UNM Health – Schedule Of Benefits

UNM Medical Plan Benefits and Coverage	UNM Health Network	Extended Network (*Benefit Determination Required*) [1]	Out-of-Network
ANNUAL PLAN YEAR DEDUCTIBLE (Deductible must be met for services subject to the deductible before benefits are paid)	Individual: $600[3] Family: $1,200[3]		Individual: $1,800 Family: $3,600
ANNUAL PLAN YEAR OUT-OF-POCKET MAXIMUM	Individual: $3,000 Family: $6,000 (Includes: Medical Deductible, Medical and Prescription Coinsurance and Copayments)		Individual: $7,500 Family: $15,000 (Includes Medical Coinsurance ONLY. Excludes Medical Deductible and Prescription Copayments and Coinsurance)
ANNUAL and MAXIMUM LIFETIME BENEFIT	Unlimited		
Pre-Existing Condition Exclusion	None		
PROVIDER/PRACTITIONER SERVICES Including:			
Non-specialist office visits – (non-preventive)	$25[2,3] Co-pay per visit	$30[1,2,3] Co-pay per visit	40%[5] Coinsurance
Specialist office visits – (non-preventive)	$35[2,3] Co-pay per visit	$45[1,2,3] Co-pay per visit	40%[5] Coinsurance
Outpatient surgery (In-Provider/Practitioner's office)	Included in office Co-pay	Included in office Co-pay	40%[5] Coinsurance
Allergy services Testing and Extract Injections Only (no office visit billed)	 $55[2,3] Co-pay No Co-pay[2]	 $55[1,2,3] Co-pay No Co-pay[1,2]	 40%[5] Coinsurance 40%[5] Coinsurance
Injections such as insulin, heparin and antibiotics	Included in office visit Co-pay	Included in office visit Co-pay	40%[5] Coinsurance
Infertility services – diagnosing only Non-specialist office visits	$25[2,3] Co-pay per visit	$30 [1,2,3] Co-pay per visit	40%[5] Coinsurance
Specialist office visit	$35[2,3,6] Co-pay per visit	$45[1,2,3,6] Co-pay per visit	40%[5,6] Coinsurance

UNM Health – Schedule Of Benefits

UNM Medical Plan Benefits and Coverage	UNM Health Network	Extended Network (*Benefit Determination Required*) [1]	Out-of-Network
HOSPITAL SERVICES – Inpatient[6,7] 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	10%[3,4] Coinsurance	30%[1,3,4] Coinsurance	40%[5] Coinsurance
MEDICAL SERVICES – Outpatient Surgeries[6,7]			
Hospital/ASC Facility Fees	10%[3,4] Coinsurance	30%[1,2,3] Coinsurance	40%[5] Coinsurance
Professional Fees	10%[3,4] Coinsurance	30%[1,3,4] Coinsurance	40%[5] Coinsurance
X-ray, laboratory, and diagnostic tests (Not including CT/ PET Scans, MRI, or Nuclear Medicine)			
Preventive	No Co-pay[2]	No Co-pay[1,2]	Not Covered
Non-preventive	No Co-pay[2]	No Co-pay[1,2]	40%[5] Coinsurance
Endoscopy	10%[3,4] Coinsurance	30%[1,3,4] Coinsurance	40%[5] Coinsurance
Colonoscopy (Non-preventive)	No Co-pay[2]	No Co-pay[1,2]	40%[5] Coinsurance
Radiation therapy (Non-Surgical)[6]			
In Provider/Practitioner's office	Office visit Co-pay[2,3]	Office visit Co-pay[1,2,3]	40%[5] Coinsurance
Outpatient facility	10%[3,4] Coinsurance	30%[1,3,4] Coinsurance	40%[5] Coinsurance
Chemotherapy[6]			
In Provider/Practitioner's office	Office Visit Co-pay[2,3]	Office visit Co-pay[1,2,3]	40%[5] Coinsurance
Outpatient facility	10%[3,4] Coinsurance	30%[1,3,4] Coinsurance	40%[5] Coinsurance
Computed Axial Tomography (CAT) Scans[6]	10%[3,4] Coinsurance	30%[1,3,4] Coinsurance	40%[5] Coinsurance
Positron Emission Tomography (PET) Scans[6]	10%[3,4] Coinsurance	30%[1,3,4] Coinsurance	40%[5] Coinsurance
Magnetic Resonance Imaging (MRI) tests[6]	10%[3,4] Coinsurance	30%[1,3,4] Coinsurance	40%[5] Coinsurance
Nuclear Medicine[6]	10%[3,4] Coinsurance	30%[1,3,4] Coinsurance	40%[5] Coinsurance
Sleep studies	10%[3,4] Coinsurance	30%[1,3,4] Coinsurance	40%[5] Coinsurance

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RECONSTRUCTIVE SURGERY(6)	Usual copayment or coinsurance based on place of treatment and type of service(1,2,3,4,5,7,9)		
EMERGENCY ROOM CARE **Including trauma 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%(5) Coinsurance
AMBULANCE SERVICES Includes: • Emergency or high risk Ground and Air ambulance • Inter-facility transfer services Ground and Air ambulance	Applies to In-Network Benefit	30%(3,4) Coinsurance No Co-pay(2)	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 • Colonoscopy	No Co-pay(2,8)	No Co-pay(1,2,8)	Not Covered
WOMEN'S HEALTH CARE Preventive Care Services • Well-woman visits to include adult and female-specific screenings • Mammograms • Cytological Screening (Pap tests) including screening for papillomavirus • Screening for gestational diabetes • Counseling for HIV and sexually transmitted diseases • Screening and counseling for interpersonal and domestic violence	No Co-pay(2,8)	No Co-pay(1,2,8)	40%(5) Coinsurance

UNM Health – Schedule Of Benefits

UNM Medical Plan Benefits and Coverage	UNM Health Network	Extended Network (*Benefit Determination Required*) (1)	Out-of-Network
WOMEN'S HEALTH CARE (continued)			
Preventive Care Services • FDA Approved Surgical sterilization procedures for women's sterilization • Contraceptive implant insertion/re-insertion fee • Contraception counseling • Breast feeding support, supplies and counseling(8)	No Co-pay(2,8)	No Co-pay(1,2,8)	40%(5) Coinsurance
Non-preventive Non-specialist	$25(2,3) Co-pay per visit	$30(1,2,3) Co-pay per visit	40%(5) Coinsurance
Specialist (includes Perinatologist)	$35(2,3) Co-pay per visit	$45(1,2,3) Co-pay per visit	40%(5) Coinsurance
Obstetrical/Maternity/Prenatal and Postnatal care (excludes delivery)	$25(2, 3) Co-pay for first visit. (Plan pays 100% thereafter)	$30(1,2,3) Co-pay for first visit. (Plan pays 100% thereafter)	40%(5) Coinsurance
DIABETES SERVICES Office visit and Diabetes Education			
Non-specialist	$25(2,3) Co-pay per visit	$30(1,2,3) Co-pay per visit	40%(5) Coinsurance
Specialist	$35(2,3) Co-pay per visit	$45(1,2,3) Co-pay per visit	40%(5) Coinsurance
Diabetes supplies (6) (If purchased through a Durable Medical Equipment Provider). Other Diabetic Supplies are covered under the Express Scripts Prescription Drug Benefit.	10%(3,4) Coinsurance	30%(1,3,4) Coinsurance	40%(5) Coinsurance
PRESCRIPTION DRUGS(2,3)	**Administered by Express Scripts**. Call Express Scripts at **1-800-232-6549**.		

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MENTAL HEALTH SERVICES			
Outpatient	$35(2,3) Co-pay per visit	$45(1,2,3) Co-pay per visit	40%(5) Coinsurance
Inpatient/Partial Hospitalization(6)	10%(3,4) Coinsurance	30%(1,3,4) Coinsurance	40%(5) Coinsurance
ALCOHOL AND SUBSTANCE ABUSE SERVICES			
Rehabilitation			
Outpatient(6)	$35(2,3) Co-pay per visit	$45(1,2,3) Co-pay per visit	40%(5) Coinsurance
Inpatient/Partial Hospitalization(6)	10%(3,4) Coinsurance	30%(1,3,4) Coinsurance	40%(5) Coinsurance
Detoxification			
Outpatient(6)	$35(2,3) Co-pay per visit	$45(1,2,3) Co-pay per visit	40%(5) Coinsurance
Inpatient/Partial Hospitalization(6)	10%(3,4) Coinsurance	30%(1,3,4) Coinsurance	40%(5) Coinsurance
REHABILITATION AND THERAPY SERVICES			
Cardiac rehabilitation (36 visits per Annual Plan Year)(6)	$35(2,3) Co-pay per visit	$45(1,2,3) Co-pay per visit	40%(5) Coinsurance
Dialysis/Plasmapheresis/ Photopheresis(6)	10%(3,4) Coinsurance	30%(1,3,4) Coinsurance	40%(5) Coinsurance
Pulmonary rehabilitation(6) (up to 24 visits per Annual Plan Year)	$35(2,3) Co-pay per visit	$45(1,2,3) Co-pay per visit	40%(5) Coinsurance
Short-term rehabilitation (up to 70 visits **combined** per Annual Plan Year) • Physical therapy • Occupational therapy • Speech and Hearing Therapy	$35(2,3) Co-pay per visit	$45(1,2,3) Co-pay per visit	40%(5) Coinsurance
AUTISM/APPLIED BEHAVIORAL ANALYSIS(6)	Usual copayment or coinsurance based on place of treatment and type of service(1,2,3,4,5,6,7,9) (Autism related short-term rehabilitation services are subject to the combined 70 visit limitation listed above in the Short-term rehabilitation section)		

UNM Health – Schedule Of Benefits

UNM Medical Plan Benefits and Coverage	UNM Health Network	Extended Network (*Benefit Determination Required*) (1)	Out-of-Network
TRANSPLANTS(6)	10%(3,4) Coinsurance	30%(1,3,4) Coinsurance	Not Covered
COMPLEMENTARY THERAPIES (Limited)			
Acupuncture treatment (20 visits per Annual Plan Year)	$35(2,3) Co-pay per visit	$45(1,2,3) Co-pay per visit	40%(5) Coinsurance
Chiropractic services (20 visits per Annual Plan Year)	$35(2,3) Co-pay per visit	$45(1,2,3) Co-pay per visit	40%(5) Coinsurance
SKILLED NURSING FACILITY(6) (Up to 60 days per Annual Plan Year)	10%(3,4) Coinsurance	30%(1,3,4) Coinsurance	40%(5) Coinsurance
HOME HEALTH CARE SERVICES/ HOME INTRAVENOUS SERVICE(6) 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)	10%(3,4) Coinsurance	30%(1,3,4) Coinsurance	40%(5) Coinsurance
HOSPICE CARE(6)	10%(3,4) Coinsurance	30%(1,3,4) Coinsurance	40%(5) Coinsurance
DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND APPLIANCES(6) 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"	10%(3,4) Coinsurance	30%(1,3,4) Coinsurance	40%(5) 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	10%(3,4) Coinsurance	30%(1,3,4) Coinsurance	Not Covered
• Refraction eye exam associated with post-cataract surgery or Keratoconus correction	10%(3,4) Coinsurance	30%(1,3,4) Coinsurance	Not Covered

UNM Health – Schedule Of Benefits

UNM Medical Plan Benefits and Coverage	UNM Health Network	Extended Network (*Benefit Determination Required*) [1]	Out-of-Network
DENTAL SERVICES (LIMITED)/ CMJ/TMJ	10%[3,4,6] Coinsurance	30%[1,3,4,6] Coinsurance	40%[5] 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[2] $3,500 per Participant per Plan Year Maximum annual benefit Not applicable to any lifetime maximums or annual limits	No Co-pay[1,2]	Not Covered

[1]Benefit Determination is required prior to receiving services from an Extended Network Provider. Please work with your Primary Care Provider to obtain Benefit Determination. Claims submitted without Benefit Determination are subject to the Out-of-Network benefit level.

[2]Not Subject to the Deductible.

[3]Included in the *UNM Health Network and Extended Network* ***Out-of-Pocket Maximum.***

[4]Subject to the *UNM Health Network and Extended Network* ***Deductible.***

[5]Subject to the Out-of-Network Deductible and Out-of-Network Out-of-Pocket Maximum.

[6]May require preauthorization for medical necessity before receiving services. If services requiring Prior Authorization are received and Prior Authorization is not obtained, you will be responsible for the resulting charges. Services rendered beyond the scope of Prior Authorization are not covered.

[7]Each Inpatient or Outpatient facility visit will generate at least two claims; a facility claim and a professional claim, both will apply Deductible and Coinsurance.

[8]The Patient Protection and Affordable Care Act requires the UNM Medical Plan to cover specific Preventive Care Services, including Women's Preventive Care Services, at no cost to Participants when the services are provided by a UNM Health Network or Extended Network Participating Provider. Though these specific services are covered at no charge, the provider may charge a Co-payment or other applicable fees for other services provided during the office visit. Additionally, some covered Family Planning services, for example male vasectomies, continue to require some Participant cost sharing. If you have questions regarding the Preventive Care Services that are covered under your plan, including Family Planning services, or your cost for these services, please refer to your PBB or contact the Customer Care Center.

[9]Patients are responsible for Co-payments related to place of services, ancillary services, and additional procedures performed at the same time. Prior authorization rules still apply.

UNM Health - Schedule Of Benefits

EXCLUSIONS FOR UNM MEDICAL PLAN:

Any exclusion listed would not be applicable, if covered under, the FIT Program in accordance with that which is defined in NMAC Title 7, Chapter 30, Part 8 Health Family & Children Health Care Services. Refer to your Participant Benefit Booklet for details.

Please refer to the Participant Benefit Booklet for a more complete description of exclusions and limitations.

- Any service, treatment, procedure, facility, equipment, drugs, drug usage, device or supply determined to be **not Medically Necessary** or accepted medical practice. This includes any service, which is not generally recognized by the medical community as conforming to accepted medical practice, or any service for which the required approval of a government agency has not been granted at the time the service is provided.
- **Alternative/complementary therapies** except as specified in the Covered Services Section under "Complementary Therapies" of the *Participant Benefit Booklet*.)
- **Artificial aids** including speech synthesis devices (except items identified as being covered in the Covered Services Section under "Durable Medical Equipment" in the *Participant Benefit Booklet.)*
- **Athletic trainers**
- **Autopsies and/or transportation costs** for deceased Participants, except as outlined in the Covered Section under "Repatriation Reimbursement."
- **Baby food** (including baby formula or breast milk) or other regular grocery products that can be blenderized for oral or tube feedings.
- **Behavioral Health Services:**
    - **Halfway houses**
    - **Residential Treatment Centers**
    - **Co-dependency treatment**
    - **Counseling –** sex, pastoral/spiritual, and bereavement counseling
    - **Psychological testing** when not Medically Necessary
    - **Special education**, school testing or evaluations, counseling, therapy or care for learning deficiencies or disciplinary problems. This applies whether or not associated with manifest mental illness or other disturbances except as Covered under the Family, Infant and Toddler Program. Refer to the *Participant Benefit Booklet* for more information.
- **Benefits and services not specified as Covered**
- **Biofeedback**
- **Cancer Clinical Trials** must be provided for in the State of New Mexico in **accordance with the provisions set forth in the *Participant Benefit Booklet.*** Refer to your *Participant Benefit Booklet* for details.
- **Care for conditions which state or local law requires** be treated in a public or correctional facility.

- **Care for military service connected disabilities** to which the Participant is legally entitled and for which facilities are reasonably available to the Participant.
- **Charges that are determined to be unreasonable by PHP and charges in excess of Reasonable and Customary Charges.**
- **Circumcisions** performed other than during the newborn's Hospital stay, unless Medically Necessary.
- **Clothing or other protective devices** including prescribed photo protective clothing, windshield tinting, lighting fixtures and/or shields, and other terms or devices whether by prescription or not.
- **Common disposable medical supplies** that can be purchased over the counter such as, but not limited to, bandages, band aids, gauze (such as 4 by 4's), and ace bandages, except when provided in a Hospital or Physician's office or by and home health professional.
- **Convenience items** as listed in the Exclusions Section under "Convenience items of the *Participant Benefit Booklet*."
- **Corrective eyeglasses** or sunglasses, frames, lens prescriptions, contact lenses or fitting thereof, except as identified in the Covered Services Section under "Durable Medical Equipment" of the *Participant Benefit Booklet*.
- **Cosmetic Surgery, treatments, devices, orthotics, and medications,** including treatment of hair loss as listed in the *Participant Benefit Booklet*.
- **Costs for extended warranties** and premiums for other insurance coverage.
- **Court ordered evaluation or treatment** or treatment that is a condition of parole or probation or in lieu of sentencing, such as Alcohol or Substance Abuse programs and/or psychiatric evaluation or therapy.
- **Custodial or domiciliary or Respite care**
- **Dental Services:**
  - **Dental care** and dental ex-rays except as provided in the *Participant Benefit Booklet*
  - **Dental implants**
  - **Malocclusion treatment,** if part of routine dental care and
  - orthodontics
  - **Orthodontic appliances, endodontics, dental prosthetics,**
    - **crowns, bridges, and dentures**
  - **Orthodontic appliances** and orthodontic treatment (braces), crowns, bridges and dentures used for the treatment of Craniomandibular and Temporomandibular Joint disorders, unless the disorder is trauma related
- **Durable Medical Equipment:**
  - **Duplicate Durable Medical Equipment items** (i.e. for home and office)
  - **Foot orthotics,** functional and/or customized except as described in the *Participant Benefit Booklet.*
  - **Upgraded or deluxe Durable Medical Equipment**
  - **Additional wheelchairs,** if the Participant has a functional wheelchair, regardless of the original purchaser of the wheelchair.
  - **Repair or replacement of Durable Medical Equipment,** Orthotic Appliances and Prosthetic Devices due to loss, neglect, misuse, abuse, to improve appearance or convenience.
  - **Repair and replacement** of items under the manufacturer or supplier's warranty.
- **Elastic support hose**
- **Elective abortions** after the 24th week of pregnancy

- **Elective Home Birth** and any prenatal or postpartum services connected with an elective home birth.
- **Emergency facility** used for non-emergent services
- **Exercise equipment and videos,** personal trainers, club membership and weight reduction programs.
- **Experimental or Investigational,** as determined by PHP, drugs, medicines, treatments, or procedures as listed in the Exclusions Section under "Experimental or Investigational" of the *Participant Benefit Booklet.*
- **Extracorporeal shock wave therapy** involving the musculoskeletal system.
- **Foot care (routine),** except as provided in the *Participant Benefit Booklet.*
- **Genetic Inborn Errors of Metabolism** as listed in the *Participant Benefit Booklet.*
- **"Get acquainted"** visits without physical assessment or diagnostic or therapeutic intervention provided.
- **Gloves,** unless part of a wound treatment kit.
- **Hair loss** (or baldness) treatments, medications, supplies and devices including wigs, and special brushes.
- **Hearing aids** and the evaluation for the fitting of hearing aids except for school-aged children under 18 years old (or under 21 years of age if still attending high school).
- **Home sleep studies**
- **Hospice benefits are not available for the following services**
  - **Food, housing, and delivered meals;** or
  - **Volunteer services;** or
  - **Comfort items** such as, but not limited to, aromatherapy, clothing, pillows, special chairs, pet therapy, fans, humidifiers, and special beds (excluding those Covered under Durable Medical Equipment benefits); or
  - **Homemaker and housekeeping services;** or
  - **Private duty nursing;** or
  - **Pastoral and spiritual counseling;** or
  - **Bereavement counseling**
- **Hypnotherapy**
- **Infant formula**
- **Infertility/Artificial conception:**
  - **Artificial insemination**
  - **Donor sperm**
  - **In-vitro, GIFT and ZIFT fertilization**
- **Lay midwife** – Services of a lay midwife or an unlicensed midwife. (Services of a certified lay midwife in an inpatient facility are covered)
- **Massage Therapy**
- **Medical and Hospital services of a donor** when the recipient of an organ transplant is not a Participant or when the transplant procedure is not covered.
- **Nutritional supplements** unless for prenatal care as prescribed by the attending Physician or as sole source of nutrition.
- **Organ transplants (Non-human),** except for porcine (pig) heart valve.
- **Orthopedic or corrective shoes,** arch supports, shoe appliances, foot orthotics, and custom fitted braces or splints except for patients with diabetes or other significant neuropathies.
- **Personal or comfort items, services or treatments**
- **Photopheresis** for all conditions other than mycosis fungoides.

- **Physical examinations,** vaccinations, drugs and immunizations for the primary intent of medical research or non-Medically Necessary purpose(s) such as, but not limited to, licensing, certification, employment, insurance, flight, travel, passports or functional capacity examinations related to employment.
- **Private-duty nursing**
- **Reversals of voluntary sterilization**
- **Rolfing**
- **Routine foot care, except** as listed in the *Participant Benefit Booklet.*
- **Services for which the Participant or Dependent is eligible under any governmental program** (except Medicaid) or services for which, in the absence of any health service plan or insurance plan, no charge would be made to the Participant or Dependent.
- **Services,** other than Emergent or urgent in nature, received **outside of the United States.**
- **Services requiring Benefit Certification** when Benefit Certification was not obtained.
- **Sexual dysfunction treatment,** including medication, counseling, and clinics except for penile prosthesis as provided in the *Participant Benefit Booklet.*
- **Storage of banking** of sperm, ova (human eggs), embryos, zygotes, or other human tissue.
- **"Telephone visits"** by a Provider/Practitioner or "environmental intervention" or "consultation" by telephone for which a charge is made to the patient.
- **Transportation costs** for deceased Participants except as outlined in the Covered Services Section under "Repatriation Reimbursement" of the *Participant Benefit Booklet*.
- **Travel and lodging** expenses, except as provided in the *Participant Benefit Booklet*.
- **Vision Services:**
  - **Eye movement therapy**
  - **Eye refractive procedures** including radial keratotomy, laser procedures and other techniques
  - **Routine vision care and Eye Refractions** for determining prescriptions for corrective lenses, except as listed as Covered in the *Participant Benefit Booklet*.
- **Visual training**
- **Vocational Rehabilitation services and Long-Term Rehabilitation services.**
- Medical and surgical services for **weight management** except as listed as Covered in the *Participant Benefit Booklet.* Treatment and medications for the purpose of **weight reduction** or control
- **Work-related accidents** or injuries or occupational illness or disease if the Participant is required to be covered under workers' compensation insurance, whether or not such coverage actually exists.

Please refer to the Participant Benefit Booklet for a more complete description of exclusions and limitations.

This Schedule of Benefits and services is subject to the provisions of the contract and cannot modify or affect the Participant Benefit Booklet in any way; nor shall you accrue rights because of any statement in or omission from this Schedule.