*UNM MEDICAL PLAN*
*Summary of Benefits*
*July 1, 2011 - June 30, 2012*

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*Administered by*

Presbyterian Health Plan

PRESBYTERIAN

# UNIVERSITY OF NEW MEXICO
## Summary of Benefits
PPO Medical Plan
Plan Code:
EFFECTIVE: July 1, 2011

Offered by University of New Mexico (UNM)

*The following are the Highlights of the UNM Medical Plan. This Summary contains highlights only and is subject to change. Any services received must be Medically Necessary to be covered.*

| UNM Medical Plan (HWP10016) Benefits and Coverage | LoboCare | In-network Limits (PHP) (4) | Out-of-network Limits |
|---|---|---|---|
| **ANNUAL PLAN YEAR DEDUCTIBLE** (Deductible must be met for services subject to the deductible before benefits are paid) | Individual: $200<br>Family: $600 | | Individual: $750<br>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<br>Family: $4,750 | | Individual: $5,000<br>Family: $15,000 |
| **ANNUAL and MAXIMUM LIFETIME BENEFIT** | Unlimited | | |
| **Pre-Existing Condition Exclusion** | None | | |
| **UNM Medical Plan Benefits And Coverage** | **LoboCare** | **In-network (PHP)** (4) | **Out-of-network** |
| **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 | $50(2,3) Co-pay | $50(2,3) Co-pay | 40% Coinsurance |
| Injections Only (no office visit billed) | No Co-pay | No Co-pay | 40% Coinsurance |
| Injections such as insulin, heparin and antibiotics | Included in office visit co-pay | Included in office visit 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 |

| UNM Medical Plan (HWP10016) Benefits and Coverage | LoboCare | In-network (PHP) [4] | Out-of-network |
|---|---|---|---|
| **HOSPITAL SERVICES** – Inpatient[1]<br>Coverage includes:<br>• Room and board<br>• Newborn delivery and other hospital obstetrical services<br>• In-hospital Provider/Practitioner visits, Surgeons, Anesthesiologist and other Inpatient services<br>• Detoxification<br>• Administration of blood/blood components | 15% Coinsurance | 20% Coinsurance | 40% Coinsurance |
| **MEDICAL SERVICES** – Outpatient | | | |
| Surgeries[1] | | | |
| Hosp/ASC | 15% Coinsurance | 20% Coinsurance | 40% Coinsurance |
| Pro Fees | 15% Coinsurance | 20% Coinsurance | 40% Coinsurance |
| X-ray, laboratory, and diagnostic tests | | | |
| Preventive | No Co-pay[3] | No Co-pay[3] | Not Covered |
| Non-preventive | No Co-pay[3] | No Co-pay[3] | 40% Coinsurance |
| Colonoscopy | | | |
| Non-preventive | No Co-pay[3] | No Co-pay[3] | 40% Coinsurance |
| Radiation therapy (non-surgical) | | | |
| In Provider/Practitioner's office | Office visit co-pay[2,3] | Office visit co-pay[2,3] | 40% Coinsurance |
| Outpatient facility | 15% Coinsurance | 20% Coinsurance | 40% Coinsurance |
| Chemotherapy | | | |
| In Provider/Practitioner's office | Office visit co-pay[2,3] | Office visit co-pay[2,3] | 40% Coinsurance |
| Outpatient facility | 15% Coinsurance | 20% 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**<br>**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% Coinsurance |
| **AMBULANCE SERVICES** including:<br>Emergency or high risk<br>• Ground and Air ambulance<br>Inter-facility transfer services<br>• Ground and Air ambulance | Applies to In-Network Benefit | 20% Coinsurance<br><br>No Co-pay[3] | Applies to In-Network Benefit |

| UNM MEDICAL PLAN (HWP10016) BENEFITS and COVERAGE | LoboCare | In-network (PHP) [4] | Out-of-network |
|---|---|---|---|
| **CLINICAL PREVENTIVE SERVICES** | No Co-pay [3] | No Co-pay [3] | Not Covered |
| 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 | No Co-pay [3] | No Co-pay [3] | 40% Coinsurance |
| Colonoscopy | No Co-pay [3] | No Co-pay [3] | 40% Coinsurance |
| **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 | 40% Coinsurance |
| 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. (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 |

| UNM Medical Plan (HWP10016) Benefits and Coverage | LoboCare | In-network (PHP) [4] | Out-of-network |
|---|---|---|---|
| **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 (Physical and Occupational 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 |
| 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 |
| **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 |

| UNM Medical Plan (HWP10016) Benefits and Coverage | LoboCare | In-network (PHP) [4] | Out-of-network |
|---|---|---|---|
| **DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND APPLIANCES**[1]<br>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**<br>Limited to the following:<br>• Eyeglasses and contact lenses within 12 months following cataract surgery or for the correction of Keratoconus[1]<br>• Refraction eye exam associated with post-cataract surgery or Keratonconus correction | 15% Coinsurance<br>15% Coinsurance | 20% Coinsurance<br>20% Coinsurance | Not Covered<br>Not Covered |
| **FAMILY, INFANT AND TODDLER PROGRAM**<br>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<br>$3,500 per Participant per Plan Year Maximum annual benefit<br>Not applicable to any lifetime maximums or annual limits | No Co-pay | Not Covered |
| **DENTAL SERVICES (LIMITED)/ CMJ/TMJ** | 15% Coinsurance | 20% Coinsurance | Not Covered |

***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 contact Presbyterian Health Plan or work with the MultiPlan/PHCS provider in obtaining Benefit Certification.***

**EXCLUSIONS FOR UNM (HWP10016):**

***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.***

- 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 photoprotective 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 a home health professional.

**EXCLUSIONS FOR UNM (HWP10016):**

- **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 x-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.**

**EXCLUSIONS FOR UNM (HWP10016):**

- **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.
- **Sex transformation surgery and drugs** relating to sex transformations.
- **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.

**EXCLUSIONS FOR UNM (HWP10016):**

- "**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.

***Refer to the Participant Benefit Booklet for a more complete description of Exclusions and Limitations.***

This Summary 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 Summary.

*Plan ID – HWP10016 (for internal use)*