



University of New Mexico Medical Plan Participant Benefit Booklet

Effective July 1, 2026 - June 30, 2027

Offered by the Regents of the University of
New Mexico for its Public Operation Known
as UNM

Administered by Presbyterian Health Plan

SCHEDULE OF BENEFITS



UNM Medical Plan Benefits and Coverage	LoboCare	In-Network ⁽⁶⁾	Out-of-Network ⁽¹⁾
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) Specialist office visits – (non-preventive) Virtual Visits/Telehealth Visits (PCP/Specialist) Outpatient surgery (In-Provider/Practitioner’s office) Allergy services Testing and Extract Injections Only (no office visit billed) Injections such as insulin, heparin and Antibiotics Infertility services – diagnosing only Non-specialist office visits Specialist office visit	\$25 ^(2,3) Co-pay per visit \$35 ^(2,3) Co-pay per visit \$25/\$35 ^(2,3) Co-pay per visit Included in office visit Co-pay \$55 ^(2,3) Co-pay No Co-pay ⁽²⁾ Included in office visit Co-pay \$25 ^(2,3) Co-pay per visit \$35 ^(2,3) Co-pay per visit	\$30 ^(2,3) Co-pay per visit \$45 ^(2,3) Co-pay per visit \$30/\$45 ^(2,3) Co-pay per visit Included in office visit Co-pay \$55 ^(2,3) Co-pay No Co-pay ⁽²⁾ Included in office visit Co-pay \$30 ^(2,3) Co-pay per visit \$45 ^(2,3) Co-pay per visit	40% ⁽⁵⁾ Coinsurance 40% ⁽⁵⁾ Coinsurance Not Covered 40% ⁽⁵⁾ Coinsurance 40% ⁽⁵⁾ Coinsurance 40% ⁽⁵⁾ Coinsurance 40% ⁽⁵⁾ Coinsurance 40% ⁽⁵⁾ Coinsurance

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UNM Medical Plan Benefits and Coverage	LoboCare	In-Network ⁽⁶⁾	Out-of-Network ⁽¹⁾
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 Virtual Visits/Telehealth Visits (Urgent Care)	\$75 ^(2,3) Co-pay per visit	\$75 ^(2,3) Co-pay per visit	40% ⁽⁵⁾ Coinsurance
VIDEO VISITS (Virtual National Carrier 24/7)	Not Available	\$10 Copay	Not Covered
AMBULANCE SERVICES Includes: <ul style="list-style-type: none"> Emergency or high risk Ground and Air ambulance Inter-facility transfer services Ground and Air ambulance 	25% Coinsurance No Co-pay ⁽²⁾	25% Coinsurance No Co-pay ⁽²⁾	25% Coinsurance No Co-pay ⁽²⁾
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 ^(2,8)	40% ⁽⁵⁾ Coinsurance (No Copay if using a National Network Provider)
WOMEN'S HEALTH CARE Preventive Care Services <ul style="list-style-type: none"> Well-woman visits to include adult and female-specific screenings 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 fee Contraception counseling Breast feeding support, supplies and counseling⁽⁸⁾ 	No Co-pay ^(2,8)	No Co-pay ^(2,8)	40% ⁽⁵⁾ Coinsurance (No Copay if using a National Network Provider)

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UNM Medical Plan Benefits and Coverage	LoboCare	In-Network ⁽⁶⁾	Out-of-Network ⁽¹⁾
WOMEN'S HEALTH CARE (continued) Non-preventive Non-specialist Specialist (includes Perinatologist) Obstetrical/Maternity/Prenatal and Postnatal care (excludes delivery)	\$25 ^(2,3) Co-pay per visit \$35 ^(2,3) Co-pay per visit \$25 ^(2,3) Co-pay for first visit. (Plan pays 100% thereafter)	\$30 ^(2,3) Co-pay per visit \$45 ^(2,3) Co-pay per visit \$30 ^(2,3) Co-pay for first visit. (Plan pays 100% thereafter)	40% ⁽⁵⁾ Coinsurance 40% ⁽⁵⁾ Coinsurance 40% ⁽⁵⁾ Coinsurance
DIABETES SERVICES Office visit and Diabetes Education Non-specialist Specialist Certified Diabetes Educator and Training Telephone visits Diabetic supplies ⁽¹⁾ (If purchased through a Durable Medical Equipment Provider). Other Diabetic Supplies are covered under the CVS Caremark Prescription Drug Benefit.	\$25 ^(2,3) Co-pay per visit \$35 ^(2,3) Co-pay per visit No Co-pay ⁽²⁾ Not Available	\$30 ^(2,3) Co-pay per visit \$45 ^(2,3) Co-pay per visit No Co-pay ⁽²⁾ 25% ^(3,4) Coinsurance	40% ⁽⁵⁾ Coinsurance 40% ⁽⁵⁾ Coinsurance Not Covered 40% ⁽⁵⁾ Coinsurance
PRESCRIPTION DRUGS^(2,3)	Administered by Express Scripts. Call Express Scripts at 1-800-743-1720		
MENTAL HEALTH SERVICES Outpatient ⁽¹⁾ Inpatient/Partial Hospitalization ⁽¹⁾ Residential Treatment Center (RTC) ⁽¹⁾ (Up to 60 days per Annual Plan Year)	\$10 ^(2,3) Co-pay per visit 15% ^(3,4) Coinsurance Not Available	\$10 ^(2,3) Co-pay per visit 25% ^(3,4) Coinsurance 25% ^(3,4) Coinsurance	40% ⁽⁵⁾ Coinsurance 40% ⁽⁵⁾ Coinsurance 40% ⁽⁵⁾ Coinsurance

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ALCOHOL AND SUBSTANCE ABUSE SERVICES Rehabilitation Outpatient ⁽¹⁾ Inpatient/Partial Hospitalization ⁽¹⁾ Detoxification Outpatient ⁽¹⁾ Inpatient/Partial Hospitalization ⁽¹⁾ Residential Treatment Center (RTC) ⁽¹⁾ (Up to 60 days per Annual Plan Year)	\$10 ^(2,3) Co-pay per visit Not Available \$25 ^(2,3) Co-pay per visit 15% ^(3,4) Coinsurance Not Available	\$10 ^(2,3) Co-pay per visit 25% ^(3,4) Coinsurance \$30 ^(2,3) Co-pay per visit 25% ^(3,4) Coinsurance 25% ^(3,4) Coinsurance	40% ⁽⁵⁾ Coinsurance 40% ⁽⁵⁾ Coinsurance 40% ⁽⁵⁾ Coinsurance 40% ⁽⁵⁾ Coinsurance 40% ⁽⁵⁾ Coinsurance
REHABILITATION AND THERAPY SERVICES Cardiac rehabilitation (36 visits per Annual Plan Year) ⁽¹⁾ Dialysis/Plasmapheresis/Photopheresis ⁽¹⁾ Pulmonary rehabilitation ⁽¹⁾ (up to 24 visits per Annual Plan Year) Short-term rehabilitation (up to 70 visits combined per Annual Plan Year, if determined medically necessary, additional visits may be approved) <ul style="list-style-type: none"> • Physical therapy • Occupational therapy • Speech and Hearing Therapy 	\$35 ^(2,3) Co-pay per visit 15% ^(3,4) Coinsurance \$35 ^(2,3) Co-pay per visit \$25 ^(2,3) Co-pay per visit	\$45 ^(2,3) Co-pay per visit 20% ^(3,4) Coinsurance \$45 ^(2,3) Co-pay per visit \$30 ^(2,3) Co-pay per visit	40% ⁽⁵⁾ Coinsurance 40% ⁽⁵⁾ Coinsurance 40% ⁽⁵⁾ Coinsurance 40% ⁽⁵⁾ Coinsurance
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⁾	15% ^(3,4) Coinsurance	25% ^(3,4) Coinsurance	Not Covered

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COMPLEMENTARY THERAPIES (Limited to a combined total of 40 visits per Annual Plan Year) Acupuncture treatment Chiropractic services	\$35 ^(2,3) Co-pay per visit \$35 ^(2,3) Co-pay per visit	\$45 ^(2,3) Co-pay per visit \$45 ^(2,3) Co-pay per visit	40% ⁽⁵⁾ Coinsurance 40% ⁽⁵⁾ Coinsurance
SKILLED NURSING FACILITY⁽¹⁾ (Up to 60 days per Annual Plan Year)	Not Available	25% ^(3,4) Coinsurance	40% ⁽⁵⁾ 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	25% ^(3,4) Coinsurance	40% ⁽⁵⁾ Coinsurance
HOSPICE CARE⁽¹⁾ LoboCare services limited to Pediatric Hospice only.	15% ^(3,4) Coinsurance	25% ^(3,4) Coinsurance	40% ⁽⁵⁾ Coinsurance
DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND APPLIANCES⁽¹⁾ Hearing Aids Up to \$2,500 every 36 months "per hearing-impaired ear"	15% ^(3,4) Coinsurance Applies to In-Network Level of Benefits	25% ^(3,4) Coinsurance 25% ^(3,4) Coinsurance	40% ⁽⁵⁾ Coinsurance 40% ⁽⁵⁾ Coinsurance
EYEGASSES AND CONTACT LENSES Limited to the following: <ul style="list-style-type: none"> • Eyeglasses and contact lenses within 12 months following cataract surgery or for the correction of Keratoconus⁽¹⁾ • Refraction eye exam associated with post-cataract surgery or Keratonconus correction 	15% ^(3,4) Coinsurance 15% ^(3,4) Coinsurance	25% ^(3,4) Coinsurance 25% ^(3,4) Coinsurance	40% ⁽⁵⁾ Coinsurance 40% ⁽⁵⁾ Coinsurance
DENTAL SERVICES (LIMITED)/ CMJ/TMJ	15% ^(3,4) Coinsurance	25% ^(3,4) Coinsurance	40% ⁽⁵⁾ Coinsurance

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UNM Medical Plan Benefits and Coverage	LoboCare	In-Network	Out-of-Network
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⁾	No Co-pay ⁽²⁾	Not Covered
	\$3,500 per Participant per Plan Year Maximum annual benefit Not applicable to any lifetime maximums or annual limits		

Footnotes:

- (1)Benefit Certification/Prior Authorization/Prior Authorization may be required.***
- (2)Not Subject to the Deductible.***
- (3)Included in the LoboCare/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)National Network Providers/Practitioners outside of New Mexico are considered to be In-Network for claims payment purposes. Prior to receiving services from National Network Providers, please work with the National Network Provider in obtaining Benefit Certification/Prior Authorization/Prior Authorization.***
- (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 LoboCare or In-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 service, ancillary services, and additional procedures performed at the same time. Benefit Certification/Prior Authorization/Prior Authorization 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 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*
 - **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 homebirth.
- **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.
- **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/Prior Authorization** when Benefit Certification/Prior Authorization 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.
- **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 except as listed in the Participant Benefit Booklet for rehabilitation services related to post physical brain injury.**
 - **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.

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.