UNM Medical Plan
summary of benefits

Effective: July 1, 2012

Offered by The Regents of the University of New Mexico
Administered by Lovelace Insurance Company

administered by

Lovelace
Insurance Company

UNM Medical Plan – Summary of Benefits

Type of Service/Benefits	Participant Cost		
	LoboCare Network	Lovelace Expanded Network	Out-of-Network
ANNUAL PLAN YEAR DEDUCTIBLE (Deductible must be met for services subject to the deductible before benefits are paid)	Individual: $200 Family: $600		Individual: $750 Family: $2,250
ANNUAL PLAN YEAR OUT-OF-POCKET MAXIMUM (Does not include Deductible, certain Co-pays, charges above Reasonable and Customary or non-covered charges including charges incurred after the benefit maximum has been reached)	Individual: $1,750 Family: $4,750		Individual: $5,000 Family: $15,000
ANNUAL and MAXIMUM LIFETIME BENEFIT	Unlimited		
Pre-Existing Condition Exclusion	None		
PROVIDER/PRACTITIONER SERVICES including:			
Non-specialist office visits (non-preventive)	$20[2, 3] Co-pay per visit	$25[2, 3] Co-pay per visit	40% Coinsurance
Specialist office visits (non-preventive)	$30[2, 3] Co-pay per visit	$40[2, 3] Co-pay per visit	40% Coinsurance
Outpatient surgery (in Provider/Practitioner's office)	Included in office Co-pay	Included in office Co-pay	40% Coinsurance
Allergy services Testing and Extract Injections Only (no office visit billed)	$50[2, 3] Co-pay No Co-pay[3]	$50[2, 3] Co-pay No Co-pay[3]	40% Coinsurance 40% Coinsurance
Injections such as insulin, heparin and antibiotics	Included in office Co-pay	Included in office Co-pay	40% Coinsurance
Infertility services – diagnosing only Non-specialist office visits	$20[2, 3] Co-pay per visit	$25[2, 3] Co-pay per visit	40% Coinsurance
Specialist office visit	$30[2, 3] Co-pay per visit	$40[2, 3] Co-pay per visit	40% Coinsurance
HOSPITAL SERVICES – Inpatient[1] Coverage includes: • Room and board • Newborn delivery and other hospital obstetrical services • In-hospital Provider/Practitioner visits, Surgeons, Anesthesiologist and other Inpatient services • Detoxification • Administration of blood/blood components	15% Coinsurance	20% Coinsurance	40% Coinsurance

FOOTNOTES:

(1) Benefit Certification may be required. (2) Not Included in the OOP Max. (3) Not Subject to the Deductible. (4) MultiPlan/PHCS Providers are considered to be In-Network for claims payment purposes. Prior to receiving services from MultiPlan/PHCS Providers, please work with the MultiPlan/PHCS provider in obtaining Benefit Certification.

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MEDICAL SERVICES – Outpatient			
Surgeries[1] Hosp/ASC Pro Fees	 15% Coinsurance 15% Coinsurance	 20% Coinsurance 20% Coinsurance	 40% Coinsurance 40% Coinsurance
X-ray, laboratory, and diagnostic tests Preventive Non-preventive	 No Co-pay[3] No Co-pay[3]	 No Co-pay[3] No Co-pay[3]	 Not Covered 40% Coinsurance
Colonoscopy Non-preventive	 No Co-pay[3]	 No Co-pay[3]	 40% Coinsurance
Radiation therapy (non-surgical) In Provider/Practitioner's office Outpatient facility	 Office visit Co-pay[2, 3] 15% Coinsurance	 Office visit Co-pay[2, 3] 20% Coinsurance	 40% Coinsurance 40% Coinsurance
Chemotherapy In Provider/Practitioner's office Outpatient facility	 Office visit Co-pay[2, 3] 15% Coinsurance	 Office visit Co-pay[2, 3] 20% Coinsurance	 40% Coinsurance 40% Coinsurance
Computed Axial Tomography (CAT) Scans[1]	15% Coinsurance	20% Coinsurance	40% Coinsurance
Positron Emission Tomography (PET) Scans[1]	15% Coinsurance	20% Coinsurance	40% Coinsurance
Magnetic Resonance Imaging (MRI) tests[1]	15% Coinsurance	20% Coinsurance	40% Coinsurance
Sleep studies	15% Coinsurance	20% Coinsurance	40% Coinsurance
Administration of blood/blood components	15% Coinsurance	20% Coinsurance	40% Coinsurance
RECONSTRUCTIVE SURGERY[1]	Based on services provided	Based on services provided	Based on services provided
EMERGENCY ROOM CARE Including Trama Services	$150[2, 3] Co-pay per visit	$150[2, 3] Co-pay per visit	$150[2, 3] Co-pay per visit
URGENT CARE	$75[2, 3] Co-pay per visit	$75[2, 3] Co-pay per visit	40% Coinsurance
AMBULANCE SERVICES including: Emergency or high risk • Ground and Air ambulance Inter-facility transfer services • Ground and Air ambulance	 Applies to In-Network Benefit	 20% Coinsurance No Co-pay[3]	 Applies to In-Network Benefit
CLINICAL PREVENTIVE SERVICES Includes: Well child care including vision and hearing screening Preventive physical exam Adult and child immunizations Office based health education Family planning services Cytologic screening (Pap smear) Human Papillomavirus (HPV) screening HPV Vaccine for females nine to 14 years of age Mammography Colonoscopy	No Co-pay[3] No Co-pay[3] No Co-pay[3]	No Co-pay[3] No Co-pay[3] No Co-pay[3]	Not Covered 40% Coinsurance 40% Coinsurance

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WOMEN'S HEALTH CARE			
Preventive Gynecological care			
• Preventive – see Clinical Preventive Services	No Co-pay[3]	No Co-pay[3]	40% Coinsurance
• Non-preventive			
Non-specialist	$20[2, 3] Co-pay per visit	$25[2, 3] Co-pay per visit	40% Coinsurance
Specialist (includes Perinatologist)	$30[2, 3] Co-pay per visit	$40[2, 3] Co-pay per visit	
Implantable contraceptive device	Included in office visit Co-pay	Included in office visit Co-pay	40% Coinsurance
Obstetrical/Maternity/Prenatal and Postnatal care (excludes delivery)	$20[2, 3] Co-pay for first visit only. (Plan pays 100% thereafter)	$25[2, 3] Co-pay for first visit only. (Plan pays 100% thereafter)	40% Coinsurance
DIABETES SERVICES			
Office visit and Diabetes Education			
Non-specialist	$20[2, 3] Co-pay per visit	$25[2, 3] Co-pay per visit	40% Coinsurance
Specialist	$30[2, 3] Co-pay per visit	$40[2, 3] Co-pay per visit	40% Coinsurance
Diabetes supplies[1] (If purchased through a Durable Medical Equipment Provider). Other Diabetic Supplies are covered under the Express Scripts Prescription Drug Benefit.)	Not Available	20% Coinsurance	40% Coinsurance
PRESCRIPTION DRUGS	Administered by Express Scripts. Call Express Scripts at 1-800-232-6549.		
MENTAL HEALTH SERVICES			
Outpatient[1]	$30[2, 3] Co-pay per visit	$40[2, 3] Co-pay per visit	40% Coinsurance
Inpatient/Partial Hospitalization[1]	15% Coinsurance	20% Coinsurance	40% Coinsurance
ALCOHOL AND SUBSTANCE ABUSE SERVICES			
Rehabilitation			
Outpatient[1]	$30[2, 3] Co-pay per visit	$40[2, 3] Co-pay per visit	40% Coinsurance
Inpatient/Partial Hospitalization[1]	15% Coinsurance	20% Coinsurance	40% Coinsurance
Detoxification			
Outpatient[1]	$30[2, 3] Co-pay per visit	$40[2, 3] Co-pay per visit	40% Coinsurance
Inpatient/Partial Hospitalization[1]	15% Coinsurance	20% Coinsurance	40% Coinsurance
REHABILITATION AND THERAPY SERVICES			
Cardiac rehabilitation (36 visits per Annual Plan Year)	$30[2, 3] Co-pay per visit	$40[2, 3] Co-pay per visit	40% Coinsurance
Dialysis/Plasmapheresis/ Photopheresis	15% Coinsurance	20% Coinsurance	40% Coinsurance
Pulmonary rehabilitation (up to 24 visits per Annual Plan Year)	$30[2, 3] Co-pay per visit	$40[2, 3] Co-pay per visit	40% Coinsurance
Short-term rehabilitation	$30[2, 3] Co-pay per visit	$40[2, 3] Co-pay per visit	40% Coinsurance
Physical therapy (up to 30 visits per Annual Plan Year)			
Occupational therapy (up to 20 visits per Annual Plan Year)			
Speech and Hearing therapy (up to 20 visits per Annual Plan Year)	$30[2, 3] Co-pay per visit	$40[2, 3] Co-pay per visit	40% Coinsurance

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TRANSPLANTS(1)	15% Coinsurance	20% Coinsurance	Not Covered
COMPLEMENTARY THERAPIES (LIMITED) Acupuncture treatment (20 visits per Annual Plan Year)	$30(2, 3) Co-pay per visit	$40(2, 3) Co-pay per visit	40% Coinsurance
Chiropractic services (20 visits per Annual Plan Year)	Not Available	$40(2, 3) Co-pay per visit	40% Coinsurance
SKILLED NURSING FACILITY(1) (Up to 60 days per Annual Plan Year)	Not Available	20% Coinsurance	40% Coinsurance
HOME HEALTHCARE SERVICES/ HOME INTRAVENOUS SERVICE(1) Services provided by an RN, LPN and other specified specialist to include, but not limited to home IV services (up to 100 days per Annual Plan Year)	Not Available	20% Coinsurance	40% Coinsurance
HOSPICE CARE(1) LoboCare services limited to Pediatric Hospice only.	15% Coinsurance	20% Coinsurance	40% Coinsurance
DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND APPLIANCES1 Hearing Aids (for school-aged children under age 18 or 21 years of age if still attending high school). Up to $2,200 every 36 months "per hearing-impaired ear"	Not Available	20% Coinsurance	40% Coinsurance
EYEGLASSES AND CONTACT LENSES Limited to the following: • Eyeglasses and contact lenses within 12 months following cataract surgery or for the correction of Keratoconus(1)	15% Coinsurance	20% Coinsurance	Not Covered
• Refraction eye exam associated with post-cataract surgery or Keratonconus correction	15% Coinsurance	20% Coinsurance	Not Covered
DENTAL SERVICES (LIMITED)/ CMJ/TMJ	15% Coinsurance	20% Coinsurance	40% Coinsurance
FAMILY, INFANT AND TODDLER PROGRAM Family, Infant and Toddler Program (FIT): Medically Necessary early intervention services provided as part of an individualized family service plan and delivered by certified and licensed personnel as defined in NMAC Title 7, Chapter 30, Part 8 Health Family & Children Health Care Services.	No Co-pay(3)	No Co-pay(3)	Not Covered
	$3,500 per Participant per Plan Year Maximum annual benefit Not applicable to any lifetime maximums or annual limits		

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Exclusions and Limitations

EXCLUSIONS

Refer to the UNM Medical Plan Benefit Booklet for a complete listing of Plan Exclusions. Your Plan provides coverage for Medically Necessary and/or services Pre-Authorized by the Plan Medical Director. Your Plan does not provide coverage for the following, except as required by law:

- Alternative treatments including but not limited to aroma, massage or hypno therapy
- Any treatment, procedure, service, facility, equipment, drugs, drug usage, device or supply determined not to be Medically Necessary, except for those that are Authorized by the Plan
- Artificial aids including but not limited to hearing aids, devices or computers to assist in communication or speech except as required by law
- Benefits and services not specified as Covered in this document or the UNM Medical Plan Benefit Booklet
- Care for military service-connected disabilities for which the Participant is legally entitled to and for which facilities are reasonably available to the Participant
- Charges that are determined to be unreasonable by the Plan
- Cosmetic surgery or treatment except as Authorized by the Plan or as listed in the UNM Medical Plan Benefit Booklet
- Custodial, domiciliary or respite care
- Dental care, except as required by law and as written in the UNM Medical Plan Benefit Booklet
- Diapers and incontinence supplies
- Expenses for services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Plan
- Experimental services, investigational or unproven procedures or protocols, including drugs or equipment, except as required by law
- Foot care including but not limited to cutting or removal of corns/calluses, nail trimming, cutting or debriding
- Infertility & reproductive services/procedures including but not limited to In-vitro, GIFT, ZIFT, surrogate parenting, reversal of voluntary sterilization, donor egg or sperm retrieval and storage
- Immunizations, inoculations, exams, and other related services required for licensing, employment, marriage, insurance or travel purposes
- Infant or baby food/formula or breast milk or other regular grocery products that can be processed for oral or tube feedings
- Medical or surgical services for the treatment or control of obesity, including (but not limited to) bariatric surgery
- Nursing home care, except those services Authorized by the Plan and provided in a Plan approved skilled nursing facility
- Orthopedic shoes and foot orthotics, unless determined to be Medically Necessary for the treatment of diabetes
- Outpatient prescription drugs.For Prescription drug information, please refer to your Express Scripts benefit materials.
- Repairs for Durable Medical Equipment (DME), prosthetic or orthotic devices that were not provided by the Plan
- Services and procedures for sexual transformation
- Services for which other coverage is required to provide through other arrangements, including but not limited to workers' compensation, automobile insurance or similar coverage
- Services of a provider which are not within his/her scope of practice

EXCLUSIONS (continued)

- Services/benefits related to the treatment of mental illness and substance abuse conditions that are not described in the Benefits and Services or Limitations sections of the UNM Medical Plan Benefit Booklet; Excluded services/benefits include but are not limited to residential treatment center (RTC) and treatment foster care (TFC) services
- Travel, lodging and other related expenses, except as defined in the UNM Medical Plan Benefit Booklet
- Treatment for sexual dysfunction, including but not limited to medications, counseling and clinics
- Treatment or services provided in connection with or to comply with involuntary commitments, police detention, court-orders or other similar arrangements
- Vision/eye refractive services and optical appliances, except as required by law and as written in the UNM Medical Plan Benefit Booklet
- Vitamins (except Medically Necessary prenatal vitamins), minerals, food supplements (except Special Medical Foods as outlined in the UNM Medical Plan Benefit Booklet)
- Vocational rehabilitation services
- Weight loss, physical conditioning programs or exercise programs of any type

LIMITATIONS

Refer to the UNM Medical Plan Benefit Booklet for a complete listing of Plan Limitations. Your plan has limited coverage for the following services:

- Acupuncture
- Ambulance service
- Cardiac Rehabilitation
- Chiropractic services
- Circumstances beyond the Plan's control
- Consumable medical supplies
- Craniomandibular joint (CMJ) and temporomandibular joint (TMJ) dysfunction conditions – surgical and non-surgical treatment of TMJ is covered when Medically Necessary and Authorized by the Plan Medical Director as required
- Durable Medical Equipment (DME)
- External Prosthetic Appliances (EPA)
- Family planning evaluation and treatment services
- Growth Hormone therapy
- Home Health Services
- Infertility Diagnostic Services
- Long-term rehabilitative therapy
- Organ transplants, immunosuppressive drugs and transplant related travel and lodging
- Outpatient Substance Abuse Services
- Physical, Occupational and Speech Therapy
- Podiatric services
- Pulmonary Rehabilitation
- Skilled nursing and Rehabilitation services
- Tobacco cessation
- Vision and hearing screening/care

Out-of-Network services are subject to Annual Deductible and reimbursement/payment is limited to reasonable/usual and customary (U&C) charges. U&C refers to the rates that prevail in the area where the services are obtained. Participant is responsible for paying 100% of charges that exceed the U&C amount.