## Sandia Total Health (Out of Area)

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, visit hr.sandia.gov or call 1-877-835-9855. 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 https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 1-877-835-9855 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters</th>
</tr>
</thead>
</table>
| What is the overall deductible?                       | **Network:** $750 Individual / $2,250 Family  
**Non-Network:** $750 Individual / $2,250 Family per calendar year.  
Does not apply to pharmacy drugs, and services listed below as “No Charge”. | 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. Preventive Care and primary care services are covered before you meet your deductible.                                                                                                                                                                           | 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ |
| Are there other deductibles for specific services?     | No, there are no other deductibles.                                                                                                                                                                     | 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.                                                                 |
| What is the out-of-pocket limit for this plan?         | **Medical:**  
For network provider: $2,750 Individual / $8,250 Family  
For out-of-network providers: $2,750 Individual / $8,250 Family per calendar year  
**Prescription Drugs:**  
Network: $1,500 Individual / $5,950 Family  
Out-of-network: $1,500 Individual / $5,950 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. |
### Important Questions

<table>
<thead>
<tr>
<th></th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, balance-billing charges, health care this plan doesn’t cover, penalties for failure to obtain pre-notification for services.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></td>
<td>Not Applicable</td>
<td>This plan does not use a provider network. You can receive covered services from any provider.</td>
</tr>
<tr>
<td><strong>Do you need a referral to see a specialist?</strong></td>
<td>No</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th><strong>What You Will Pay</strong></th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td><strong>Network Provider</strong> (You will pay the least) 20% coinsurance <strong>Out-of-Network Provider</strong> (You will pay the most) 20% coinsurance</td>
<td>Virtual visit - $10 copay per visit by a Designated Virtual Network Provider. If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>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.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% coinsurance</td>
<td>Prior Authorization required for Sleep Studies or benefit will have $300 penalty applied.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>-----------------------------------------------------</td>
</tr>
</tbody>
</table>
| If you need drugs to treat your illness or condition | Generic Drugs (Tier 1) | Retail: 20% coinsurance deductible does not apply  
Mail Order: 20% coinsurance deductible does not apply | Retail: 50% coinsurance deductible does not apply | Retail: member pays 20% (min $5/max $10); Mail Order: member pays 20% (min $12.50/max $25) |
| If you need drugs to treat your illness or condition | Preferred brand drugs (Tier 2) | Retail: 30% coinsurance deductible does not apply  
Mail Order: 30% coinsurance deductible does not apply | Retail: 50% coinsurance deductible does not apply | Retail: member pays 30%; (min $30/max $45); Mail Order: member pays 30% (min $75/max $112.50) |
| If you need drugs to treat your illness or condition | Non-preferred brand drugs (Tier 3) | Retail: 40% coinsurance deductible does not apply  
Mail Order: 40% coinsurance deductible does not apply | Retail: 50% coinsurance deductible does not apply | Retail: member pays 40%; (min $50/max $75); Mail Order: member pays 40% (min $125/max $187.50) |
| If you have outpatient surgery | Specialty drugs (Tier 4) | Retail: N/A  
Mail Order: N/A | Retail: N/A  
Mail Order: N/A | Retail: 30 day supply; Mail Order: 90 day supply. OTC medications with exception required by ACA; fertility meds, nutritional supplements; drugs for cosmetic purposes |
<p>| If you need immediate medical attention | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 20% coinsurance | None |
| If you need immediate medical attention | Physician/surgeon fees | 20% coinsurance | 20% coinsurance | None |
| If you have a hospital stay | Emergency room care | 20% coinsurance | 20% coinsurance | None |
| If you have a hospital stay | Emergency medical transportation | 20% coinsurance | 20% coinsurance | None |
| If you have a hospital stay | Urgent care | 20% coinsurance | 20% coinsurance | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance | 20% coinsurance | Prior Authorization required or benefit will have $300 penalty applied. |</p>
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td></td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance</td>
<td>Outpatient services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>abuse services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health</td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>needs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Habilitation services</td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Network Provider</strong> (You will pay the least)</td>
<td><strong>Out-of-Network Provider</strong> (You will pay the most)</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Hospice services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Children’s eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

**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.)**

- Child dental check-up
- Child routine vision exam (i.e. refraction)
- Child vision glasses
- Cosmetic Surgery

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

- Acupuncture
- Adult routine vision exam (i.e. refraction)
- Bariatric Surgery

- Dental Care (Adult)
- Habilitation services
- Long-term care
- Non-emergency care when traveling outside the U.S.

- Routine Foot Care
- Weight loss programs
- Wigs

- Chiropractic care
- Hearing aids
- Infertility treatment

- Private-duty nursing
- Routine foot care

**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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/ebsa/healthreform. 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 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: 1-877-835-9855 or visit www.myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.
**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?** 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.

**Language Access Services:**


Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-835-9855.

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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe’s type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia’s Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ The plan’s overall deductible</td>
<td>■ The plan’s overall deductible</td>
<td>■ The plan’s overall deductible</td>
</tr>
<tr>
<td>$750</td>
<td>$750</td>
<td>$750</td>
</tr>
<tr>
<td>■ Specialist coinsurance</td>
<td>■ Specialist coinsurance</td>
<td>■ Specialist coinsurance</td>
</tr>
<tr>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>■ Hospital (facility) coinsurance</td>
<td>■ Hospital (facility) coinsurance</td>
<td>■ Hospital (facility) coinsurance</td>
</tr>
<tr>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>■ Other coinsurance</td>
<td>■ Other coinsurance</td>
<td>■ Other coinsurance</td>
</tr>
<tr>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>This EXAMPLE event includes services like:</td>
<td>This EXAMPLE event includes services like:</td>
<td>This EXAMPLE event includes services like:</td>
</tr>
<tr>
<td>Specialist office visits (pre-natal care)</td>
<td>Primary care physician office visits (including disease education)</td>
<td>Emergency room care (including medical supplies)</td>
</tr>
<tr>
<td>Childbirth/Delivery Professional Services</td>
<td>Diagnostic tests (blood work)</td>
<td>Diagnostic test (x-ray)</td>
</tr>
<tr>
<td>Childbirth/Delivery Facility Services</td>
<td>Prescription drugs</td>
<td>Durable medical equipment (crutches)</td>
</tr>
<tr>
<td>Diagnostic tests (ultrasounds and blood work)</td>
<td>Durable medical equipment (glucose meter)</td>
<td>Rehabilitation services (physical therapy)</td>
</tr>
<tr>
<td>Specialist visit (anesthesia)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Example Cost</strong></td>
<td><strong>Total Example Cost</strong></td>
<td><strong>Total Example Cost</strong></td>
</tr>
<tr>
<td>$12,700</td>
<td>$5,600</td>
<td>$2,800</td>
</tr>
<tr>
<td>In this example, Peg would pay:</td>
<td>In this example, Joe would pay:</td>
<td>In this example, Mia would pay:</td>
</tr>
<tr>
<td><strong>Cost Sharing</strong></td>
<td><strong>Cost Sharing</strong></td>
<td><strong>Cost Sharing</strong></td>
</tr>
<tr>
<td>Deductibles</td>
<td>$750</td>
<td>$740</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,000</td>
<td>$1,800</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td><strong>What isn’t covered</strong></td>
<td><strong>What isn’t covered</strong></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
<td>$60</td>
</tr>
<tr>
<td>The total Peg would pay is</td>
<td>The total Joe would pay is</td>
<td>The total Mia would pay is</td>
</tr>
<tr>
<td>$2,810</td>
<td>$2,600</td>
<td>$1,140</td>
</tr>
</tbody>
</table>

The plan would be responsible for the other costs of these EXAMPLE covered services.
We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

**Online:** UHC_Civil_Rights@uhc.com  
**Mail:** Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC), TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

**Online:** https://ocrportal.hhs.gov/ocr/portal/lobby.jsf  
**Complaint forms are available at** http://www.hhs.gov/ocr/office/file/index.html.  
**Phone:** Toll-free 1-800-368-1019, 800-537-7697 (TDD)  
**Mail:** U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC), TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

**ATENCIÓN:** Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

**請注意**：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請撥打本福利和承保摘要 (Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

**XIN LƯU ý:** Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đại thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.
알림: 한국어 (Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서 (Summary of Benefits and Coverage, SBC)에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русском (Russian). Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

Summary of Benefits and Coverage (SBC):

تنبيه: إذا كنت تتحدث العربية (Arabic)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج بداخل مخلص المزايا والتغطية (Benefits and Coverage, SBC).

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez français (French), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l’italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.

注意事項： 日本語 (Japanese)を話される場合、無料の言語支援サービスをご利用いただけます。
本「保障および給付の概要」 (Summary of Benefits and Coverage, SBC) に記載されているフリー ダイヤルにてお電話ください。
توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در انتخاب شما می‌باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش (Benefits and Coverage, SBC) تماس بگیرید.