45 copay/visit	40% coinsurance	Limited to 70 visits combined with Habilitation Services per plan year.
	Habilitation services	$35 copay/visit	$45 copay/visit	40% coinsurance	See Rehabilitation Services above for limits. The deductible does not apply to participating providers.
	Skilled nursing care	10% coinsurance	30% coinsurance	40% coinsurance	Limited to 60 days per plan year. Prior authorization may be required
	Durable medical equipment	10% coinsurance	30% coinsurance	40% coinsurance	Prior authorization may be required

Common Medical Event	Services You May Need	Your Cost If You Use a UNM Health Provider	Your Cost If You Use a Tier 2 Provider	Your Cost If You Use an Out Of Network Provider	Limitations & Exceptions
	Hospice service	10% coinsurance	30% coinsurance	40% coinsurance	Prior authorization may be required.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Not covered	Covered under Pediatric Preventive Services
	Glasses	Not Covered	Not Covered	Not covered	
	Dental check-up	Not covered	Not covered	Not covered	----------none----------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- **Bariatric surgery**
- **Cosmetic surgery**
- **Dental care (covered under stand-alone dental plan)**
- **Glasses (covered under stand-alone vision plan)**
- **Infertility treatment**
- **Private-duty nursing**
- **Routine eye care (covered under stand-alone vision plan)**
- **Routine foot care**
- **Weight loss programs**

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- **Acupuncture and Chiropractic care**
- **Non-emergency care when traveling outside the U.S.**

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at (505) 925-2432. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file **a grievance**. For questions about your rights, this notice, or assistance, you can contact UNM Health at (505) 925-2432 for medical claims or BCBSNM Appeals Unit at 1-800-205-9926. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 1-855-427-5674or www.osi.state.nm.us

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

(Español): Para obtener asistencia en Español, llame al 1-800-378-1179.

(Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-378-1179.

(Chinese): (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-378-1179.

(Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-378-1179.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $6,320**
- **Patient pays $1,220**

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**
Patient pays:	
Deductibles	$600
Copays	$20
Coinsurance	$450
Limits or exclusions	$150
Total	**$1,220**

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan pays $4,010**
- **Patient pays $1,390**

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**
Patient pays:	
Deductibles	$600
Copays	$610
Coinsurance	$100
Limits or exclusions	$80
Total	**$1,390**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums.**
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- Coverage examples are based on single coverage only.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from participating **providers**. If the patient had received care from non-participating **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.