

# UNM Hospitals

## Standard (LoboCare) Network

### Summary of Benefits

Administered by:



Blue Cross and Blue Shield  
of New Mexico

**This is a summary only** that lists the deductible, out-of-pocket maximum, copayment and coinsurance amounts, and provides a brief description of UNM Hospitals Standard (LoboCare) Network benefits.

UNM Hospitals Standard (LoboCare) Network Benefits	Member's Share of Covered Charges	
	Standard Network (In-Network Services)	Out-of-Network Services *
<b>Calendar Year Deductible</b>	None	\$1,500 (\$3,000 Family Aggregate)
<b>Calendar Year Out-of-Pocket Maximum</b> (Includes copayments and coinsurance only. Does NOT include deductible; drug, mental health, or chemical dependency benefit payments; noncovered charges; or penalty amounts. In-Network and Out-of-Network amounts do not cross-apply.)	\$5,000 per individual	\$10,000 per individual
<b>Annual and Lifetime Benefit Payment Limits</b>	\$2,000,000 per member per calendar year and a lifetime benefit pay maximum of \$5,000,000 per member	
<b>Primary Care Physician (PCP) and OB/GYN Office Visit</b>	\$25 per visit	40%*
<b>Specialist Physician Office Visit</b>	\$35 per visit	40%*
Office Surgery (including casts, splints, and dressings)	\$25 (or \$35 specialist) per visit	40%*
Maternity Prenatal & Post-Partum Visits	\$25 (or \$35 specialist) initial visit only	40%*
Lab Tests, X-Rays, EKGs, Other Diagnostic Tests	\$0 copay (included in office visit)	40%*
Allergy Injections, Serum; Therapeutic Injections	\$0 copay (included in office visit)	Not Covered
Allergy Testing	\$35 per visit	Not Covered
<b>Preventive Care Services</b>		
Adult Wellness/Physical Exams	\$25 (or \$35 specialist) per visit	Not Covered
Well Child Care, Immunizations, Mammography, Pap Tests, Vision & Hearing Screening (through age 17)	\$25 (or \$35 specialist) per visit	
	\$0 (included in office visit)	
<b>Acupuncture (max. 20 visits/year)</b>	\$35 per visit	Not Covered
<b>Chiropractic Services **</b>	\$35 per visit	Not Covered
<b>Ambulance Services: Ground and Emergency Air</b>	Ground \$75 or Air \$125	
<b>Emergency Room Treatment</b>	\$200 per visit (waived if admitted)	40%*
<b>Urgent Care Facility</b>	\$75 per visit	40%*
<b>Home Health/Home I.V. Care (max. 100 visits/year) **</b>	\$25 per visit	40%*
<b>Hospice Services</b> (lifetime max. \$10,000; includes up to 7 days of respite care) **	\$0 copay	40%*
<b>Inpatient Hospital/Facility Services **</b> (See "Skilled Nursing Facility" for skilled nursing facility admissions. See "Psychotherapeutic Services" for inpatient treatments related to mental health or chemical dependency. See "Transplant Services," if applicable.)		
Medical/Surgical and Maternity-Related Room and Board and Covered Ancillaries	\$200 per admission (no charge for inpatient physician services)	40%*
<b>Skilled Nursing Facility (max. 60 days/lifetime) **</b>	\$0 copay	40%*
<b>Surgery (Outpatient/Ambulatory Surgical Center)</b>	\$100 copay	40%*
<b>Observation Room Treatment (no emergency room)</b>	\$0 copay	40%*

BCBSNM is a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, and Independent Licensee of the Blue Cross and Blue Shield Association.

UNM Hospitals Standard (LoboCare) Network Benefits	Member's Share of Covered Charges	
	Standard Network	Out-of-Network
Colonoscopy	\$100 copay	40% *
Lab, X-Ray, Other Diagnostic Tests	\$0 copay	
PET Scans, CT Scan **	\$100 copay	40%*
Magnetic Resonance Imaging (MRI)	\$150 copay	
<b>Psychotherapeutic Services – Inpatient **</b> Mental Health	\$200 per Mental Health admission (no charge for inpatient physician services)	40% Mental Health *
Chemical Dependency, Alcohol/Substance Abuse (up to 30 days/calendar year; 60 days/lifetime for rehab)	30% Detox; 25% Rehab	50% Detox * Rehab - Not Covered
<b>Psychotherapeutic Services – Outpatient **</b> Mental Health	\$35 per Mental Health visit	40% Mental Health *
Chemical Dependency, Alcohol/Substance Abuse (up to 30 visits/calendar year; 60 visits/lifetime for rehab)	30% Detox; 25% Rehab	50% Detox * Rehab – Not Covered
<b>Infertility Services</b> , including drugs and injections (lifetime max. of 12 attempts per employee/spouse) **	50%	Not Covered
<b>Medical Supplies, Durable Medical Equipment, Prosthetics, Orthotics **</b>	20%	40%*
<b>Smoking/Tobacco Cessation Counseling</b> (90 minutes total or 2 group sessions per calendar year)	\$25 PCP visit \$35 Specialist visit	Not Covered
<b>TMJ, Dental-Related Accident, Oral Surgery</b>	Usual copays based on type of service and place of treatment	40%*
<b>Physical, Occupational, and Speech Therapy**</b>	\$35 per visit	40%*
<b>Other Therapy, Outpatient Treatment Facility:</b> Chemotherapy, Radiation, Inhalation Therapy Dialysis	No charge 20%	40%*
<b>Transplant Services **</b> (Must be received at a facility that contracts with a Standard or Extended Network provider for the transplant being received, including a facility in the national transplant network.)		
<b>Cornea, Kidney, and Bone Marrow, Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney</b> (Max. two transplants per lifetime. Max. \$5,000 per transplant for lodging and meal expenses and \$5,000 per transplant for travel expenses.)	Usual copays based on place of treatment and type of service	Not Covered

### Prescription Drugs, Insulin, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods, & Smoking/Tobacco Cessation

**Note:** Deductible does not apply and copayments are not applied to the out-of-pocket limit nor waived once the limit is met. Certain drugs, nutritional products/special medical foods, and certain injectable medications require prior approval. Covered drugs and other items must be purchased at a pharmacy that participates in the Retail Pharmacy/Specialty or Mail Order Service programs. (BCBSNM has contracted with a separate program for administration of the prescription drug benefits.)

Prescription Plan Copayments:	Retail 30-day	Mail-Order 90-day
	<b>Generic Drug</b>	\$10
<b>Brand (no generic available) – On Drug List</b>	\$35	\$70
<b>Drug - Not On Drug List (Brand-Name with generic equivalent available)</b>	\$60	\$120
<b>Specialty Medications</b> (May require prior authorization; Mail-Order does <b>not</b> apply)	20% or \$250 whichever is less	
<b>Nonprescription enteral nutritional products and special medical foods</b> (prior authorization required)	20%	

\* Member's share of out-of-network covered services after deductible is met. Member also pays difference between the covered charge, as determined by the Claims Administrator, and the provider's billed charge.

\*\* These services require prior authorization from BCBSNM (or Mesa Mental Health) or benefits will be reduced or denied. See a benefit booklet for full limitations and requirements.

**Note:** You do not need a PCP referral in order to receive benefits at the Standard (LoboCare) Network level of coverage. You may visit any Standard (LoboCare) Network provider and receive Standard (In-Network) benefits for covered services. If you choose to visit a provider who is not a member of the Standard (LoboCare) Network, however, you will have to first meet a deductible and pay a percentage of covered charges (some exceptions, such as for emergency care are explained in the member's benefit booklet). Out-of-network providers may bill you for amounts that are over the covered charge. This amount can sometimes be significant, and is not applied to your out-of-pocket limit. Also, some benefits are available only if received from Standard (LoboCare) Network providers.

**Note: BCBSNM provides administrative claims payment services only and do not assume any financial risk or obligation with respect to claims, except as may be specified in the Administrative Services Agreement.**