
 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 1-866-569-3491 or visit uhc.com/xnm0004xpolicy2025. 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.healthcare.gov/sbc-glossary/ or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	Network: \$950 Individual / \$1,900 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-Benefits available with no charge such as Network Preventive-care and Mental & Behavioral Health services are covered before you meet your deductible . The cost-sharing below indicates when the deductible does not apply for each benefit.	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 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 ?	Network: \$6,800 Individual / \$13,600 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 , 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 Choice Network at uhc.com/xnmdocfindoa2025 or call 1-866-569-3491 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	\$20 copay /visit, deductible does not apply	Not Covered	No charge for anything related to COVID-19 screening , testing vaccines or medical treatment. You may be subject to additional facility/clinic fees. Please check with your provider .
	Specialist visit	\$50 copay /visit, deductible does not apply	Not Covered	No charge for anything related to COVID-19 screening , testing vaccines or medical treatment. You may be subject to additional facility/clinic fees. Please check with your provider .
	Preventive care/screening/immunization	No Charge	Not Covered	No charge for anything related to COVID-19 screening , testing vaccines or medical treatment. 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)	Lab Testing: Free Standing/Office: \$10 copay /service, deductible does not apply Hospital: \$65 copay /service, deductible does not apply X-Ray/Diagnostics: Free Standing/Office: \$65 copay /service, deductible does not apply Hospital: \$100 copay /service, deductible does not apply	Not Covered	No charge for anything related to COVID-19 screening , testing vaccines or medical treatment. You may be subject to additional facility/clinic fees. Please check with your provider .
	Imaging (CT/PET scans, MRIs)	Free Standing/Office: \$200 copay /service, deductible does not apply Hospital: \$350 copay /service, deductible does not apply	Not Covered	You may be subject to additional facility/clinic fees. Please check with your provider .
If you need drugs	Tier 1 - Zero Cost-Share Drugs	No Charge	Not Covered	Provider means pharmacy for purposes of this section. Retail: One month supply up to a 30-day supply or a 90-

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)	
to treat your illness or condition More information about prescription drug coverage is available at uhc.com/xnmdruglist2025	Tier 2 – Preferred Generic Drugs	\$1 copay /prescription, deductible does not apply	Not Covered	day supply at 2.5x the 30-day cost-share . Mail-Order: Up to a 90-day supply at 2.5x the 30-day cost-share . Specialty drugs limited to a 30-day supply at a network pharmacy. Certain drugs may have a preauthorization requirement. Certain medications for preventive care, contraception, and behavioral health are covered at No Charge. Third party payments such as drug manufacturer’s coupons are accepted and applicable rebated amounts will apply toward your cost-sharing . See the website listed for information on drugs covered by your plan . Not all drugs are covered. Insulin products listed on the Prescription Drug List are covered at No Charge at a network pharmacy. Other covered insulin products will not exceed \$25 for a 30-day supply at a network pharmacy.
	Tier 3 - Non-Preferred Generic, Preferred Brand Drugs	\$30 copay /prescription, deductible does not apply	Not Covered	
	Tier 4 - Preferred Specialty Drugs	30% coinsurance	Not Covered	
	Tier 5 - Non-Preferred Brand Drugs	30% coinsurance	Not Covered	
	Tier 6 - Non-Preferred Specialty Drugs	40% coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not Covered	None
	Physician/surgeon fees	Free Standing/Office: \$300 copay /date of service, deductible does not apply Hospital: \$450 copay /date of service, deductible does not apply	Not Covered	You may be subject to additional facility/clinic fees. Please check with your provider .
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Balance-billing is not allowed for out-of-network services.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Balance-billing is not allowed for out-of-network services.
	Urgent care	\$35 copay /visit, deductible does not apply	Not Covered	Virtual visits - No Charge by a Designated Virtual Network Provider .
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not Covered	None
	Physician/surgeon fees	20% coinsurance	Not Covered	None
If you need mental health, behavioral	Outpatient services	Office Visit: No Charge Intensive Outpatient:	Not Covered	None

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)	
health, or substance abuse services		No Charge All Other Outpatient: No Charge		
	Inpatient services	No Charge	Not Covered	None
If you are pregnant	Office visits	No Charge	Not Covered	Cost-sharing does not apply for preventive services . Depending on the type of service, a copayment , coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Prior-authorizations for gynecological or obstetrical ultrasounds are not required.
	Childbirth/delivery professional services	20% coinsurance	Not Covered	
	Childbirth/delivery facility services	20% coinsurance	Not Covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not Covered	Limited to 100 visits/year.
	Rehabilitation services	\$20 copay /visit, deductible does not apply	Not Covered	Limits/year: Cardiac, Physical, Speech, Pulmonary, Occupational: Unlimited visits each
	Habilitative services	\$20 copay /visit, deductible does not apply	Not Covered	Limits/year: Speech, Physical, Occupational: Unlimited visits each You may be subject to additional facility/clinic fees. Please check with your provider .
	Skilled nursing care	20% coinsurance	Not Covered	Skilled nursing is limited to 60 days/year.
	Durable medical equipment	20% coinsurance	Not Covered	None
	Hospice services	20% coinsurance	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Limited to 1 exam/12 months.
	Children's glasses	20% coinsurance	Not Covered	Limited to 1 pair/12 months.
	Children's dental check-up	No Charge	Not Covered	Limited to 2 visits/12 months.

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) | • Glasses (Adult) | • Private duty nursing |
| • Cosmetic surgery | • Long-term care | • Routine eye care (Adult) |
| • Dental care (Adult) | • Non-emergency care when traveling outside the U.S. | • Routine foot care - except as covered for certain diseases |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your **plan** document.)

- | | | |
|---|--|---|
| • Acupuncture - 20 visits/year, no limit for rehabilitation or habilitative treatment | • Chiropractic (manipulative) care - 20 visits/year, no limit for rehabilitation or habilitative treatment | • Infertility treatment - diagnosis and treatment of underlying causes |
| • Bariatric surgery | • Hearing aids - 1 purchase per hearing impaired ear/36 months | • Weight loss programs – limited to prescription drugs and programs for obesity |

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: UnitedHealthcare of New Mexico, Inc. at 1-866-569-3491 or U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa or New Mexico Office of Superintendent of Insurance, 1120 Paseo De Peralta, Santa Fe, NM 87501, 1-855-427-5674 or osi.state.nm.us or Office of Personnel Management Multi State Plan Program: 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 [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 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: the Member Service number listed on the back of your ID card or myuhc.com/exchange or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa or New Mexico Office of Superintendent of Insurance, at 1-855-427-5674 or osi.state.nm.us.

Additionally, a consumer assistance program may help you file your **appeal**. Contact dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa.

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 the 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 1-866-569-3491

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-569-3491

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-569-3491

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-569-3491

*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	\$950
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

- [Specialist](#) office visits (*pre-natal 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:	
<i>Cost Sharing</i>	
Deductibles	\$950
Copayments	\$400
Coinsurance	\$1,700
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,110

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

■ The plan's overall deductible	\$950
■ Specialist copayment	\$50
■ 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*)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$400

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

■ The plan's overall deductible	\$950
■ Specialist copayment	\$50
■ 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*)

Total Example Cost	\$2,800
In this example, Mia would pay:	
<i>Cost Sharing</i>	
Deductibles	\$950
Copayments	\$200
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,350