



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/xnm0006bpolicy2024. 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 ?	\$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; or \$3,000 Individual / \$6,000 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 : \$5,300 Individual / \$10,600 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/xnmocfindoa2024 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
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP 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	No Charge	\$20 copay /visit, deductible does not apply	Not Covered	Cost-sharing waived at non-IHCP with IHCP referral . No charge for anything related to COVID-19 screening, testing vaccines or medical treatment.
	Specialist visit	No Charge	\$60 copay /visit, deductible does not apply	Not Covered	Cost-sharing waived at non-IHCP with IHCP referral . No charge for anything related to COVID-19 screening, testing vaccines or medical treatment.
	Preventive care/ screening/ immunization	No Charge	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)	No Charge	\$60 copay /service, deductible does not apply	Not Covered	Cost-sharing waived at non-IHCP with IHCP referral . No charge for anything related to COVID-19 screening, testing vaccines or medical treatment.
	Imaging (CT/PET scans, MRIs)	No Charge	\$60 copay /service, deductible does not apply	Not Covered	Cost-sharing waived at non-IHCP with IHCP referral .
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at uhc.com/xnmdruglist2024	Tier 1 - Zero Cost-Share Preventive Drugs	No Charge	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-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 preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your plan . Not all drugs are covered. Cost-sharing waived at non-IHCP with IHCP referral . Third party payments apply toward your cost sharing .
	Tier 2 – Generic Drugs	No Charge	\$20 copay /prescription, deductible does not apply	Not Covered	
	Tier 3 - Non-Preferred Generic, Preferred Brand Drugs	No Charge	\$30 copay /prescription, deductible does not apply	Not Covered	
	Tier 4 - Specialty Drugs	No Charge	\$75 copay /prescription, deductible does not apply	Not Covered	
	Tier 5 - Non-Preferred Brand Drugs	No Charge	\$100 copay /prescription	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
	Tier 6 - Specialty Drugs	No Charge	\$190 copay /prescription, deductible does not apply	Not Covered	Preferred prescription insulin or medically necessary insulin alternative will not exceed \$25 per 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	\$125 copay /service, deductible does not apply	Not Covered	Cost-sharing waived at non-IHCP with IHCP referral .
	Physician/surgeon fees	No Charge	\$125 copay /service, deductible does not apply	Not Covered	Cost-sharing waived at non-IHCP with IHCP referral .
If you need immediate medical attention	Emergency room care	No Charge	\$150 copay /visit	\$150 copay /visit	Cost-sharing waived at non-IHCP with IHCP referral . Balance-billing is not allowed for out-of-network services.
	Emergency medical transportation	No Charge	\$60 copay /transport, deductible does not apply	\$60 /transport, deductible does not apply	Cost-sharing waived at non-IHCP with IHCP referral . Balance-billing is not allowed for out-of-network services.
	Urgent care	No Charge	\$60 copay /visit, deductible does not apply	Not Covered	Cost-sharing waived at non-IHCP with IHCP referral .
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	\$150 copay /admission with deductible	Not Covered	Cost-sharing waived at non-IHCP with IHCP referral .
	Physician/surgeon fees	No Charge	\$125 copay , deductible does not apply	Not Covered	Cost-sharing waived at non-IHCP with IHCP referral .
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	Office Visit: No Charge Outpatient: No Charge	Not Covered	Cost-sharing waived at non-IHCP with IHCP referral .
	Inpatient services	No Charge	No Charge	Not Covered	Cost-sharing waived at non-IHCP with IHCP referral .
If you are pregnant	Office Visits	No Charge	No Charge	Not Covered	Cost-sharing does not apply for preventive services .
	Childbirth/ delivery professional services	No Charge	\$125 copay , deductible does not apply	Not Covered	Depending on the type of service, a copayment , coinsurance or deductible may apply. Maternity care may include tests and services described

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
	Childbirth/ delivery facility services	No Charge	\$150 copay /admission with deductible	Not Covered	elsewhere in the SBC (i.e. ultrasound.) Prior-authorizations for gynecological or obstetrical ultrasounds are not required. Cost-sharing waived at non-IHCP with IHCP referral .
If you need help recovering or have other special health needs	Home health care	No Charge	\$20 copay /visit, deductible does not apply	Not Covered	Limited to 100 visits/year. Cost-sharing waived at non-IHCP with IHCP referral .
	Rehabilitation services	No Charge	\$20 copay /visit, deductible does not apply	Not Covered	Limits/year: Physical, Occupational, Speech, Cardiac, Pulmonary: Unlimited visits each Cost-sharing waived at non-IHCP with IHCP referral .
	Habilitative services	No Charge	\$20 copay /visit, deductible does not apply	Not Covered	Limits/year: Physical, Occupational, Speech: Unlimited visits each Cost-sharing waived at non-IHCP with IHCP referral .
	Skilled nursing care	No Charge	\$60 copay /admission, deductible does not apply	Not Covered	Skilled Nursing is limited to 60 days/year. Cost-sharing waived at non-IHCP with IHCP referral .
	Durable medical equipment	No Charge	\$20 copay /device, deductible does not apply	Not Covered	Cost-sharing waived at non-IHCP with IHCP referral .
	Hospice services	No Charge	\$60 copay /day, deductible does not apply	Not Covered	Cost-sharing waived at non-IHCP with IHCP referral .
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	Not Covered	Limited to 1 exam/12 months. Cost-sharing waived at non-IHCP with IHCP referral .
	Children's glasses	No Charge	\$60 copay , deductible does not apply	Not Covered	Limited to 1 pair/12 months. Cost-sharing waived at non-IHCP with IHCP referral .
	Children's dental check-up	No Charge	No Charge	Not Covered	Limited to 2 visits/12 months. Cost-sharing waived at non-IHCP with IHCP referral .

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 US | • 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 | • 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	\$3,000
■ Specialist copayment	\$60
■ Hospital (facility) copayment	\$150
■ Other coinsurance	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 plan's overall deductible	\$3,000
■ Specialist copayment	\$60
■ Hospital (facility) copayment	\$150
■ Other coinsurance	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 plan's overall deductible	\$3,000
■ Specialist copayment	\$60
■ Hospital (facility) copayment	\$150
■ Other coinsurance	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*)

Total Example Cost	\$12,700
In this example, Peg would pay:	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$60

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

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

Note: These numbers assume the patient received care from an IHCP or with an IHCP [referral](#) to a non-IHCP. If you received care from a non-IHCP without a [referral](#) from an IHCP your costs may be higher.