UNM LoboHEALTH Plan

Summary of Benefits

Effective July 1, 2023 – June 30, 2024

UNM Medical Plan Benefits and Coverage	UNM LoboHEALTH Network (Tier 1)	BCBSNM In-Network[6] (Tier 2)	Out-of-Network[1] (Tier 3)
ANNUAL PLAN YEAR DEDUCTIBLE (Deductible must be met for services subject to the deductible before benefits are paid)	Individual: $600[3]		Individual: $1,800
	Family: $1,200[3]		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			
Non-specialist office visits – (non-preventive)	$10 Copay[2,3] per visit	$30 Copay[2,3] per visit	40% Coinsurance[5]
Telemedicine Visits	$10 / $20 Copay[2,3] per visit	$30 / $45 Copay[2,3] per visit	40% Coinsurance[5]
Virtual Visits (MDLIVE providers)	Applies to Tier 2 Benefit Level	$30 Copay per visit[2,3]	Not Covered
Specialist office visits – (non-preventive)	$20 Copay[2,3] per visit	$45 Copay[2,3] per visit	40% Coinsurance[5]
Outpatient surgery (In Provider / Practitioner's office)	Included in office visit copay	Included in office visit copay	40% Coinsurance[5]
Allergy Services			
Testing and Extract	$55 Copay[2,3] per visit	$55 Copay[2,3] per visit	40% Coinsurance[5]
Injections Only (no office visit billed)	No copay[2]	No copay[2]	40% Coinsurance[5]
Injections such as insulin, heparin and antibiotics	Included in office visit copay	Included in office visit copay	40% Coinsurance[5]
INFERTILITY SERVICES – diagnosing only			
Non-specialist office visits Specialist office visit	$10 Copay[2,3] per visit $20 Copay[2,3] per visit	$30 Copay[2,3] per visit $45 Copay[2,3] per visit	40% Coinsurance[5] 40% Coinsurance[5]
HOSPITAL SERVICES – Inpatient[1,7]			
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	$500 Copay[2,3] per Inpatient Admission	25% Coinsurance[3,4]	40% Coinsurance[5]
MEDICAL SERVICES – Outpatient			
Surgeries[1,7]			
Hospital/ASC Facility	$250 Copay[2,3]	25% Coinsurance[3,4]	40% Coinsurance[5]
Fees / Professional Fees	Included in Copay	25% Coinsurance[3,4]	40% Coinsurance[5]
X-ray, laboratory, and diagnostic tests			
Preventive	No Copay[2]	No Copay[2]	Not Covered
Non-preventive	No Copay[2]	No Copay[2]	40% Coinsurance[5]
Endoscopy	$250 Copay[2,3]	25% Coinsurance [3,4]	40% Coinsurance[5]
Colonoscopy (Non-preventive)	No Copay[2]	No Copay[2]	40% Coinsurance[5]
Radiation Therapy (Non-surgical)[1]			
In Provider/Practitioner's office	Office Visit Copay[2,3]	Office Visit Copay[2,3]	40% Coinsurance[5]
Outpatient Facility	$50 Copay[2,3]	25% Coinsurance[3,4]	40% Coinsurance[5]
Chemotherapy[1]			
In Provider / Practitioner's office	Office Visit Copay[2,3]	Office Visit Copay[2,3]	40% Coinsurance[5]
Outpatient Facility	$50 Copay[2,3]	25% Coinsurance[3,4]	40% Coinsurance[5]

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MEDICAL SERVICES – Outpatient Cont.			
Computed Axial Tomography (CAT) Scans[1]	$150 Copay[2,3] per service	25% Coinsurance[3,4]	40% Coinsurance[5]
Positron Emission Tomography (PET) Scans[1]			
Magnetic Resonance Imaging (MRI) Tests[1]			
Nuclear Medicine[1]			
Sleep Studies[1]			
Administration of blood / blood components[1]			
RECONSTRUCTIVE SURGERY[1]	Usual copayment or coinsurance based on place of treatment and type of service[2,3,4,5,7,9]		
EMERGENCY ROOM CARE Including trauma services	$150 Copay[2,3] per visit	$150 Copay[2,3] per visit	$150 Copay[2,3] per visit
URGENT CARE	$50 Copay[2,3] per visit	$75 Copay[2,3] per visit	40% Coinsurance[5]
AMBULANCE SERVICES			
Emergency or high-risk Ground and Air Ambulance	Applies to In-Network Benefit	25% Coinsurance[3,4]	Applies to In-Network Benefit
Inter-facility transfer services Ground and Air Ambulance	Applies to In-Network Benefit	No copay[2]	Applies to In-Network Benefit
CLINICAL PREVENTIVE SERVICES			
Well child care including vision and hearing screening	No copay[2,8]	No copay[2,8]	Not Covered
Preventive physical exam			
Adult and child immunizations			
Office-based health education			
Family planning services			
Colonoscopy			
WOMEN'S HEALTH CARE – Preventive and Non-Preventive Care Services			
Well-woman visits to include adult and female-specific screenings	No copay[2,8]	No copay[2,8]	40% Coinsurance[5]
Mammograms			
Cytologic 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			
FDA-approved surgical sterilization procedures for women's sterilization			
Contraceptive implant insertion/re-insertion			
Contraception counseling			
Breast feeding support, supplies and counseling[8]			
Non-preventive Non-specialist	$10 Copay[2,3] per visit	$30 Copay[2,3] per visit	40% Coinsurance[5]
Specialist (includes Perinatologist)	$20 Copay[2,3] per visit	$45 Copay[2,3] per visit	40% Coinsurance[5]
Obstetrical / Maternity / Prenatal and Postnatal care (excludes delivery)	$10 Copay[2,3] for first visit (Plan pays 100% thereafter)	$30 Copay[2,3] for first visit (Plan pays 100% thereafter)	40% Coinsurance[5]
DIABETES SERVICES			
Office visit and Diabetes Education Non-specialist	$10 Copay[2,3] per visit	$30 Copay[2,3] per visit	40% Coinsurance[5]
Specialist	$20 Copay[2,3] per visit	$45 Copay[2,3] per visit	40% Coinsurance[5]
Certified Diabetes Educator training	No copay[2]	No copay[2]	Not Covered
Diabetic supplies (if purchased through a Durable Medical Equipment Provider). Other Diabetic Supplies are covered under the Express Scripts Prescription Drug Benefit.	10% Coinsurance[3,4]	25% Coinsurance[3,4]	40% Coinsurance[5]
PRESCRIPTION DRUGS[2,3]	**Administered by CVS Caremark** Call CVS Caremark at **1-877-745-4394**		

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MENTAL HEALTH SERVICES			
Outpatient (Includes Telehealth/Virtual Visits)[1]	$10 Copay[2,3] per visit	$10 Copay[2,3] per visit	40% Coinsurance[5]
Inpatient/Partial Hospitalization[1]	$500 Copay[2,3]	25% Coinsurance[3,4]	40% Coinsurance[5]
Residential Treatment Centers[1] (Up to 60 days per Annual Plan Year)	Not Available	25% Coinsurance[3,4]	40% Coinsurance[5]
ALCOHOL and SUBSTANCE USE DISORDER SERVICES			
Rehabilitation/Detoxification Outpatient (Includes Telehealth/Virtual Visits)[1]	$10 Copay[2,3] per visit	$10 Copay[2,3] per visit	40% Coinsurance[5]
Inpatient/Partial Hospitalization[1]	$500 Copay[2,3]	25% Coinsurance[3,4]	40% Coinsurance[5]
Residential Treatment Centers[1] (Up to 60 days per Annual Plan Year)	Not Available	25% Coinsurance[3,4]	40% Coinsurance[5]
REHABILITATION and THERAPY SERVICES			
Cardiac rehabilitation [1] (36 visits per Annual Plan Year)	$20 Copay[2,3] per visit	$45 Copay[2,3] per visit	40% Coinsurance[5]
Dialysis[1] / Plasmapheresis[1] / Photopheresis[1]	$50 Copay[2,3]	25% Coinsurance[3,4]	40% Coinsurance[5]
Pulmonary Rehabilitation[1] (up to 24 visits per Annual Plan Year)	$20 Copay[2,3] per visit	$45 Copay[2,3] per visit	40% Coinsurance[5]
Short-term Rehabilitation (up to 70 visits **combined** per Annual Plan Year) – Physical Therapy – Occupational Therapy – Speech and Hearing Therapy	$10 Copay[2,3] per visit	$30 Copay[2,3] per visit	40% Coinsurance[5]
AUTISM / APPLIED BEHAVIORAL ANALYSIS[1]	Usual copayment or coinsurance based on place of treatment and type of service[2,3,4,5,7,9]		
TRANSPLANTS[1]	$500 Copay[2,3]	25% Coinsurance[3,4]	Not Covered
COMPLEMENTARY THERAPIES (Limited)			
Acupuncture treatment and Chiropractic Services (40 visits Combined per Annual Plan Year)	$20 Copay[2,3] per visit	$45 Copay[2,3] per visit	40% Coinsurance[5]
SKILLED NURSING FACILITY[1]			
(Up to 60 days per Annual Plan Year)	$250 Copay[2,3]	25% Coinsurance[3,4]	40% Coinsurance[5]
HOME HEALTH CARE 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)	$40 Copay[2,3]	25% Coinsurance[3,4]	40% Coinsurance[5]
HOSPICE CARE[1]			
Inpatient Hospice	$500 Copay[2,3]	25% Coinsurance[3,4]	40% Coinsurance[5]
Home Hospice	$40 Copay[2,3]		
DURABLE MEDICAL EQUIPMENT, PROSTHETICS, AND APPLIANCES[1]	10% Coinsurance[3,4]	25% Coinsurance[3,4]	40% Coinsurance[5]
Hearing Aids. Up to $2,500 every 36 months "per hearing-impaired ear"	10% Coinsurance[3,4]	25% Coinsurance[3,4]	40% Coinsurance[5]
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]	$150 Copay[2,3]	25% Coinsurance[3,4]	40% Coinsurance[5]
Refraction eye exam associated with post-cataract surgery or Keratoconus correction	$20 Copay[2,3]	25% Coinsurance[3,4]	40% Coinsurance[5]
DENTAL SERVICES (LIMITED) / CMJ / TMJ	Usual copayment or coinsurance based on place of treatment and type of service[2,3,4,5,7]		40% Coinsurance[5]
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 and Children Health Care Services.	No Copay[2] $3,500 per Participant per Plan Year Maximum annual benefit Not applicable to any lifetime maximums or annual limits	No Copay[2]	Not Covered

Footnotes

[1]Benefit Certification may be required.

[2]Not Subject to the Deductible.

[3]Included in the UNM LoboHEALTH / In-Network Out-of-Pocket Maximum.

[4]Subject to the In-Network Deductible.

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

[6]Blue Cross and Blue Shield PPO Providers outside of New Mexico are considered to be In-Network for claims payment purposes. Prior to receiving services from Blue Cross and Blue Shield Providers outside of New Mexico, please work with the Blue Cross and Blue Shield provider in obtaining Benefit Certification.

[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 LoboHEALTH or In-Network Participating Provider. Though these specific services are covered at no charge, the provider may charge a copayment 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 Copayments related to place of service, ancillary services, and additional procedures performed at the same time. Benefit Certification rules still apply.

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**
  - **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 BCBSNM 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 photoprotective clothing, windshield tinting, lighting fixtures and/or shields, and other items 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 a 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.

EXCLUSIONS FOR UNM MEDICAL PLAN: CONT.

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

- **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 X-rays, except as provided in the *Participant Benefit Booklet*.
  - **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 BCBSNM, 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.
- **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**

EXCLUSIONS FOR UNM MEDICAL PLAN: CONT.

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

- **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 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 or banking** of sperm, ova (human eggs), embryos, zygotes, or other human tissue.
- **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 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**.
- Treatment and medications for the purpose of **weight reduction** or control, unless medically necessary treatment for morbid obesity.
- **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.

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.