



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/xnm0006policy2024](http://uhc.com/xnm0006policy2024). 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/](http://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 <a href="#">deductible</a> ?	<a href="#">Network</a> : \$3,000 Individual / \$6,000 Family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes-Benefits available with no charge such as <a href="#">Network Preventive care</a> and Mental & Behavioral Health services are covered before you meet your <a href="#">deductible</a> . The <a href="#">cost-sharing</a> below indicates when the <a href="#">deductible</a> does not apply for each benefit.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="http://healthcare.gov/coverage/preventive-care-benefits">healthcare.gov/coverage/preventive-care-benefits</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<a href="#">Network</a> : \$5,300 Individual / \$10,600 Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See Choice <a href="#">Network</a> at <a href="http://uhc.com/xnmocfindoa2024">uhc.com/xnmocfindoa2024</a> or call 1-866-569-3491 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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)	
<b>If you visit a health care <a href="#">provider's office</a> or clinic</b>	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a> /visit, <a href="#">deductible</a> does not apply	Not Covered	No charge for anything related to COVID-19 screening, testing vaccines or medical treatment.
	<a href="#">Specialist</a> visit	\$60 <a href="#">copay</a> /visit, <a href="#">deductible</a> does not apply	Not Covered	No charge for anything related to COVID-19 screening, testing vaccines or medical treatment.
	<a href="#">Preventive care/screening</a> / 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 <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$60 <a href="#">copay</a> /service, <a href="#">deductible</a> does not apply	Not Covered	No charge for anything related to COVID-19 screening, testing vaccines or medical treatment.
	Imaging (CT/PET scans, MRIs)	\$60 <a href="#">copay</a> /service, <a href="#">deductible</a> does not apply	Not Covered	None
<b>If you need drugs to treat your illness or condition</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://uhc.com/xnmdruglist2024">uhc.com/xnmdruglist2024</a>	Tier 1 - Zero Cost-Share Preventive Drugs	No Charge	Not Covered	<a href="#">Provider</a> means pharmacy for purposes of this section. Retail: One month supply up to a 30-day supply or a 90-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 <a href="#">network</a> pharmacy. Certain drugs may have a <a href="#">preauthorization</a> requirement. Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your <a href="#">plan</a> . Not all drugs are covered. Third party payments apply toward your <a href="#">cost sharing</a> . Preferred prescription insulin or medically necessary insulin alternative will not exceed \$25 per 30-day supply.
	Tier 2 – Generic Drugs	\$20 <a href="#">copay</a> /prescription, <a href="#">deductible</a> does not apply	Not Covered	
	Tier 3 - Non-Preferred Generic, Preferred Brand Drugs	\$30 <a href="#">copay</a> /prescription, <a href="#">deductible</a> does not apply	Not Covered	
	Tier 4 - Specialty Drugs	\$75 <a href="#">copay</a> /prescription, <a href="#">deductible</a> does not apply	Not Covered	
	Tier 5 - Non-Preferred Brand Drugs	\$100 <a href="#">copay</a> /prescription	Not Covered	
	Tier 6 - Specialty Drugs	\$190 <a href="#">copay</a> /prescription, <a href="#">deductible</a> does not apply	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$125 <a href="#">copay</a> /service, <a href="#">deductible</a> does not apply	Not Covered	None
	Physician/surgeon fees	\$125 <a href="#">copay</a> /service, <a href="#">deductible</a> does not apply	Not Covered	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$150 <a href="#">copay</a> /visit	\$150 <a href="#">copay</a> /visit	<a href="#">Balance-billing</a> is not allowed for <a href="#">out-of-network</a> services.
	<a href="#">Emergency medical transportation</a>	\$60 <a href="#">copay</a> /transport, <a href="#">deductible</a> does not apply	\$60 /transport, <a href="#">deductible</a> does not apply	<a href="#">Balance-billing</a> is not allowed for <a href="#">out-of-network</a> services.

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)	
	<a href="#">Urgent care</a>	\$60 <a href="#">copay</a> /visit, <a href="#">deductible</a> does not apply	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$150 <a href="#">copay</a> /admission with deductible	Not Covered	None
	Physician/surgeon fees	\$125 <a href="#">copay</a> , <a href="#">deductible</a> does not apply	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: No Charge Outpatient: No Charge	Not Covered	None
	Inpatient services	No Charge	Not Covered	None
If you are pregnant	Office visits	No Charge	Not Covered	<a href="#">Cost-sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of service, a <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) <a href="#">Prior-authorizations</a> for gynecological or obstetrical ultrasounds are not required.
	Childbirth/delivery professional services	\$125 <a href="#">copay</a> , <a href="#">deductible</a> does not apply	Not Covered	
	Childbirth/delivery facility services	\$150 <a href="#">copay</a> /admission with deductible	Not Covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	\$20 <a href="#">copay</a> /visit, <a href="#">deductible</a> does not apply	Not Covered	Limited to 100 visits/year.
	<a href="#">Rehabilitation services</a>	\$20 <a href="#">copay</a> /visit, <a href="#">deductible</a> does not apply	Not Covered	Limits/year: Physical, Occupational, Speech, Cardiac, Pulmonary: Unlimited visits each
	<a href="#">Habilitative services</a>	\$20 <a href="#">copay</a> /visit, <a href="#">deductible</a> does not apply	Not Covered	Limits/year: Physical, Occupational, Speech: Unlimited visits each
	<a href="#">Skilled nursing care</a>	\$60 <a href="#">copay</a> /admission, <a href="#">deductible</a> does not apply	Not Covered	Skilled Nursing is limited to 60 days/year.
	<a href="#">Durable medical equipment</a>	\$20 <a href="#">copay</a> /device, <a href="#">deductible</a> does not apply	Not Covered	None
	<a href="#">Hospice services</a>	\$60 <a href="#">copay</a> /day, <a href="#">deductible</a> does not apply	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	\$60 <a href="#">copay</a> , <a href="#">deductible</a> does not apply	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)
- Cosmetic surgery
- Dental care (Adult)
- Glasses (Adult)
- Long-term care
- Non-emergency care when traveling outside - the US
- Private duty nursing
- Routine eye care (Adult)
- Routine foot care - except as covered for diabetes

### 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
- Bariatric surgery
- Chiropractic (manipulative) care - 20 visits/year, no limit for rehabilitation or habilitative treatment
- Hearing aids - 1 purchase per hearing impaired ear/36 months
- Infertility treatment - diagnosis and treatment of underlying causes
- 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](http://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](http://osi.state.nm.us) or Office of Personnel Management Multi State Plan Program: [opm.gov/healthcare-insurance/multi-state-plan-program/external-review/](http://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](http://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](http://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](http://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](http://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](http://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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000
■ <a href="#">Specialist copayment</a>	\$60
■ Hospital (facility) <a href="#">copayment</a>	\$150
■ Other <a href="#">coinsurance</a>	0%

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*)

**Managing Joe's Type 2 Diabetes**

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000
■ <a href="#">Specialist copayment</a>	\$60
■ Hospital (facility) <a href="#">copayment</a>	\$150
■ Other <a href="#">coinsurance</a>	0%

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*)

**Mia's Simple Fracture**

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000
■ <a href="#">Specialist copayment</a>	\$60
■ Hospital (facility) <a href="#">copayment</a>	\$150
■ Other <a href="#">coinsurance</a>	0%

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>\$12,700</b>
<b>In this example, Peg would pay:</b>	
<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$3,000
<a href="#">Copayments</a>	\$700
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,760</b>

<b>Total Example Cost</b>	<b>\$5,600</b>
<b>In this example, Joe would pay:</b>	
<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$900
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$900</b>

<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,000
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,500</b>