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 https://goto.unm.edu/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.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 1-505-925-2432 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For the UNM Health and Extended Network providers: $600 Individual/$1,200 Family For Out-of-Network Providers: $1,800 Individual/$3,600 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. Certain preventive care, services that charge a copay, and emergency room services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible, 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For the UNM Health Network and Extended Network providers: $3,000 Individual/$6,000 Family For Out-of-Network: $7,500 Individual/$15,000 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, 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://goto.unm.edu/unmhealthor call 1-505-925-2432 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. 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. Specialist visits do not require a written PCP referral from the plan if the provider is in the UNM Health network.	This plan will pay some or all of the costs to see a specialist for covered services without a referral before you see the specialist if you utilize a UNM Health specialist. The specialist's office may require a referral. A Benefit Determination from the plan is required to see a specialist 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 prior authorized)	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	$25 copay/visit; deductible does not apply	$30 copay/visit; deductible does not apply	40% coinsurance	None
	Specialist visit	$35 copay/visit; deductible does not apply	$45 copay/visit; deductible does not apply	40% coinsurance	None
	Preventive care/screening/ immunization	No charge; deductible does not apply	No charge; deductible does not apply	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)	No charge; deductible does not apply	No charge; deductible does not apply	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	40% coinsurance	Prior authorization may be required for imaging.

*For more information about limitations and exceptions, see the plan or policy document at https://goto.unm.edu/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 prior authorized)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.expressscripts.com.	Generic drugs	$10 copay (30-day retail) and $20 copay (90-day retail and mail-order); deductible does not apply	$10 copay (30-day retail) and $20 copay (90-day retail and mail- order); deductible does not apply	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 limitations. For more information, call 1-800-232-6549, or go to 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); deductible does not apply	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); deductible does not apply	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) ; deductible does not apply	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) ; deductible does not apply	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; deductible does not apply	$20% coinsurance to max $250/prescription. After $1,250 plan year out-of-pocket, $55/prescription; deductible does not apply	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	Prior authorization may be required.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	40% coinsurance	

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 prior authorized)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$150 copay/visit; deductible does not apply	$150 copay/visit; deductible does not apply	$150 copay/visit; deductible does not apply	None
	Emergency medical transportation	30% coinsurance	30% coinsurance	30% coinsurance	Emergency ground and air. No charge for inter-facility transfer.
	Urgent care	$75 copay/visit; deductible does not apply	$75 copay/visit; deductible does not apply	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	40% coinsurance	Prior authorization required.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay/visit; deductible does not apply	$45 copay/visit; deductible does not apply	40% coinsurance	Certain services require prior authorization. See your benefits booklet for more information.
	Inpatient services	10% coinsurance	30% coinsurance	40% coinsurance	Prior authorization required for IOP, inpatient, and partial hospitalization. Residential Treatment Centers limited to 60 days per year (not available under UNM Health Network).
If you are pregnant	Office visits	$25 copay/visit; deductible does not apply	$30 copay/visit; deductible does not apply	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	40% coinsurance	Prior authorization required.
	Home health care	10% coinsurance	30% coinsurance	40% coinsurance	Limited to 100 days per plan year.

*For more information about limitations and exceptions, see the plan or policy document at https://goto.unm.edu/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 prior authorized)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Rehabilitation services	$35 copay/visit; deductible does not apply	$45 copay/visit; deductible does not apply	40% coinsurance	Includes: Physical, Occupational, Speech, Hearing and Autism Therapies limited to 70 visits per plan year combined. Inpatient: Prior authorization required.
	Habilitation services	$35 copay/visit; deductible does not apply	$45 copay/visit; deductible does not apply	40% coinsurance	
	Skilled nursing care	10% coinsurance	30% coinsurance	40% coinsurance	Limited to 60 days per plan year.
	Durable medical equipment	10% coinsurance	30% coinsurance	40% coinsurance	Prior authorization may be required.
	Hospice services	10% coinsurance	30% coinsurance	40% coinsurance	Prior authorization may be required.
If your child needs dental or eye care	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

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.)

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs (unless medically necessary for treatment of morbid obesity)

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
- Bariatric surgery
- 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.

*For more information about limitations and exceptions, see the plan or policy document at https://goto.unm.edu/unmhealth.

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, 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. 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: Blue Cross and Blue Shield of New Mexico (BCBSNM) Appeals Unit at 1-800-205-9926 or visit 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. 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.

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 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** **$600**
- **Specialist *copayments*** **$35**
- **Hospital (facility) *coinsurance*** **10%**
- **Other *coinsurance*** **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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$600
Copayments	$100
Coinsurance	$800
What isn't covered	
Limits or exclusions	60$
The total Peg would pay is	**$1,560**

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

- **The plan's overall deductible** **$600**
- **Specialist *copayments coinsurance*** **$35**
- **Hospital (facility) *coinsurance*** **10%**
- **Other *coinsurance*** **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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$10
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,470**

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

- **The plan's overall deductible** **$600**
- **Specialist *copayments coinsurance*** **$35**
- **Hospital (facility) *coinsurance*** **10%**
- **Other *coinsurance*** **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)*

Total Example Cost	**$2,000**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$600
Copayments	$200
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$820**

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

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 yanilti 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: 1-505-272-8255ملحوظة: إذا تحدث كنت تريد المساعدة خدمات فإن اللغوية المساعدة خدمات فإن اللغة، اذكر تتوافر اللغوية المساعدة خدمات فإن اللغة، اذكر تتوافر المجان لك تتوافر اللغوية المساعدة خدمات فإن اللغة، اذكر تتوافر. بالمجان لك تتوافر اللغوية المساعدة خدمات فإن اللغة، اذكر تتوافر اتصل برقم 1505-272-5399. والكلام بكم الصم هاتف:
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 द: 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: توجه: اگر به زبان فارسی صحبت می‌کنید، تسهیلات زبانی رایگان به شما ارائه می‌شود. با 1-505-272-8255 (TTY: 1-505-272-2399) تماس بگیرید.
Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-505-272-8255 (TTY: 1-505-272-5399).**