individual plan
evidence of coverage

Lovelace
Insurance Company

Lovelace
Insurance Company

INDIVIDUAL PLAN
EVIDENCE OF COVERAGE

Lovelace Insurance Company
4101 Indian School Rd, NE Ste 110 S
Albuquerque, NM 87110

P. O. Box 27107
Albuquerque, NM 87125-7107
1.505.262.7363 (In Albuquerque)
1.800.808.7363 (Outside Albuquerque)
1.800.659.8331 TTY Services provided by NM Relay
lovelaceiplan.com

Form #: LINC 113-0207

WELCOME TO THE LOVELACE INSURANCE COMPANY

Thank you for making the Lovelace Insurance Company your choice for health care benefits. This benefits booklet, also known and referred to as the Evidence of Coverage (EOC) describes this Preferred Provider Organization (PPO) plan. This PPO plan is an individual health insurance program. Lovelace will issue to each Member this EOC at the time of enrollment.

Your EOC is designed to make it easy for you to make the most of the benefits and services available. Your EOC will guide you in using the Plan benefits by helping you to understand:

- How your Plan works
- What services are covered by your plan; and
- Where to turn when you need assistance.

This EOC is a very important document. We encourage you to read this document carefully. We especially encourage you to review the Summary of Benefits, which you received along with this EOC, as well as the Benefit Limitations and Exclusions sections of the EOC. Many of the sections of this EOC are related to other sections of the document. You may not have all of the information you need by reading just one section.

We encourage you to keep this document, as well as any other attachments or amendments you may receive, for your future reference. Please be aware that your Physicians and other Providers do not have a copy of your EOC, and are not responsible for knowing or communicating your benefits.

By enrolling in this Plan you have agreed to the terms of this Policy. This EOC will guide you in using the Plan benefits. If you need more information about the Plan's coverage, please contactthe Customer Care Center. Lovelace's address and telephone number are listed on the cover of this EOC.

This EOC, the Summary of Benefits, the Enrollment Application form, the Member Agreement and Lovelace ID card constitute the entire contract between the parties and, as of the Effective Date hereof, supersede all other agreements between the parties.

This EOC is sent to all new and renewing Members following enrollment. If you do not have a copy or need additional copies, contact the Customer Care Center for a copy. Additionally, if you have questions about this benefit Plan you can contact the Customer Care Center at the phones listed below:

Customer Care Center
505.232.1881 or 1.800.808.7363

1.800.659.8331 TTY Services provided by NM Relay

Consumer Assistance Office
505.232.1870 or 1.800.808.7363

You may also visit our web site at: lovelaceiplan.com for more useful information and services.
Lovelace Insurance Company is part of the Lovelace Health System.

WELCOME TO THE LOVELACE INSURANCE COMPANY

Explanation Of Terms

Since this Evidence of Coverage is a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the Glossary and the Policy Provision section at the end of this EOC.

Lovelace Insurance Company, a Lovelace Health System, Inc. company, is called “Lovelace” and “Plan” in this document. When we use the words "we," "us," and "our" in this document, we are referring to the Plan. When we use the words "you" and "your" we are referring to people who are covered persons. Covered persons who receive health care benefits through this Plan are also sometimes called “Members” or “Enrollees”.

Medical benefits of Lovelace Insurance Company’s PPO Plan are described in this Evidence of Coverage.

LOVELACE INSURANCE COMPANY

A Lovelace Health System, Inc. company (also called “Lovelace” and “Plan” in this document) certifies that it insures certain individual for the benefits provided by the following Policy:

COVERAGE - MEDICAL EXPENSE INSURANCE

The benefits described in the pages to follow are underwritten by Lovelace Insurance Company.

This Evidence of Coverage and Policy describes the features of the insurance.

If questions arise, this Policy(s) will govern.

This Evidence of Coverage takes the place of any other issued to you on a prior date, which described the insurance.

Corporate Secretary

The Summary of Benefits

The Summary of Benefits you received with this EOC is a brief outline of the most utilized benefits that may be payable under your health insurance plan. For a full description of each benefit, refer to the appropriate section of this document.

Lovelace Insurance Company

INDIVIDUAL PLAN EVIDENCE OF COVERAGE

TABLE OF CONTENTS

TABLE OF CONTENTS

RIGHTS AND RESPONSIBILITIES

Lovelace is committed to providing its Members personalized high-quality health care. You have a right to receive this type of care. You also assume certain responsibilities as you enter into a partnership with us. It is important that you fully understand both your rights and your responsibilities.

You have a right:

- To be given information about your coverage, maximum benefits, the Plan, services offered, and any exclusion of specific conditions, ailments and disorders including restricted pharmacy benefits. In addition your rights include access to information pertaining to the Plan's Practitioners & providers, and Member rights & responsibilities.
- To affordable health care with information on your out-of-pocket expense limitations, the right to seek care from an Out-of-Network Provider, and an explanation of your financial responsibility when services are provided by an Out-of-Network Provider or without a pre-authorization.
- To be treated in a manner that respects your privacy and dignity as a person.
- To participate with practitioners in making decisions about your health care.
- To be informed of your diagnosis, prognosis, and treatment plan. This must be done in terms you understand. If you do not understand the information, you have right to conduct a candid discussion to explain the treatment plan with you or your next of kin or guardian, if available. This information will also be documented in your medical record.
- To be informed by your health care provider about your treatment. This pertains to any appropriate or Medically Necessary treatment you may receive. This right exists regardless of cost of benefit coverage. Your treating professional will request your consent for all treatment. This is required unless there is an emergency and your life and health are in serious danger.
- To voice complaints, grievances or appeals with the Plan or its regulatory bodies about Lovelace or the care it provides. The Member also has the right to receive an answer to such within a reasonable time and without fear of retaliation.
- To make recommendations regarding Member Rights & Responsibilities policies.
- To receive assistance in a prompt, courteous and responsible manner.
- To the confidential handling of all communications, including medical and financial information maintained by the Plan and Participating Providers. There are laws and professional medical ethics that call for this. Your written permission will always be required for the release of medical and financial information. The exceptions occur:
  - When clinical data is needed by health care Providers for your care.
  - When the Plan is bound by law to release information.
  - When the Plan prepares and releases data but without identifying names of Members.
  - When necessary, to support Lovelace's programs or operations that evaluates quality and service.
- To be promptly informed of termination or changes in benefits, services or Participating Providers.
- To refuse treatment. You also have the right to be advised of the likely results of your decision. We encourage you to discuss your concerns with your Physician or other Provider. He or she will discuss alternate treatment plans with you; however, you will make the final decision.
- To a complete explanation of why care is denied. You will be guided through the Appeals and Grievance procedure if you are not satisfied with the Plan's decision.
- To know, upon request, of any financial arrangements or provisions between the Plan and its Participating Providers, which may restrict authorization or treatment options or limit the services offered to you.
- To adequate access to qualified health professionals.
- To always have available and accessible urgent and emergency medical services twenty-four (24) hours a day, seven (7) days a week.
- To receive information about how services are authorized or denied. You have the right to know how new technology for Covered Services are evaluated. You can also request information about the quality assurance plan and utilization patterns.

- To have access to a current list of Providers in the Lovelace network. You are also entitled to information about a particular Provider's education, training and practice.

All Members are responsible for learning how the Plan works. This is achieved by carefully studying and referring to this EOC and the Summary of Benefits. Contact the Customer Care Center when you have questions or concerns about the Plan.

You have a responsibility:

- To provide honest, complete, to the extent possible, information to those providing care.
- To follow your Physician's advice, plans and instructions that you have agreed on with your physician or other Provider and consider the likely results if you do not.
- To question your Physician and other Providers so you can fully understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
- To review and understand fully the information you receive about your Plan.
- To know the proper use of the services covered by the Plan.
- To present your Plan ID card before you receive care.
- To consult a Physician before receiving medical care, unless your condition is life-threatening.
- If you will be delayed or unable to keep an appointment, you are to notify your Physician's office promptly.
- To pay all charges or Co-Payments for missed appointments. This also applies to non-covered benefits and Services.
- To establish an ongoing and satisfactory relationship with a Physician.
- To know what medication you are taking. You should also know why you are taking it and the right way to take it. You are to follow instructions if Follow-up Care is needed.
- To express your opinions, concerns or complaints in a constructive way to the Customer Care Center or your Provider.
- To inform Lovelace of any changes in family size, address, phone number or membership status. This is to be done within thirty (30) days of the change.
- To make prepayment Premium payments on time.
- To pay all Co-Payments or Co-Insurance amounts at the time service is received.
- To notify the Plan of other insurance coverage.
- To follow the Plan's complaint and grievance process when displeased with the Plan's actions or decisions.
- To understand your health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- To obtain and provide medical records requested by the Plan for the purpose of medical investigation and/or Pre-existing Condition determination.

Consumer Advisory Board

Lovelace recognizes the importance of receiving feedback from our members regarding our operations and the services we provide. To accomplish this, we have established a Consumer Advisory Board that meets quarterly to discuss the Plan. As a Member of Lovelace Insurance Company, you are eligible to participate on this Board. If you are interested in doing so, contact the Consumer Assistance Office. The numbers are 505.232.1870 or 1.800.808.7363 (outside of Albuquerque).

HOW YOUR PPO PLAN WORKS

Your PPO Plan gives you important options. Each time you need care, you can choose the providers and the level of coverage that best meet your health and financial needs. You can enjoy greater benefits and savings by electing to receive all or most of your health care from Lovelace In-Network Providers. At the same time, you and your covered family members have the flexibility offered by your Out-of-Network benefits, allowing you to see any Physician you choose.

Refer to your Summary of Benefits for a list of services that are not covered as an Out-of-Network benefit.

The Lovelace Individual PPO Plan is offered statewide; however, the premiums differ between the "Albuquerque Area" and the "Non-Albuquerque Area". The Albuquerque Area includes all U.S. Postal Service Zip Codes within the following New Mexico counties: Bernalillo, Sandoval, Torrance and Valencia. The Non-Albuquerque Area includes all U.S. Postal Service Zip Codes in all other New Mexico counties.

Co-Payments/Co-Insurance

You will need to pay Co-Payments or Co-Insurance at the time you receive health services, once you have met your Annual Deductible. For example, you will need to pay a Co-Payment or Co-Insurance amount when you visit your Physician or are admitted into the hospital. The Co-Payment or Co-Insurance required for each type of service is listed in your Summary of Benefits. Your Annual Deductible is also listed in the Summary of Benefits and is described in the next section of this EOC.

A Co-Payment is a fixed dollar amount that you must pay each time you obtain a particular Covered Service. Co-Insurance is the percent of a Provider's Allowable Charges that you must pay for Covered Services after the Deductible has been met, if applicable. The Co-Insurance will be applied to the total Allowable Charges for the service. The percent you must pay is generally higher when you use Out-of-Network Providers. Refer to your Summary of Benefits for more information.

Allowable Charge

In-Network Providers may not bill more than the Allowable Charge. An Allowable Charge is the amount Lovelace will pay an In-Network Provider for a service minus applicable Co-Payments and Co-Insurance.

Usual and Customary Charge

Out-of-Network Providers may bill any amount they wish for a health service. This charge may be more than the Usual and Customary Charge that Lovelace has set for a service. The Lovelace payment will be based on the lesser of the Provider's billed charge or the Usual and Customary Charge for the service rendered. If you receive care from an Out-of-Network Provider and the provider bills more than the Usual and Customary Charge, you are responsible for the sum of the Co-Insurance amount and any amount that is over the Usual and Customary Charge.

Listed below is an example of how your expenses could vary, depending on if you receive care from an In-Network or Out-of-Network Provider. In this example, you have met your Annual Deductible and you obtain the same medical care from both an In-Network and an Out-of-Network Provider.

In this example, Covered Services from an In-Network Provider will be considered as follows:

The In-Network Provider charges $100 for a service. Lovelace's Allowable Charge for the service is $100. If your Co-Insurance is 20%, you will pay $20 and Lovelace will pay $80.

The same Covered Services from an Out-of-Network Provider, who charges $115 for these services, would be considered as follows:

Lovelace has set a Usual and Customary Charge of $105 for the service. If your Out-of-Network Co-Insurance is 40%, Lovelace will pay $63 (60% of $105); you will pay the $42 (40% of $105) in Co-Insurance, plus an additional $10 ($115 minus $105) for that part of the bill that was more than the Usual and Customary Charge.

The exception to this Policy is the initial treatment of a medical emergency. You pay the same level of Co-Payment for emergency care if it is provided by an In-Network or Out-of-Network Provider. You are not responsible for charges that are more than the Allowable Charge.

Co-Payments and/or Co-Insurance amounts are due for every visit, even if you have more than one appointment in one day. You may be charged a collection fee if your Co-Payment is not paid at the time of service. These charges are not reimbursable by Lovelace. Keep your receipts as proof of payment.

If you are in doubt as to whether a Co-Payment and/or Co-Insurance are due, contact the Customer Care Center before your visit.

Annual Deductible

The Annual Deductible is the amount you must pay for Covered Services each year before health benefits are paid by Lovelace. Some Covered Services are not subject to the Annual Deductible. They will be covered by Lovelace even when the Annual Deductible is not met. Refer to your Summary of Benefits for services that are exempt from the Annual Deductible.

In-Network and Out-of-Network deductibles are accumulated separately. Payments for In-Network services contribute to the In-Network deductible only. Payment for Out-for-Network services contributes to the Out-of-Network Deductible only.

Payments for covered charges are counted toward the required Annual Deductible as described below. Refer to your Summary of Benefits for the amount of your Deductible.

When each individual Member meets the Deductible for the Contract Year, covered benefits will then be paid.

In-Network Deductible

Each Member's out-of-pocket expenses for In-Network Covered Services are counted towards the In-Network per-person Deductible. Once a Member completes the In-Network Deductible, Lovelace will begin to pay its share of the In-Network costs for covered benefits for that Lovelace PPO Member for the remainder of the Contract Year. Each Member will be responsible for the applicable Co-Insurance.

Out-of-Network Deductible

Each Member's out-of-pocket expenses for Out-of-Network Covered Services are counted towards the Out-of-Network Deductible. Once a Member completes the Out-of-Network Deductible, Lovelace will begin to pay its share of the Out-of-Network costs for covered benefits for that Lovelace PPO Member for the remainder of the Contract Year. Each Member will be responsible for the applicable Co-Insurance.

There is no Deductible "carryover" from one year to another. Carryover is defined as credit for any Deductible amounts paid from October through December and then applied to the next Contract Year's Deductible.

Out-of-Pocket Maximum

This Policy includes annual Out-of-Pocket Maximum amounts to protect you from catastrophic health care expenses. The Out-of-Pocket Maximum is generally the maximum amount you pay in Co-Insurance for Covered Services each Contract Year after the required Deductible is met.

In-Network and Out-of-Network Maximums are treated separately. Payments for In-Network Covered Services contribute only to the In-Network maximum. Payments for Out-of-Network Covered Services contribute only to the Out-of-Network Maximum.

After your annual Out-of-Pocket Maximum is reached for In-Network Covered Services, Lovelace will pay 100% of the Covered Services up to Usual and Customary Charges if applicable, for In-Network Covered Services. After your annual Out-of-Pocket Maximum is reached for Out-of-Network services, Lovelace will pay 100%, up to Usual and Customary Charges, for Out-of-Network Covered Services.

Once your Deductible is met, your Co-Insurance expenses accumulate toward your annual Out-of-Pocket Maximum. Deductibles, Penalty Amounts, payments for Non-Covered Services, Co-Payments, Premium Payments and payments you make for charges that are above the Usual and Customary Charges **do not** accumulate toward your Out-Of-Pocket Maximum. Benefits paid for coverage of children, from birth through three (3) years of age, for or under the Family, Infant, Toddler Program (FIT) administered by the New Mexico Department of Health will not be applied against any maximum lifetime and annual limits specified in this Plan.

The annual Out-of-Pocket Maximum amounts for individuals are calculated as described below. Refer to your Summary of Benefits for the amount of your Deductible.

When each individual Member meets the Out-of-Pocket Maximum for the Contract Year, covered benefits will then be paid.

In-Network Maximum

Each Member's individual payments for In-Network Covered Services are counted towards his In-Network Maximum. When a Member meets the In-Network Maximum, Lovelace will pay 100% of his In-Network charges for the remainder of the Contract Year.

Out-of-Network Maximum

Each Member's individual payments for Out-of-Network Covered Services are counted towards his Out-of-Network Maximum. When a Member meets the Out-of-Network Maximum, Lovelace will pay 100%, up to Usual and Customary Charges, of his Out-of-Network charges for the remainder of the Contract Year.

You are responsible for coordinating and/or notifying Lovelace when the annual Out-of-Pocket Maximum has been reached. To inquire about your Out-of-Pocket Maximum or report that you have reached one or both of your Out-of-Pocket Maximums, contact the Lovelace Customer Care Center at 505.232.1881 or 1.800.808.7363.

Accessing Services Outside New Mexico Contact Lovelace Insurance Company for benefits available to you if you require services outside of New Mexico. If you live in New Mexico and choose not to use In-Network Providers, you will be eligible only for benefits available through Out-of-Network Providers.

If you choose to receive care from Out-of-Network Providers, payment by Lovelace for Covered Services will be limited to Usual and Customary Charges by geographic location. You will be responsible for any balance due above the Usual and Customary Charges, in addition to any applicable Deductible or Co-Insurance. Out-of-Network Providers may require you to pay them directly at the time of service. You will then have to file your claim for reimbursement to Lovelace. The only exception to this Policy is initial treatment of a medical emergency at an Out-of-Network Provider, which is paid at the In-Network level.

Prior Authorization

Prior Authorization is a process where the Plan must be contacted to provide approval so that certain health care services and benefits will be covered by your Lovelace PPO Plan. Approval from the Plan must be obtained prior to you receiving services. If you have questions, contact the Customer Care Center for more information.

For Out-of Network benefits, if Prior Authorization is not obtained for Medically Necessary Covered Services when it is required, a non-notification penalty of $400 will be applied. The Plan will reduce its payment of claims by $400 and the $400 payment will be your responsibility.

Below are the Covered Services and Supplies that require Prior Authorization for In-Network or Out-of-Network benefits:

All Inpatient Care (Required for In-Network and Out-of-Network Services/Benefits):

- Acute Hospital (except as otherwise prohibited by law, EMTALA, and Newborn and Mothers Health Protection Act);
- Skilled Nursing Facility (SNF)*;
- Long Term Acute Care Facility;
- Rehabilitation Facility*;
- Sub-acute similar to that provided in a SNF, and
- Non-emergency ambulance transportation.

Outpatient Care (Required for In-Network benefits ONLY):

A select group of outpatient surgeries at an acute care hospital or specialized facility;
A select group of therapy services* such as Cardiac, Occupational, Physical, Speech and Pulmonary Rehab;
A select group of Diagnostic services* such as Nuclear Medicine, CT, MRA, MRI and PET scans;
Organ and Tissue Transplants*;
Dental Services*;
Durable Medical Equipment*;
Prosthetics* and Orthotics*;
Injectables*;
Home Health Care*.

*Subject to benefit limitations.

The responsibility for obtaining Prior Authorization is as follows:

- In-Network Providers: When you seek services from an In-Network Provider, the provider is responsible for obtaining Prior Authorization from Lovelace before providing the Covered Services.

- Out-of-Network Providers: When you seek services from an Out-of-Network Provider, you are responsible for ensuring that Prior Authorization is obtained from Lovelace before obtaining the Covered Services. You or the Out-of-Network Provider should contact the Customer Care Center.

If coverage under this plan ends, services received after coverage ends will not be covered, even if Prior Authorization was obtained from Lovelace. Obtaining Prior Authorization does not guarantee that you will receive benefits.

Affirmation Statement

Lovelace only makes Utilization Management decisions based on appropriateness of care, service, and existence of coverage. The Plan does not specifically reward Providers or employees for issuing denials of coverage or service care. Financial incentives for Utilization Management decision makers do not encourage decisions that result in underutilization of care.

Pre-existing Condition Exclusions

This Plan imposes a Pre-existing Condition exclusion. This means that if you have a medical Condition before acceptance for enrollment in the Plan, you might have to wait a certain period of time before Lovelace will provide coverage for that Condition. This exclusion applies only to Conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period before your coverage becomes effective. This six-month period ends the day before your coverage becomes effective. The exclusion does not apply to pregnancy; or to a child who is enrolled in the Plan within 31 days after birth, adoption or placement for adoption.

The Pre-existing Condition exclusion extends for a period of six months after the initial Enrollment Date. No Covered Services are payable for any Pre-existing Condition during the exclusion time period. However, in many cases, you can reduce the number of days in your exclusion period if you have prior "creditable coverage," as described below.

Certificate(s) of Creditable Coverage will not be evaluated or take effect as detailed above until after an Applicant is accepted and enrolled.

Exempted Conditions and Individuals

Pre-existing Condition exclusions do not apply:

1) to a Member who, as of the last day of the thirty-one (31) day period beginning with the date of birth (newborn), is covered under creditable coverage; or
2) to a Member who is adopted or placed for adoption before his eighteenth birthday and who, as of the last day of the thirty-one (31) day period beginning on and following the date of the adoption or placement for adoption, is covered under creditable coverage

The provisions of (1) and (2) above do not apply to any Member after the end of the first continuous sixty-three (63) day period during which the Member was not covered under any creditable coverage.

Reduction of the Exclusion Period: You can reduce the length of the exclusion period by the number of days

of your prior creditable coverage. However, days of creditable coverage can not be used to reduce the exclusion period if, after the period of creditable coverage and before your Enrollment Date, there was a sixty-three (63) day continuous period during which you were not covered under any creditable coverage. In determining the continuous period you may not count: days that you were in a waiting period for any coverage under a group Health Plan; days in a waiting period for group health insurance coverage; or days that you were in an affiliation period.

Types of Creditable Coverage: Most prior health coverage is creditable coverage. It includes group Health Plan coverage, COBRA continuation coverage, coverage under an individual health Policy, Medicaid, Medicare, State Children's Health Insurance Program (SCHIP), the New Mexico State Insurance Coverage (SCI) plan, a medical care program of the Indian Health Service of an Indian nation, tribe or pueblo, the Comprehensive Health Insurance Pool Act and the Peace Corps.

The Plan will count a period of creditable coverage without regard to the specific benefits covered during the period.

Creditable Coverage does not include: (1) accident only insurance; (2) disability income insurance; (3) liability insurance; (4) supplemental to liability insurance; (5) Workers' Compensation or similar insurance; (6) automobile medical payment insurance; (7) credit-only insurance; (8) coverage for on-site medical clinics; (9) limited scope dental or vision insurance sold under a separate Policy or rider, and with benefits that are generally excluded from a hospital/medical/surgical benefits package; (10) long-term care insurance; (11) specific disease insurance; (12) fixed dollar indemnity insurance ; (13) supplemental insurance benefits that are provided under a separate Policy, certificate, or contract of insurance; or (14) benefits that are not an integral part of the Plan, in that the participant has the right to elect not to receive coverage for the benefits and, if coverage is elected, an additional Premium or contribution is required for the coverage.

Certificate of Creditable Coverage: To reduce the 6-month (or 18-month) exclusion period by your creditable coverage, you should give Lovelace a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, you need to contact your prior health care coverage provider to request a copy.

All questions about the Pre-existing Condition exclusion and creditable coverage should be directed to the Lovelace Customer Care Center at 505.232.1881 or 1.800.808.7363.

Subject to Insurability

All claims received within the first twelve (12) months from the Effective Date of the Evidence of Coverage will be Subject to Insurability. This means that claims received with a diagnosis included on the Automatically Declined Medical Conditions list will be subject to medical investigation.

The medical investigation will involve a request for information from the Provider of service, however, you may be asked to provide additional information. It is your responsibility to ensure that the Provider of service submits to the requested information to Lovelace in the timeframe indicated and/or that any additional information is provided as requested.

Claims received prior to the completion of the medical investigation will be denied. If the results of the investigation conclude that the onset of the Condition was after your effective date of coverage with the Plan, claims will be re-adjudicated and considered for payment. If the results of the investigation conclude that the onset of the Condition was prior to the Effective Date of coverage on the Plan and not indicated on the Enrollment Application, coverage will be terminated and considered null and void from its inception; you will be responsible for any claims paid by the Plan during the period of enrollment on the Plan.

Your Medical Records

The Plan keeps medical and other information private. It may be used for administering this Plan as well as for medical research or education. Information may also be used to determine subrogation issues and to coordinate benefits with other Plans. The information may also be needed to review a claim that is disputed or Subject to Medical Investigation. To get a copy of your own medical records you will need to contact your Physician or other Provider and sign a special form.

Independent Contractors

Although many Providers who treat Members at Lovelace-owned facilities are Lovelace employees, the balance of Participating Providers are not employees, representatives or agents of Lovelace. They are independent contractors. The Plan is not liable or responsible for their actions or failure to act. You are encouraged to contact the Customer Care Center if you are not satisfied with your care.

How to File a Claim for Out-of-Network Services

When you receive medical services from an In-Network Provider, your claims will be filed automatically on your behalf. If you receive care from an Out-of-Network Provider, you may be responsible for submitting the claim(s) to Lovelace. You may obtain a claim form by contacting the Customer Care Center. You must submit your claims within one year after date of service; however, we encourage you to submit your claims soon after you receive your Out-of-Network medical care.

Please submit your claims to:

Claims Department
Lovelace Insurance Company
P. O. Box 760
Pueblo, CO 81002-0760

If you have any questions, please feel free to contact the Customer Care Center at 505.232.1881 or statewide at 1.800.808.7363.

Recovery of Excess Benefit Overpayments

An "excess benefit" overpayment is a service or benefit not required by this Evidence of Coverage, but provided by Lovelace. Lovelace shall have the right to recover the overpayment made. If the excess benefit is a service, recovery shall be based upon the usual rate for that service. If the excess benefit is a payment, recovery shall be based on the payment made. Recovery may be sought from one or more of the following: any person to, for, or with respect to whom such services were provided or such payments were made; any insurance company; any health care Plan or other organization.

This right of recovery shall be Lovelace's alone. It is used at Lovelace's sole discretion. If Lovelace notifies you (or your legal representative if you are a minor or legally incompetent) that we are pursuing the recovery of these benefits, we ask that you will give to Lovelace what is needed to secure these recovery rights.

Circumstances Beyond the Plan's Control

If a disaster occurs, Lovelace will try to provide for or arrange Covered Services. Examples of disasters are epidemic, war, and riot. Lovelace will make a good faith effort to help Members get Covered Services and will remain responsible for payment of Covered Services; however, Lovelace will not be liable for damages resulting from delays or failures due to a lack of facilities or personnel that is beyond Lovelace's control.

Evaluating New Technology for Inclusion as a Covered Benefit

Lovelace excludes coverage of diagnostic tests, medications, medical procedures and other health care services that are considered by Lovelace to be experimental or investigational in nature, except as listed in this EOC under the section Clinical Cancer Trials. We have a process to evaluate health services that might be considered experimental or investigational. If the Plan determines the procedure or service experimental or investigational, the service will not be covered by Lovelace.

The Medical Director will perform a search of the published, peer-reviewed medical literature to see if there is support for a particular health service. This support will generally be in the form of prospective, randomized, controlled clinical trials that support the safety and effectiveness of the health service in question. If the Medical Director is not able to locate support, they may consult with an outside vendor that the Plan uses to help us evaluate new technologies. Finally, the Lovelace Health System has a Technology assessment committee that can assist the Plan in evaluating the safety and effectiveness of new procedures. The decision of this committee will be final unless additional information becomes available that would require reconsideration by the Medical Director or the committee.

Fraud & Abuse

The Lovelace Fraud & Abuse Program is dedicated to detecting, investigating, and preventing all forms of suspicious activities related to possible health insurance fraud or abuse, including any reasonable belief that insurance fraud will be, is being, or has been committed.

Definitions of Fraud & Abuse:

Fraud–An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Abuse–Provider or Member practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to health programs, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the health program.

How to Report Potential Fraud, Abuse, or Suspicious Activity

If you suspect insurance fraud, abuse, or suspicious activity has occurred, is occurring, or will occur, please report it immediately through any of the following ways:

- Fraud & Abuse Telephone Hotline: 505.232.1884
- Fax Information to the Fraud & Abuse Department: 505.262.3010
- Mail: Lovelace Insurance Company
  Attention: Fraud & Abuse Department
  4101 Indian School Rd NE Ste 110-S
  Albuquerque, NM 87110

Please include as much detail as possible to ensure our ability to investigate each issue. Reports may be made anonymously. All reports are treated as confidential and will be investigated as appropriate, including applicable referral to law enforcement and regulatory bodies. Members and Providers found to be engaging in suspicious activity, fraud, or abuse are subject to removal from the Plan and recovery of any overpayments, as applicable.

Misrepresentation of Information

If the Plan finds that information was intentionally omitted from a Member's coverage Application or is inaccurate, there are serious consequences. If this is discovered within one (1) year from the Effective Date of a Member's coverage, the coverage for that Member shall be null and void from the beginning. The Member must pay for any services or other benefits that have been provided. In the case of fraud, no time limits apply.

HOW TO OBTAIN HEALTH CARE

Your PPO Plan offers you a network of doctors, Specialists, health care centers, labs and pharmacies. From your neighborhood health care center to acute care hospitals, our statewide network of nearly 6,500 contracted Physicians, hospitals and related medical services means you're covered all across New Mexico. Of course, you may also obtain Covered Services from Out-of-Network Providers. These services will be covered at the Out-of-Network benefit level. This section of your EOC will provide you with information on how and where you can obtain care. Refer to your Summary of Benefits for Co-Payment and/or Co-Insurance information.

In order for Lovelace to provide you with care in a convenient and timely fashion, you must follow these basic steps:

- Contact your Physician or other health care Provider when you have a health care need;
- Identify yourself as a Member. Have your Plan ID card on hand when making appointments;
- Upon arriving for a scheduled appointment, show your Plan ID card to the receptionist;
- Make Co-Payments before receiving care, or Co-Insurance after receiving care;
- Obtain Prior Authorization for the services noted in the Summary of Benefits and as described in the Prior Authorization section of this EOC;
- Notify Lovelace of an Emergency admission within forty-eight (48) hours after such an admission;
- Submit all claims within 1 year (365 days) after the date of service; and
- Contact the Customer Care Center if you have a question, concern or complaint.

To obtain professional qualification information regarding In-Network Providers, contact the Customer Care Center. This information may include medical school attended, residency completed and Board certification status.

Customer Care Center

Customer Care Representatives are available to assist you with the following:

- Provider information and selection;
- Enrollment information and ID card requests;
- Questions about Covered Services/Benefits;
- Procedures for obtaining care;
- Complaints or concerns;
- Information about Prior Authorization;
- Appeals and Grievance procedures;
- Appointment information; and
- Status of claim payment.

If you have a question or concern, contact the Customer Care Center at 505.232.1881 (in Albuquerque) or 1.800.808.7363 (outside of Albuquerque). The Customer Care Center is open Monday through Friday. Office hours are 8:00 a.m. to 5:00 p.m. (Mountain Time). Calls received after hours or on weekends will be directed to leave a message that will be returned within the next business day. Sé habla Español and most other languages. We have bilingual Spanish-speaking representatives and our Language Line translates more than 140 other languages.

NurseAdvice New Mexico

If your question is in relation to a non-emergency medical Condition, you can call NurseAdvice New Mexico at 1.877.725.2552 (TDD/TTY 1.866.283.7540). NurseAdvice New Mexico also offers alternative language services. Translation services are available if a language other than English is spoken.

Your Plan ID Card

You have been issued a Plan ID card. If additional cards are needed, contact the Customer Care Center. Always carry your Plan ID card with you. The Plan ID card lists some of those benefits to which you are entitled that may require Co-Payments and/or Co-Insurance. Additional information can be found in your Summary of Benefits. If you are unsure of the benefits covered under this Plan contact the Customer Care Center for assistance. The Plan ID card does not constitute an all-inclusive list of benefits.

Following is a list of abbreviations of benefits used on Plan ID cards:

ER	=	Emergency Room
HOSPITAL	=	Hospital Admission
PHYSICIAN	=	Primary Care Office Visit
SPECIALIST	=	Specialist Office Visit
RX	=	Prescription Drugs
URGENT CARE	=	Urgent Care
OP SURGERY	=	Outpatient Surgery

** Please note that a separate ID card is not required for your Prescription Drug Benefits. Instead, your Lovelace Individual Plan ID card will also serve as your Prescription Drug ID card. Simply present your card to a participating retail pharmacy or include your membership ID number with your order for mail order prescriptions or refills.*

You are entitled to Plan services and benefits if all applicable Premiums, Co-Payments and/or Co-Insurance have been paid. Possession of a Plan ID card does not entitle you to benefits. Do not allow a non-Member to use your Plan ID card. By doing so, you will be responsible for the cost of services provided to the non-Member. In addition, your Plan membership may be terminated.

Contact the Customer Care Center immediately if your Plan ID card is lost or stolen.

Office Visits

Physicians and other Providers who you see in an office setting will provide you both primary care and specialty care services. These Covered Services may include annual examinations, routine immunizations, and treatment of non-emergency/acute illnesses and injuries. For preventive, routine or specialty care, call or make an appointment with your Physician or other Provider. In-Network Providers will arrange for Prior Authorization as appropriate, as described in the Prior Authorization section of this EOC.

If you need a same day appointment or have an Urgent Illness, call your physician's office to make an appointment. You may be offered an appointment with a nurse practitioner or Physician Assistant.

When you arrive for your appointment show your Plan ID card to the receptionist. If a particular benefit requires a Co-Payment, you must pay it before receiving services. If you are unable to keep an appointment, cancel as soon as possible.

After Hours

If your medical Condition permits, you can call NurseAdvice New Mexico after normal work hours at 1.877.725.2552 (TDD/TTY 1.866.283.7540). On-duty Nurses can help you determine the kind of care most appropriate to your specific needs. If you have a serious medical Condition that requires immediate attention, please dial 911.

Interpreter Services

Lovelace has over-the-phone interpreters available for those Members needing special assistance. To access these available services, contact the Customer Care Center at 505.232-1881 or 1.800.808-7363. 1.800.659.8331 TTY Services provided by NM Relay.

Urgently Needed Care

This refers to Covered Services obtained to treat an unforeseen illness, injury or Condition at an Urgent Care facility. The Covered Services must be needed in order to prevent serious harm to your health if you were to wait to obtain the services from In-Network Providers.

If your Condition permits, call the NurseAdvice New Mexico after hours. The number is: 1.800.366.3401. Registered Nurses can help you decide the kind of care most appropriate to your specific needs.

Emergency Services

Emergency care coverage for the Lovelace PPO is very specific. Please read this section carefully. Be sure that you know what steps to take when an Emergency arises.

Emergency Services are those required to treat an accidental injury or the sudden onset of what may reasonably appear to be a medical Condition that manifests itself by symptoms of sufficient severity, including severe pain. The lack of immediate medical attention could be expected by a reasonable layperson to result in jeopardy to a Member's health, serious impairment of bodily functions, serious dysfunction of a bodily organ or part, or disfigurement to a person. Prior Authorization is not required for emergency care.

Some Conditions are Emergency Medical Conditions because, if not treated promptly, they might become more serious. Some examples include deep cuts and broken bones. Others are an Emergency because they could be life-threatening. Examples include: heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute Conditions that Lovelace may determine as an Emergency. What they all have in common is the need for quick action.

Emergency Services include:

- Ambulance transportation;
- Medical procedures;
- Surgical procedures;
- Hospital services;
- Related health care services; and
- Testing to treat emergency Conditions

Lovelace will take the following factors into consideration in determining if the illness or Condition is reimbursable as emergency care:

- A reasonable person's belief that the circumstances required immediate medical care that could not wait until the next working day or next available appointment;
- The time of day the care was provided;
- The presenting symptoms; and
- Any circumstances that prevented you from seeking care under established Plan guidelines.

Coverage includes trauma services at any designated Level I or II Trauma Center. These services must be provided at a designated trauma center. Established medical services and transportation protocols must be followed.

You may have questions about acute illness other than an Emergency Medical Condition. You should contact your Physician or other Provider before going to the emergency room if at all possible.

What to do in an Emergency

In an Emergency situation, go to an emergency room. These facilities are open twenty-four (24) hours a day, seven (7) days a week. If necessary, dial 911 for help. If you are able, tell the emergency room personnel that you are a Plan Member and provide them your Plan ID Card. They can then contact the Plan for you. In those situations where you are unable to immediately notify the Plan, Members should contact the Plan as soon as they are able. The Plan will provide direction and Prior Authorization of benefits as needed.

If hospitalization is necessary, we recommend you notify Lovelace as soon as reasonably possible. If you are hospitalized within 48 hours of receiving Emergency services, the entire hospitalization will be considered part of the initial treatment.

If you are receiving care from an Out-of-Network Facility, you have the option to transfer to an In-Network Facility/Provider for continued care if it is medically wise to do so. Contact your In-Network Provider. He or she will help make arrangements to transfer you. If you receive Follow-up Care from an Out-of-Network Provider after you are discharged, Lovelace will pay for these services at the Out-of-Network benefit level.

Out-of-Network Emergency Claims and Payment

If you receive Emergency Services from non-Plan, Out-of-Network Providers, you must submit a claim to the Plan. Written notification must be given to Lovelace within 1 year (365 days) after the date of service or discharge. If written notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonably possible. The claim must contain an itemized statement of treatment, expenses, and diagnosis. If you could not reasonably do this, a valid claim will not be denied. However, the itemized claim or statement must be submitted to the Plan as soon as possible at the following address:

Claims Department
Lovelace Insurance Company
P. O. Box 760
Pueblo, CO 81002-0760

Ambulance Service

When an ambulance is necessary, call 911 or a local ambulance service. This service is covered if it is Medically Necessary because of an Emergency. The Plan Medical Director determines this by reviewing ambulance and medical records.

Non-Emergency ambulance transport requires Prior Authorization from the Plan. If ambulance services are not Medically Necessary and are not authorized by the Plan, you are responsible for payment.

Emergency Dental Care

Lovelace covers Emergency dental care. It must be needed because of accidental injury from an outside force to a sound, natural tooth. To be sound, the tooth must not have significant decay or prior trauma. Treatment of jawbones or surrounding tissues is also covered.
Contact the Customer Care Center to obtain the names of dentists authorized to provide such care.

COVERED BENEFITS AND SERVICES

With your Lovelace PPO Plan, you and your covered dependants are entitled to receive services and benefits listed in this section. You are responsible for Co-Payments, Deductibles, and/or Co-Insurance, and certain other charges. Additionally, some Covered Services may require Prior Authorization by the Plan before services are provided. Refer to the Prior Authorization section in this EOC for more information.

Hospital Inpatient Services

These services are for treatment and evaluation of certain conditions that cannot be appropriately addressed on an outpatient basis. **All inpatient admissions require Prior Authorization by the Plan.** Other services that you receive during an inpatient hospital stay may require Prior Authorization by the Plan's Medical Director.
Inpatient hospital services include:

- Semi-private room and board;
- Medications, biologicals, fluids and chemotherapy;
- Meals, special diets and nutritional supplements;
- Use of operating room and related facilities;
- Administration of blood and blood products;
- X-rays, laboratory and other diagnostic services; and
- Radiation therapy.

Outpatient Services

Outpatient services include those hospital services that can be reasonably provided on an outpatient or ambulatory basis. These include certain surgical procedures, anesthesia, administration of blood and blood products and recovery room services.

Covered Outpatient Services include:

- Medically Necessary, diagnostic and/or treatment services;
- Radiation therapy;
- Outpatient Surgical Procedures including anesthesia;
- Most outpatient blood and urine studies and other diagnostic and therapeutic procedures.

Primary Care and Specialty Care Services

Primary care and specialty care services are provided to you by licensed and certified physicians in an office setting, and by other health care providers. These are services that are reasonably required to maintain good health.

These services include, but are not limited to:

- Annual examinations;
- Routine immunizations;
- Non-emergency/non-acute illness and injury office visits with primary care and specialist physicians;
- Hospital care, consultation and surgical procedures;
- Diagnostic and/or treatment services, including diagnostic laboratory and/or diagnostic and therapeutic radiology. This includes pap smears (including cytological screening and test for papillomavirus) and mammograms;

- Treatment for diabetes; and
- Allergy services, including testing, treatment and injections.

All of these services are Covered Services when provided by appropriate In-Network Providers. Not all services may be covered when provided by Out-of-Network Providers. Refer to your Summary of Benefits for further information.

See the Glossary for a detailed description of In-Network and Out-of-Network Providers.

Periodic Health Exams

Preventive Health Services are Not Covered at the Out-of-Network benefit level.
The following periodic health exams are available to Members:

- Immunization for all adults as recommended by the United States Preventive Services Task Force;
- Well-child care;
- Childhood immunizations, Medically Necessary booster doses of all immunizing agents used in child immunizations; coverage shall be in accordance with the current schedule of immunizations recommended by the American Academy of Pediatrics. Immunizations are subject to preventive care Co-Insurance or Co-Payments;
- Members age seventeen (17) and under, vision screenings provided by an In-Network Physician are covered.
- Periodic tests to determine blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level or, alternatively, a fractionated cholesterol;
- A periodic glaucoma eye test for all persons thirty-five (35) years of age or older;
- An annual stool examination for the presence of blood for all persons forty (40) years of age or older;
- Colon examination including left-sided colon examination of 35-60 centimeters every five (5) years; for all persons forty (40) years of age or older;
- Beginning at age fifty (50), one of the five colon cancer screenings listed below:
  - Yearly fecal occult blood test (FOBT);
  - Flexible sigmoidoscopy every five (5) years;
  - Yearly fecal occult blood test every year plus sigmoidoscopy every five (5) years;
  - Double contrast barium enema every five (5) years; and
  - Colonoscopy every ten (10) years.
- In-office educational materials provided by the Physician or consultation promoting a healthy lifestyle;
- An annual consultation physical, for persons twenty (20) years of age or older and as deemed Medically Necessary or recommended by your Physician;
- Other preventive health services, under the Physician's supervision, including: reasonable health appraisal examinations and laboratory and radiological tests on a periodic basis; and
- Voluntary family planning services. Contraceptive drugs are covered as part of the outpatient prescription drug benefit. Reversal of a sterilization surgery is not covered.

Women's Health Care

Women's health care includes the following services:

- Mammograms for screening and diagnostic purposes, including, but not limited to low-dose mammography screenings performed at designated approved imaging facilities; Coverage shall include, but not be limited to, one baseline mammogram for persons age thirty-five (35) through thirty-nine (39), and one mammogram annually for persons age forty (40) and over. Additional mammograms are a Covered Service when determined to be Medically Necessary. Mammograms are subject to diagnostic test Co-Payments or Co-Insurance. Refer to your Summary of Benefits for more information;
- Prosthetic devices and reconstructive services (see the Breast Reconstruction and Breast Prosthesis section);
- Cytological Screening (Pap tests) including screening for papillomavirus, to determine the presence of precancerous or cancerous Conditions and other health problems as determined by a Physician in accordance with national medical standards, for women who are thirteen (13) years of age or older and for women who are at risk of cancer or at risk of other health Conditions that can be identified through Cytological Screening. Pap tests are subject to diagnostic test Co-Payments or Co-Insurance. Refer to your Summary of Benefits for more information;
- Services related to the diagnosis, treatment, and appropriate management of osteoporosis when determined to be Medically Necessary by the Member's Physician in consultation with the Plan;
- Direct access to obstetric/gynecological care provided by qualified women's health care In-Network Providers;
- Norplant insertion and removal;
- Direct access to obstetric/gynecological care to female dependents age thirteen (13) or older; and
- Forty-eight (48) hours of inpatient coverage for mastectomy and twenty-four (24) hours of inpatient coverage following lymph node dissection for treatment of breast cancer.

Newly Born Child Coverage

Subject to enrollment in writing within thirty-one (31) days following the date of birth, coverage of a newborn child includes coverage of injury or sickness. This includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Transportation (including flight) to the nearest available contracted tertiary care facility is covered when it is necessary to protect the life of the infant. The Plan will also provide coverage for circumcision for newborn males. Coverage begins at the moment of birth, but only if the newborn is enrolled in writing with the thirty-one (31) day time limit. Please see the "Enrollment and Effective Date of Coverage" section of this EOC for eligibility requirements and enrollment instructions.

Oxygen

Oxygen equipment and supplies are Covered benefits when they are Medically Necessary and provided by a Participating Provider.

Radiological Services –CT/PET/MRI Scans

CT scans, PET scans and MRIs are Covered Services when they are Medically Necessary.

Nutritional Evaluation

The Plan provides dietary evaluation and counseling. This is covered as medical management of a documented disease, including morbid obesity. Refer to the Exclusions section for further details specific to dietary supplements and nutritional formulae.

Diabetic Services, Equipment and Supplies

The Plan covers Medically Necessary diabetic services, equipment and supplies for Members with insulin and non-insulin-using diabetes and those with elevated blood glucose levels induced by pregnancy. When prescribed or diagnosed by a health care Practitioner with prescribing authority, Members are entitled to:

1) Diabetes self-management training that must be provided by a certified, registered or licensed health care professional with recent education in diabetes management. Training is limited to:
   - Medically Necessary visits upon the diagnosis of diabetes;
   - Visits following a Physician diagnosis that represents a significant change in the patient's symptoms or Condition that warrants changes in the patient's self-management; and
   - Visits when re-education or refresher training is prescribed.
2) Medical nutrition therapy related to diabetes management.

Services provided by a health care practitioner or at a facility will be charged the applicable Co-Payment or Co-Insurance. Please refer to your Summary of Benefits for more information.

Coverage for diabetes supplies and equipment includes:

- Blood glucose monitors, including those for the legally blind;
- Test strips for blood glucose monitors;
- Glucagon emergency kits;
- Insulin;
- Injection aids, including those adaptable to meet the needs of the legally blind;
- Lancet and lancet devices;
- Syringes;
- Visual reading urine and ketone strips;
- Prescriptive oral agents for controlling blood sugar levels; and
- Medically Necessary podiatric appliances, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment.

Contact the Customer Care Center regarding Prior Authorization requirements. These supplies and equipment are subject to applicable Co-Payments or Co-Insurance.

When new or improved equipment, appliances, Prescription Drugs for the treatment of diabetes, or insulin or supplies for the treatment of diabetes are approved by the FDA, Lovelace will maintain an adequate Formulary to provide these resources to individuals with diabetes. The Plan will guarantee reimbursement or coverage for the equipment, appliances, prescription drug, insulin or supplies described in this section within the limits of this Policy.

Disease Management

LIFELONG Steps is the name of Lovelace's Disease Management Program offered to Members living with certain chronic Conditions. Conditions currently being managed in the LIFELONG Steps program include:

- Asthma (pediatric and adult)
- Chronic Obstructive Pulmonary Disease (COPD)
- Type 2 Diabetes (over 18 years of age)
- High Cholesterol
- Heart Failure
- Overweight

There is no additional charge for this health promotion program that assists Members with self-management of their disease. The following services are available:

- Telephone counseling to eligible Members by Registered Nurses;
- Coordination of care with other health care Providers;
- Guidance and reminder notices for laboratory tests or doctor exams that are due;
- Education about medications used to treat the disease; and
- Written materials and tools to help assist Members with self-care.

For more information please contact the LIFELONG Steps program at 505.232.1844 or 1.877.480.9368.

Cancer Clinical Trials

Coverage shall be provided for Medically Necessary, pre-authorized covered routine patient care costs incurred as a result of the Member's participation in a phase II, III or IV cancer clinical trial if:

(1) The clinical trial is undertaken for the purposes of the prevention of reoccurrence, early detection or treatment of cancer for which standard cancer treatment has not been effective;

(2) The clinical trial is not designed exclusively to test toxicity or disease pathophysiology, and it has a therapeutic intent;

(3) The clinical trial is being provided in this state as part of a scientific study of a new therapy or intervention that is being conducted at an institution in this state and is for the treatment, palliation or prevention of reoccurrence of cancer in humans and in which the scientific study includes all of the following: (a) specific goals; (b) a rationale and background for the study; (c) criteria for patient selection; (d) specific direction for administering the therapy or intervention and for monitoring patients; (e) a definition of quantitative measures for determining treatment response; (f) methods for documenting and treating adverse reactions; and (g) a reasonable expectation that the treatment will be at least as efficacious as standard cancer treatment;

(4) The clinical trial is being provided as part of a study being conducted in accordance with a clinical trial approved by at least one of the following: (a) one of the federal national institutes of health; (b) a federal national institutes of health cooperative group or center; (c) the Federal Department of Defense; (d) the United States Food and Drug Administration in the form of an investigational new drug Application; (e) The United States Department of Veteran Affairs; or (f) a qualified research entity that meets the criteria established by the federal national institutes of health for grant eligibility;

(5) The clinical trial is being provided as part of a study being conducted in a phase II, phase III or phase IV cancer clinical trial;

(6) The proposed clinical trial or study has been reviewed and approved by an institutional review board that has an active federal wide assurance of protection for human subjects;

(7) The personnel providing the clinical trial or conducting the study (a) are providing the clinical trial or conducting the study within their scope of practice, experience and training and are capable of providing the clinical trial because of their experience, training and volume of patients treated to maintain their expertise; (b) agree to accept reimbursement as payment in full from the Health Plan at rates that are established by that Plan and are not more than the level of reimbursement applicable to other similar services provided by the health care Providers within the Health Plan's network; and (c) agree to provide written notification to the Health Plan when a patient enters or leaves a clinical.
(8) There is no non-investigational treatment equivalent to the clinical trial; and
(9) The available clinical or pre-clinical data provide a reasonable expectation that the clinical trial will be at least as efficacious as any non-investigational alternative.

Pursuant to the patient informed consent document, no third party is liable for damages associated with the treatment provided during a phase of a cancer clinical trial. If a patient is denied coverage of a cost and contends that the denial is in violation of this section, the patient may appeal the decision to deny the coverage of a cost to the superintendent, and that appeal shall be expedited to ensure resolution of the appeal within no more than thirty (30) days after the date of appeal to the superintendent.

Programs pursuant to Title 19 or Title 21 of the Federal Social Security Act, which have their respective expedited appeal processes, shall be exempt from this subsection.

The Plan shall not provide benefits that supplant a portion of a cancer clinical trial that is customarily paid for by government, biotechnical, pharmaceutical or medical device industry sources. The provisions of this section do not create a private right or cause of action for or on behalf of a patient against the Health Plan providing coverage. This section provides only an administrative remedy to the superintendent for violation of this section or a related rule promulgated by the superintendent.

The Plan may impose deductibles, Co-Insurance requirements or other standard cost-sharing provisions on benefits provided pursuant to this section. Please refer to your Summary of Benefits for information regarding the applicable cost-sharing amounts.

In no event shall the Plan be responsible for out-of-state or Out-of-network.

For the purposes of this specific covered Service and Benefit, the following terms have the following meaning:

- "**Clinical Trial**" – means a course of treatment provided to a patient for the purpose of prevention of reoccurrence, early detection or treatment of cancer.
- "**Cooperative Group**" – means a formal network of facilities that collaborates on research projects and has an established federal national institutes of health approved peer review program operating within the group.
- "**Health Plan**" – means: the Lovelace Insurance Company, a health insurer.
- "**Institutional Review Board**" – means a board, committee or other group that is both: (a) formally designated by an institution to approve the initiation of and to conduct periodic review of biomedical research involving human subjects and in which the primary purpose of such review is to assure the protection of the rights and welfare of the human subjects and not to review a clinical trial for scientific merit; and (b) approved by the federal national institutes of health for protection of the research risks.
- "**Investigational Drug or Device**" – means a drug or device that has not been approved by the United States Food and Drug Administration.

- "**Federal-wide Assurance of Protection for Human Subjects**" – means a contract between an institution and the United States Department of Health and Human Services that defines the relationship of the institution to the United States Department of Health and Human Services and that sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects participating in clinical trials.
- "**Patient**" – means an individual who participates in a cancer clinical trial and who is an insured, a Member or a beneficiary of a health Plan; and
- "**Routine Patient Care Cost**" – means (1) a medical service or treatment that is a benefit under the Evidence of Coverage that would be covered if the patient were receiving standard cancer treatment; or (2) a drug provided to a patient during a cancer clinical trial if the drug has been approved by the United States Food and Drug Administration, whether or not that organization has approved the drug for use in treating the patient's particular Condition, but only to the extent that the drug is not paid for by the manufacturer, distributor or Provider of the drug.

  Routine Patient Care Cost does not include (1) the cost of an investigational drug, device or procedure; (2) the cost of a non-health care service that the patient is required to receive as a result of participation in the cancer clinical trial; (3) costs associated with managing the research that is associated with the cancer clinical trial; (4) costs that would not be covered by the patient's health Plan if non-investigational treatments were provided; or (5) costs paid or not charged for by the cancer clinical trial Providers.

COVERED SERVICES WITH LIMITATIONS

Your Lovelace PPO Plan covers the following services, with some limitations. Please refer to your Summary of Benefits for benefit limitations.

Skilled Nursing Care – Inpatient Rehabilitative Facilities

Inpatient services at a skilled nursing or acute rehabilitation facility are covered when these services are Medically Necessary and are authorized by Lovelace's Medical Director.

Covered Services include:

- Semi-private room and board;
- Skilled and general nursing services;
- Physician visits;
- Rehabilitative therapy;
- X-rays; and
- Administration of drugs, medications, biologicals and fluids.

The Plan will follow Medicare guidelines on Skilled Care when appropriate. These will be used to determine the type and level of treatment needed.

Short-Term Rehabilitation Therapy

Short-term rehabilitation therapy includes outpatient services that include: physical, speech, and occupational therapy. To be covered, these services must be Medically Necessary and must be obtained from an In-Network Provider. Such coverage is available for rehabilitation due to injuries, surgeries or medical conditions. Occupational therapy is provided for purposes of training Members to perform the activities of daily living. Chronic conditions are generally not covered under the short-term rehabilitation benefit.

Short-term rehabilitation services are provided in those instances when your physician determines that such services can be expected to result in the significant improvement of your physical condition within a period of two (2) months. Diagnostic services for Short-Term Rehabilitation Therapy are counted towards the benefit accumulator.

Hospice Care Services

The Plan covers hospice care services. To be covered, these services must be provided due to terminal illness (as defined by the Plan). The services must be given under a hospice care program. Hospice care services include inpatient care and outpatient services. Also included are the professional services of a physician. Other Covered Services include those of a psychologist, social worker or family counselor. Home health services are also covered.

Hospice care services do not include the following:

- Services provided by a member of your family or your dependent's family, or someone who usually lives in your or your dependent's house;
- Services or supplies not listed in the hospice care program;
- Services for curative or life prolonging procedures;
- Services for which any other benefits are payable under the Plan;
- Services or supplies that are primarily to aid in daily living;

- Bereavement counseling;
- Services for respite care; and
- Nutritional supplements, non-prescription drugs or substances, medical supplies, vitamins or minerals.

Acupuncture/Chiropractic Services

Acupuncture and chiropractic services are covered when they are diagnostic treatment services utilized in an office setting, Medically Necessary and are services that are within the scope of the Practitioners practice. Treatment includes the conservative management of neuromusculoskeletal Conditions and ancillary physiological treatments rendered to control of hyperemesis, linked to chemotherapy or pregnancy, restore motion, reduce pain and improve functions. Services must be provided by a medical doctor, doctor of osteopathy, licensed physical therapist, Doctor of Oriental Medicine, or chiropractor acting within the scope of his/her licensure and according to the standards in New Mexico or the state in which services are rendered. This benefit excludes services of a massage therapist. Maintenance or preventive treatment/therapy is not covered. Treatment must be restorative.

Breast Reconstruction and Breast Prostheses

After a Medically Necessary mastectomy, breast reconstruction is a covered benefit. External post-operative breast prosthesis with mastectomy bra is also provided. When breast reconstruction is chosen, Covered Services include:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications in all stages of mastectomy, including treatment of lymphoedema as determined by the attending Physician and patient.

Complications of Pregnancy and Coverage for Alpha-fetoprotein IV Screening Test

Certain complications of pregnancy are covered by this Evidence of Coverage. When the pregnancy is not terminated, these are Conditions that are distinct from the pregnancy, but are affected by pregnancy or caused by pregnancy. These include, but are not limited to, acute nephritis, nephrosis, cardiac decompensation, gestational diabetes, pregnancy-induced hypertension, missed abortion, life-threatening or massive bleeding and similar medical and surgical Conditions of comparable severity; and ectopic pregnancy.

The Plan provides coverage for an alpha-fetoprotein IV screening test for pregnant women, generally between sixteen and twenty weeks of pregnancy, to screen for certain genetic abnormalities in the fetus.

Consumable Medical Supplies

Consumable medical supplies are covered during hospitalization. They are also covered during an office visit or authorized home health visit. The Plan does not cover these supplies when used at other times by you or your family.

Consumable medical supplies:

- Are usually disposable;
- Cannot be used repeatedly by more than one individual;
- Are primarily and customarily used for a medical purpose;

- Generally are useful only to a person who is ill or injured; and
- Are ordered or prescribed by a Physician.

Craniomandibular and Temporomandibular Joint (TMJ) Dysfunction Conditions

The Plan covers services for TMJ when Medically Necessary. Services include Medically Necessary surgical and non-surgical treatment similar to treatment authorized and covered for other joints in the body. The Plan does not cover orthodontic treatment and appliances, crowns, bridges and dentures. If these are required because of a trauma, these services are covered.

Dental Services

Medically Necessary dental services due to an accidental injury from an outside force to a sound, natural tooth are Covered Services. To be sound, the tooth must not have significant decay or prior trauma. Treatment of jaw-bones or surrounding tissues is also covered.

The following services are also covered when Medically Necessary:

- Treatment of tumors and cysts that require pathological examination of the jaws, cheeks, lips, tongue, or the roof and floor of the mouth;
- Cosmetic surgery that is expected to correct functional disorders. These disorders result from accidental injury; and
- General anesthesia and facility charges for Medically Necessary dental care for children under the age of five (5). The Plan does not cover the charges for the dental care.

The following are examples of benefits not covered (unless they are related to accidental injury caused by an external force to sound and natural teeth):

- Fillings, caps, crowns, removal or replacement of teeth;
- Root canal therapy;
- Surgery for impacted teeth; and
- Other surgical procedures involving the teeth or structures directly supporting the teeth.

Durable Medical Equipment (DME)

Durable Medical Equipment is defined as items that have all the following characteristics:

- Can withstand repeated use;
- Are reusable by other people;
- Are primarily and customarily used to serve a medical purpose; and
- Generally are not useful to a person who is not ill or injured.

DME is a covered benefit only upon Prior Authorization by the Plan Medical Director or delegated representative. To be covered, DME must be Medically Necessary, and prescribed or ordered by an In-Network Physician and purchased from an In-Network Provider. There are some exclusions and limitations to coverage. Repair or replacement of DME is covered if it is Medically Necessary, as determined by the Plan. However, replacement due to loss, theft or destruction is not covered.

DME suited for heavier physical activity are not covered. Such activities include fast walking, jogging, bicycling or skiing. Coverage is for medically appropriate equipment and does not include upgrades or accessories unless Medically Necessary.

This DME benefit covers Medically Necessary podiatric appliances for individuals with diabetes. Please refer to the Diabetic Services, Equipment and Supplies section of this EOC for further information.

External Prosthetic Appliances (EPA)

To be covered, these external prosthetic appliances must be Medically Necessary and appropriate. They must be ordered by an In-Network Physician. All appliances must be purchased from In-Network Providers.

External prosthetic appliances have the following characteristics:

- Are artificial substitutes worn on, or attached to the outside of the body;
- Are used to replace a missing part (such as the leg, arm, or hand);
- Are needed to alleviate or correct illness, injury, or congenital defect; and
- Are prescribed by an In-Network Physician.

Braces are considered EPA. (This does not include orthodontic braces.)

The Plan covers replacement of EPA if this is needed due to normal body growth or changes due to illness or injury. Replacement is covered if it is Medically Necessary. The Plan does not cover biomedical EPA.

EPAs suited for heavier physical activity are not covered. Such activities include fast walking, jogging, bicycling or skiing.

Family, Infant and Toddler (FIT) Program

As defined and administered by the New Mexico Department of Health, the Lovelace Insurance Company will provide coverage for children, from birth through three (3) years of age, for or under the *Family, Infant, Toddler Program (FIT)* administered by the Department of Health, provided eligibility criteria are met, for a maximum benefit of three thousand five hundred dollars *($3,500) annually* for Medically Necessary early intervention services provided as part of an individualized family service Plan and delivered by certified and licensed personnel as defined in 13.7.30.8, NMAC. No payment under the FIT Program shall be applied against any maximum lifetime or annual limits specified in the Evidence of Coverage, health benefits Plan or contract. Covered Services under the FIT Program are exempt from benefit Exclusions listed in this EOC.

Growth Hormone Therapy

The Plan does not cover growth hormone treatment for children with idiopathic short stature. An endocrinologist must document a medical diagnosis before hormone therapy is covered.

Hearing Care

Hearing exams are covered when they are used to diagnosis and treat ear injuries or diseases of the ear. For Members age seventeen (17) or younger, routine hearing screenings provided by an In-Network Physician are covered

Immunosuppressive Drugs for Organ Transplants

Inpatient immunosuppressive drugs are covered. Outpatient immunosuppressive drugs are covered under your Outpatient Prescription Drug coverage. Refer to Organ Transplant Services in this Section for benefit limitations.

Organ Transplant Services

The Plan covers human organ and tissue transplant services at the In-Network benefit level. These services are only covered at designated United States facilities and must be Prior Authorized by the Plan. *The Plan designates these facilities.* Coverage is subject to the following conditions and limitations. Out-of-Network benefits are not covered.

Organ transplant services include the recipient's medical, surgical and hospital services; inpatient immunosuppressive medications; and costs for organ procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogenic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas, or small bowel/liver.

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ for a Member, from a cadaver or a live donor. Covered Services for organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor on behalf of a Member. Compatibility testing undertaken prior to procurement is covered if Medically Necessary.

Organ Transplant Travel Services

Travel expenses incurred by you in connection with a pre-approved organ/tissue transplant are covered subject to the following conditions and limitations. Organ transplant travel benefits are not available for cornea transplants. Benefits for transportation, lodging, and food are available to you only if you are the recipient of a pre-approved organ/tissue transplant from an organ transplant facility designated by Lovelace. The term recipient is defined to include a member receiving authorized transplant related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event, or (d) post-transplant care. Travel expenses for the member receiving the transplant will include charges for:

- Transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility);
- Lodging per diem while at, or traveling to and from the transplant site;
- Food per diem while at, or traveling to and from the transplant site;
- The travel per diems must be approved by the Plan prior to traveling.

In addition to you being covered for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver. This benefit is limited to a $10,000 maximum per transplant.

The following are specifically excluded travel expenses:

- travel costs incurred due to travel within 60 miles of your home;
- laundry bills;
- telephone bills;

- alcohol or tobacco products; and
- charges for transportation that exceed coach rates.

These benefits are only available when the Member is the recipient of an organ transplant. No benefits are available where the Member is a donor.

Ostomy Supplies

The Plan covers ostomy supplies when Medically Necessary. The Plan follows CMS guidelines for quantity limitations for supplies. Quantities greater than CMS guidelines must be approved by the Plan Medical Director.

Podiatry

Only Medically Necessary services by a podiatrist are covered. Routine foot care is not covered unless Medically Necessary. Orthopedic shoes and arch supports are not covered unless they are Medically Necessary for the treatment of diabetes.

Special Medical Diets/Foods

Special medical diets/foods are covered for the treatment of inborn errors of metabolism that involve amino acids, carbohydrate and fat metabolism for which medically standard methods of diagnosis, treatment, and monitoring exist. Coverage includes expenses of diagnosing, monitoring and controlling disorders by nutritional and medical assessment, including clinical services, biochemical analysis, medical supplies, Prescription Drugs, corrective lenses for Conditions related to the genetic inborn error of metabolism, nutritional management and special medical foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status. Treatment refers to medical services provided by licensed health care professionals, including Physicians, dieticians and nutritionists, with specific training in managing patients diagnosed with genetic inborn errors of metabolism.

Genetic inborn error of metabolism is a rare, inherited, disorder that is present at birth, results in death if untreated and requires special medical foods. The foods must be authorized by the Plan Medical Director.

Special medical foods include nutritional substances in any form that are:

- Formulated to be consumed or administered internally;
- Specifically processed or formulated to be distinct in one or more nutrients present in natural foods;
- Intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary food; and
- Essential to optimize growth, health and metabolic homeostasis.

Home Health Services

Home health services are covered for certain Conditions and when Prior Authorization has been obtained from the Plan. You must require Skilled Care and be unable to receive medical care on an Ambulatory outpatient basis. Your Condition must not require you to be confined in a hospital or other health care facility.

Home health services include:

- Visits by professional nurses, including RNs and LPNs;
- Visits by Other Health Professionals, including home health aides;

- Consumable medical supplies and DME administered or used by professional staff during authorized home health visits;
- Medical social services; and
- Drugs, medications and clinical laboratory services prescribed by an In-Network Provider for the duration of home health services to the extent they would have been covered if provided to the insured on an in-patient basis.

Physical, occupational, respiratory and speech pathologist therapy provided in the home is covered. These are limited to services provided on the written order of an In-Network Provider. The Lovelace Medical Director must also authorize the services. The above Conditions must be met in order for home health rehabilitation services to be covered under the short term rehabilitation therapy benefit. Such services are subject to review and renewed approval by the Plan's Medical Director every sixty (60) days.

Coverage shall be provided for at least one hundred (100) home visits per Member per Contract Year. Each home health visit may be up to four (4) hours long, depending on your medical needs. Refer to your Summary of Benefits for more information regarding this benefit.

Outpatient Prescription Drugs

The Plan uses a Formulary, which is a list of FDA-approved Prescription Drugs that are covered by Lovelace. The Formulary includes drugs for a wide variety of disease states and Conditions. It also includes both name-brand and generic drugs. Some medications may require a Prior Authorization.

When you fill a prescription drug at an In-Network Pharmacy, you will pay either a Co-Payment or Co-Insurance, depending upon your Plan coverage. The amount you pay will also depend upon the type of prescription drug you fill, as described below:

Generic Drugs: When you use the generic drugs in the Formulary, you pay the lowest Co-Payment or Co-Insurance.

Name-Brand Drugs with No Generic Equivalent: When you use the name-brand drugs in the Formulary that have no generic equivalent, your Co-Payments or Co-Insurance will be higher.

Name-Brand Drugs with a Generic Equivalent and Drugs not on the Formulary: You will pay the highest level of Co-Payments or Co-Insurance if you use the name-brand drugs on the Formulary that have a generic equivalent; or if you use Prescription Drugs that are not on the Formulary.

Refer to your Summary of Benefits for information regarding your exact payment for each type of prescription drug.

Prescription contraceptive drugs and devices are covered under the Outpatient Prescription Drug benefit: If you receive out-of-area emergency care and it is necessary to have prescriptions filled at an Out-of-Network Pharmacy, the Plan requires that the claim must be submitted no later than 1 year (365 days) following the services. The claim must contain an itemized statement of expenses.

Each prescription order or refill shall be limited:

- To up to a consecutive thirty (30) day supply at a retail In-Network Pharmacy, unless limited by the drug manufacturer's packaging;

- To up to a consecutive ninety (90) day supply at a mail order In-Network Pharmacy, unless limited by the drug manufacturer's packaging; or
- To a limited dosage as determined by the Plan Pharmacy and Therapeutics Committee.

Your prescription drug benefit is subject to the exclusions listed in the "Exclusions" section of this EOC.

Vision Care

Eye exams are covered only to diagnose and treat eye injuries or diseases. For Members age seventeen (17) and under, vision screenings provided by an In-Network Physician are covered. In cases of Medically Necessary treatment of keratoconus and post cataract surgery, the first pair of contact lenses is covered by Lovelace.

Voluntary Family Planning Service

This service is provided on a voluntary basis and includes:

- Medical history
- Physical examination
- Related laboratory tests
- Medical supervision in accordance with generally accepted medical practice
- Information and counseling on contraception
- Implantable or injected contraceptives
- After appropriate counseling, medical services associated with surgical therapies (vasectomy or tubal ligation)

EXCLUSIONS

Any services and benefits that are not described in the Covered Benefits and Services section of this Evidence of Coverage are not covered:

- Any services that the Plan Medical Director determines are not Medically Necessary
- Charges that are determined to be unreasonable by Lovelace and charges in excess of Reasonable and Customary Charges
- Smoking cessation treatment and smoking cessation aids
- Transportation costs for deceased Members
- Services, other than emergent or urgent in nature, received outside of the United States
- Cosmetic therapy or procedures for the purpose of changing appearance. Examples are:
  - Surgical excision or reformation of sagging skin on any part of the body including, but not limited to, eyelids, face, neck, abdomen, arms, lips, or buttocks
  - Services for the enlargement, reduction, implantation or change in appearance of a part of the body. Examples include the: breast, face, lips, jaw, chin, nose, ears or genitals
  - Hair transplantation
  - Chemical or laser face peels or abrasions of the skin
  - Removal of hair by electrolysis
  - Any other surgical or non-surgical procedures which are primarily for the purpose of altering appearance
- Organ transplants. Refer to the Limitation section of this Evidence of Coverage
- The medical and hospital services of a donor when the recipient of an organ transplant is not a Member or when the transplant procedure is not a covered benefit
- Care for disabilities connected to military service. These are not covered by the Plan if the Member is legally entitled to these services at facilities that are available to the Member
- Assistance in the activities of daily living. Examples include: eating, bathing, dressing. Homemaker services and non-skilled nursing care are not covered
- Services primarily for rest, domiciliary or convalescent care
- Routine refractions, eyeglasses, corrective lenses, other eye appliances, and eye exercises. Also excluded are surgical treatments for the correction of a refractive error, including radial keratotomy, or the fitting of eyeglasses
- Hearing aids, ear molds, or fitting of hearing aids or ear molds
- Routine physical exams, checkups, medications, and inoculations and/or Biologicals required for reasons other than health; for example, those required for employment, marriage, insurance, and travel purposes
- Treatment or care provided by a Member of your family or other close relative.
- All medical and surgical services for the treatment or control of obesity, unless Medically Necessary
- Non-medical ancillary services such as vocational rehabilitation, behavioral training, sleep therapy, job counseling, psychological counseling and training, or educational therapy for learning disabilities or mental impairment
- Services not generally recognized as Medically Necessary, such as:
  - HCG injections
  - Hair analysis
  - Transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery
  - Reversal of voluntary sterilization
  - Penile implants, unless Medically Necessary

EXCLUSIONS

- Private hospital rooms and/or private duty nursing unless determined to be Medically Necessary by the Plan Medical Director
- Conditions that state or local law mandates treatment of in a public facility or court-ordered services. These are not covered if they are not ordered by the Primary Care Physician and approved by the Plan Medical Director
- Maternity Benefits including, but not limited to, any Condition which is pregnancy related, prenatal care, delivery or voluntary pregnancy termination, and postnatal care. Complications of pregnancy that are not covered under this Agreement include, but are not limited to: false labor, elective and non-elective Cesarean section, multiple gestation, non-life-threatening bleeding or occasional spotting, amniocentesis, ultrasounds, storage of cord blood, Physician prescribed rest during the period of pregnancy, morning sickness, and fetal Conditions affecting management of the mother, such as, but not limited to, fetal care, fetal surgery, and complications of the fetus or fetal demise
- Prescription Drugs not covered:
  - Any drugs or medications available over the counter that do not require a prescription by federal or state law, other than insulin, and any drug or medication that is equivalent (in strength, regardless of form) to an over the counter drug
  - Any drugs that are experimental or investigational, within the meaning set forth in the Exclusions Section of this EOC
  - Food and Drug Administration (FDA) approved prescription drugs used for purposes other than those approved by the FDA unless the drugs is recognized for the treatment of a particular indication in one of the standard reference compendia (The United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal
  - All newly FDA approved drugs, prior to review by the Pharmacy and Therapeutics Committee
  - Any prescription and non-prescription supplies, devices and appliances other than syringes used in conjunction with injectable medications
  - Any fertility drugs
  - Any prescription drug or medications used for treatment of sexual dysfunction, including, but not limited to, erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido
  - Any prescription vitamins, dietary supplements, and fluoride products
  - Prescription Drugs used for cosmetic purposes such as drugs used to reduce wrinkles, Minoxidil and other prescriptions drugs to promote hair growth as well as drugs used to control perspiration and fade cream products. Retin-A for Members over twenty-six (26) years of age and other prescription products to reduce wrinkles
  - Any diet pills or appetite suppressants
  - For the purpose of travel, immunization agents, biological product for allergy immunization, biological sera blood, blood products or fraction and medications
  - Replacement Prescription Drugs due to loss or theft
  - Medication used to enhance athletic performance
  - Progesterone suppositories, troche or gel
  - Medications which are to be taken by or administered to a Member while the Member is a patient in a licensed hospital, skilled nursing facility, rest home or similar institution which operates on it premise or allows to be operated on its premises a facility for dispensing pharmaceuticals

EXCLUSIONS

  - Prescriptions more than one (1) year from the original date of issue
  - Discharge medications provided by a Hospital pharmacy unless a Participating Pharmacy is not available
  - Prescriptions not on the Formulary unless prior authorization was obtained by the Plan
  - Infertility services not covered
  - Infertility drugs
- In vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) and variations of these procedures
- Any costs associated with artificial insemination, including donor fees
- Elective abortions
- Medical and hospital care and related costs for the infant child of a Dependent, unless the infant child is otherwise eligible for coverage under the Plan
- Membership costs or fees associated with health clubs and weight loss clinics
- Fees associated with the collection or donation of body organs. Refer to the Limitations section of this Evidence of Coverage
- Cosmetics and health and beauty aids
- Dietary supplements and nutritional formulae taken by mouth or feeding tubes are not covered except as defined under Limitations (Special Medical Foods)
- Treatment for mandibular or maxillary prognathism, micrognathism or malocclusion, surgical augmentation for orthodontics, or maxillary constriction. Medically Necessary treatment of TMJ disorder is covered
- Dental treatment of the teeth or structures directly supporting the teeth. Dental x-rays, exams, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion are not covered
- Personal or comfort items such as personal care kits provided at a hospital are not covered. Fees for television, telephone, newborn infant photographs, and other such articles are also not covered
- Services not primarily medical in nature, or supplies or equipment that are primarily and customarily used for a non-medical purpose as determined by the Plan Medical Director
- Non-medical, non-approved expenses for personal services or comfort items are not covered. Examples include: charges for legal counsel, hotel accommodations, meals, telephone charges and reimbursement for lost wages
- Repairs for Durable Medical Equipment (DME), prosthetic or orthotic devices, that were not provided to the member by the Plan except as defined under Diabetic coverage; repair or replacement of a DME will be reviewed by the Plan
- Services and inoculations for reasons other than health. Examples include those required for: jobs, marriage, insurance, or travel
- Medical, surgical or other health care procedures and treatments which are experimental or investigational. This is determined by the Plan Medical Director in accord with medical and scientific literature and the practice of the national medical community. This exclusion is for:
  - Any procedures or treatments which are not recognized as conforming to accepted medical practice
  - Any procedures or treatments in which the scientific assessment of the technique, or its application for a particular condition, has not been completed or its effectiveness has not been established
  - Any procedures or treatments for which the required approval of a governmental agency has not been granted at the time the services are given

EXCLUSIONS

  - Cancer chemotherapy or other types of therapy that are subject to ongoing clinical trials, except when the chemotherapy is prescribed under medical research protocol and submitted to regional and national databases
  - Therapy administered under experimental protocols
  - EXCEPTION: See Clinical Cancer Trials
- Services and benefits related to treatment of mental illness and substance abuse conditions that are not described in Benefits and Services and Limitations sections of this Evidence of Coverage are excluded from coverage. These excluded services include, but are not limited to, the following:
  - Any court-ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and covered under the Services and Benefits section of this Agreement
  - Treatment of organic mental disorders associated with permanent dysfunction of the brain
  - Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorder, developmental language disorder or developmental articulation disorder
  - Counseling for activities of an educational nature
  - Counseling for borderline intellectual functioning
  - Counseling for occupational problems
  - Counseling related to consciousness raising
  - Vocational or religious counseling
  - Intelligence Quotient (I.Q.) testing
  - Psychological testing on children requested by or for a school system, unless Medically Necessary
- Artificial aids including speech synthesis devices except items identified in the Summary of Benefits
- Biofeedback
- 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
- Costs for extended warranties and premiums for other insurance coverages
- Exercise equipment
- Eye movement therapy
- Routine Foot Care
- Hypnotherapy
- Infant formula
- Marriage, family or sex counseling
- Massage Therapy

If you are uncertain whether a particular treatment or service is considered experimental contact the Plan before the treatment or service is provided.

Any services and benefits not described in this Evidence of Coverage or attached Summary of Benefits are not covered under this plan.

MEMBER APPEAL AND GRIEVANCE PROCEDURE

The Plan's appeal and grievance process is overseen by the Appeals Department. Its purpose is to resolve issues from Members who are displeased with the quality of service received or decisions made by the Plan. A Member must exhaust this process before bringing any legal action against the Plan.

When You Have a Concern or Complaint

(For the purposes of this section, any reference to "you", "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.)

We want you to be completely satisfied with the Plan and the care and/or services you receive. That's why we've established a process for addressing your concerns and solving your problems. We will provide you a written copy of the grievance and appeal procedure and will assist you in filing a grievance or appeal. We will never retaliate against a Member in any way for filing a grievance or appeal.

Start with the Customer Care Center

We're here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can contact the Customer Care Center in Albuquerque 505.232.1881 or toll-free outside of Albuquerque 1.800.808.7363. 1.800.659.8331 TTY Services provided by NM Relay.. One of our Customer Care Center representatives can assist you and address your concern. You can also express that concern by walk-in interview, arranged appointment, or in writing at the following:

Our offices are located in Albuquerque, on Indian School Rd. NE, east of Carlisle

Lovelace Insurance Company
4101 Indian School Rd, NE Ste 110-S
Albuquerque, NM 87110

Or you may submit your concerns in writing to:

Lovelace Insurance Company
P.O. Box 27107
Attn: Customer Care Center
Albuquerque, NM 87125-7107

If you are not satisfied with the response you receive, you may request to start the Appeals or Grievance procedure. All requests received will be thoroughly reviewed to determine the type of concern as well as the best course of action in order to address the issue at hand.

Appeals

When you or your Provider requests a service, Lovelace shall initially determine whether the service being requested in covered by your Plan and is Medically Necessary. This decision will be made either within 24 (twenty-four) hours of receiving the request (if there are medical reasons that require an expedited decision) or within 5 (five) working days. If Lovelace makes a decision to deny, reduce or terminate requested health care services, this is called an Adverse Determination. We will notify you and your doctor by telephone of this adverse determination within twenty-four (24) hours of the decision and in writing within one (1) working day of the telephone notification.

MEMBER APPEAL AND GRIEVANCE PROCEDURE

When we make an Adverse Determination, you have the right to request an appeal. Lovelace has a two-step appeals process. To initiate an appeal, you may submit a request for an appeal in writing to Lovelace within one (1) year of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask Lovelace to register your appeal by calling the number on your Plan ID card. You may also register your appeal by an arranged appointment or walk-in interview. Once received, we will send you a written acknowledgement of your appeal.

Review of Adverse Determination Appeals

Appeals involving the review and evaluation of the clinical necessity, appropriateness, efficacy, and efficiency of health care services will be completed within twenty (20) working days of receipt of request for your appeal. Either Lovelace or the Member may request an extension of the review period for a maximum of ten (10) working days when reasonable cause can be demonstrated, and the delay will not result in increased medical risk to you. If the extension is requested by Lovelace, a written progress report and explanation of the delay will be sent to you and your treating Provider.

In cases that require an expedited decision based on a review by a Lovelace Medical Director or at the request of your Participating Provider, a decision will be made within seventy-two (72) hours of the request. Expedited decisions are made when your life or health, or ability to regain maximum function, would be jeopardized following the standard appeal process and time frames.

LEVEL ONE ADVERSE DETERMINATION APPEALS – MEDICAL DIRECTOR REVIEW

We will acknowledge in writing within one (1) working day that we have received your request for appeal. Your appeal will be reviewed by a Medical Director not involved in the original decision, to determine whether the requested health care services are Medically Necessary and covered under the health benefits Plan.

If the Medical Director decides to reverse the initial adverse determination, the Medical Director will certify care. You and your treating Provider will be notified by mail or electronic means (fax, e-mail, etc.) within three (3) working days of making the decision.

If the Medical Director decides to uphold the initial adverse determination, you and your provider will be notified by telephone within twenty-four (24) hours that the adverse determination has been upheld and by mail or electronic means within one (1) working day of the telephone notification. You will be given the choice whether you want to pursue an appeal to the Medical Panel Review committee.

If you do not wish to pursue the appeal, we will mail written notification of the Medical Director's decision and confirmation of your decision not to pursue the appeal further, to you within three (3) working days. If we are unable to contact you by telephone within seventy-two (72) hours after making the decision to uphold the initial adverse determination, then we will notify you by mail of the Medical Director's decision and will include in the notification a self-addressed stamped response letter which asks whether you want to pursue the appeal further and provide a box for you to check "yes" or "no". If you do not return the letter within ten (10) working days, we will again try to contact you by telephone.

If we verify with you either by telephone or the response letter that you want to pursue the appeal further, a Medical Panel Review committee will be selected to further review the appeal. If you do not respond to our telephone calls or return the response letter within twenty (20) working days of the original appeal request, we will close the file, documenting that you have not responded within the twenty (20) working days we have to complete the appeal process. If your appeal involves an expedited review, then a Medical Review Panel committee will automatically be selected to further review your appeal unless you advise us you do not want this review.

LEVEL TWO INTERNAL PANEL REVIEW OF ADVERSE DETERMINATION – MEDICAL PANEL REVIEW

Unless you choose not to pursue your appeal, we will notify you of the date, time, and place of the Medical Panel Review. The Medical Panel will consist of Appeals Department staff Members, a Non-Lovelace Physician and other LHP staff not involved in the original decision making process. The notice will advise you of your rights. Your rights include: attending the Medical Panel Review, presenting your case to the Medical Panel Review committee, submitting supporting material both before and at the Medical Panel Review, asking questions of any representative of the Plan, asking questions of the health care professionals on the Medical Panel, and be assisted or represented by a person of your choice, including legal representation. If you choose to have legal representation with you at the hearing, please notify the Appeals Department Representative at least three (3) business days prior to the hearing. Failure to notify may require rescheduling of the hearing. If we have an attorney present to protect our interests, the notice will advise you of such and that you may wish to obtain legal representation of your own.

No fewer than three (3) working days prior to the Medical Panel Review, we will provide to you the following information that will be reviewed at the Medical Panel. This information may include, but is not limited to: your pertinent medical records; your treating Provider's recommendation; the Summary of Benefits for your health benefit Plan; a copy of our notice of the adverse determination; generally accepted practice guidelines, evidence-based practice guidelines or practice guidelines developed by the federal government or national and professional medical societies, boards and associations; any applicable clinical review criteria, policies or protocols used by us in making the adverse determination; and all other evidence or documentation relevant in reviewing the adverse determination.

We will notify you and your treating Provider of the Medical Panel Review committee's decision by telephone within twenty-four (24) hours of making a decision in writing or by electronic means within one (1) working day of the telephone notice. The written notice will contain the following: the names, titles, and qualifying credentials of the persons on the Medical Panel Review; a statement of the Medical Panel Review committee's understanding of the nature of the appeal and all pertinent facts; a clear and complete explanation of the clinical or other rationale for the Medical Panel Review committee's decision; identification of the health benefit Plan provision relied upon in reaching the decision; reference to evidence or documentation considered by the Medical Panel Review committee in making the decision.

Grievances (Administrative Grievances)

You have the right to file a grievance for any quality of service or quality of care complaint you may have. Once you have contacted a representative in our Customer Care Center, they may be able to resolve the issue without further intervention. However, if the representative is unable to resolve the issue within five (5) business days, your issue will be sent to the grievance department to initiate the formal grievance process. You may also initiate this process in writing or in person. Once the request has been received, it will be forwarded to the grievance department staff. Lovelace will send you written acknowledgement of your grievance within three (3) working days and will send you a written resolution within fifteen (15) working days. This is a Level One Administrative Grievance. The fifteen (15) working-day period may need to be extended when there is a delay in obtaining necessary documentation for the review. We will notify by mail if this extension is needed.

If you are not satisfied with the resolution of the Level One, you may request a Level Two Formal Committee Hearing. You must request this committee hearing within twenty (20) working days after receiving your resolution letter, or the Level One decision will be final. Upon receipt of your request for a Level Two hearing, the committee will schedule and hold a meeting within fifteen (15) working days. You will have the opportunity to participate at the committee meeting. We will notify you in writing of the hearing date, time and place at least

ten (10) working days in advance. The committee Members will consist of grievance department and other Lovelace staff not involved in the original decision making process.

No fewer than three (3) working days prior to the hearing, we will provide to you all documents and information that the committee will review at the hearing. Your rights include: attending the committee hearing, presenting your case to the committee, submitting supporting material both before and at the hearing, asking questions of any representative of the Plan and be assisted or represented by a person of your choice, including legal representation. If you choose to have legal representation with you at the hearing, please notify the grievance department representative at least three (3) business days prior to the hearing. Failure to notify may require rescheduling of the hearing. If we have an attorney present to protect our interests, the notice will advise you of such and that you may wish to obtain legal representation of your own.

We will mail a written decision to you within seven (7) working days after the committee hearing. The written decision will include the following: the names, titles, and qualifications of the persons on the committee; the committee's statement of the issues involved in the complaint; a clear and complete explanation of the rationale for the committee's recommendation.

In accordance with the Patient Protection Act, Lovelace cannot, and will not, take retaliatory action against you for filing a Grievance under this Plan.

If you feel your appeal or grievance has not been resolved, you may contact the New Mexico Public Regulation Commission, Consumer Relations Division at:

P O Box 1269
Santa Fe, New Mexico 87504-1269
1.800.663.9782
Fax 505.827.4463

COVERAGE UNDER OTHER INSURANCE

Injuries Caused by Third Parties and Subrogation

Sometimes when Members are injured in an accident, other insurance companies are legally liable. There are state laws in this regard.

- The Plan has the right of subrogation. If a Member is injured through the wrongful act or omission of another person, the Plan is entitled to total billed charges for the benefits it provided. The repayment is to come from any payments received from the party held liable. It may come from that party's insurance carrier. It may also come from the Member's uninsured or underinsured motorist benefits carrier.

- The Plan also receives an assignment of any and all claims for uninsured or underinsured motorist benefits to repay total billed charges for the benefits given. The Plan is also entitled to sue in its own name or in a Member's name.

- If you are in an accident and another person or entity may be legally liable to you, notify Lovelace Subrogation Services right away. The number is listed on the back cover of this Evidence of Coverage. The Plan will work with you or your lawyer to protect the Plan's right of subrogation.

- You must not settle, compromise or release a claim for injury against a third person, that person's insurer or your uninsured or underinsured motorist benefits carrier without giving prior notice to the Plan.

- To settle or agree to a release without informing the Plan may destroy its subrogation rights. Then you will be obligated to repay the Plan for health care given you because of the accident.

- If you file suit against a third party or file an insurance claim against your uninsured or underinsured motorist benefits carrier for injuries for which the Plan provided benefits, you must notify Lovelace Subrogation Services as soon as possible. Amounts paid under your uninsured or underinsured motorist coverage will be treated the same as amounts paid by a third party. The same is true of payments made by a liability insurer on behalf of a third party.

Coordination of Benefits (COB)

Coordination of Benefits (COB) refers to Plan Members who have coverage under more than one Plan. A Plan may be another group or individual health insurer or it may be another type of insurance, such as Medicare or certain types of automobile insurance. The insurance industry has developed rules called "order of benefit determination rules" that govern the order in which each Plan will pay a claim for benefits. This ensures that Plans will apply consistent rules and that the maximum amount will be paid under each applicable Plan. The Plan that pays first is called the primary Plan. The primary Plan must pay benefits in accordance with its Policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the primary Plan is the secondary Plan. The secondary Plan may reduce the benefits it pays so that payments from all Plan benefits do not exceed 100% of the total allowable expense. (Note: In some cases, a Plan Member may be covered under three or more Plans. In that case, benefits can be coordinated among all the applicable Plans to ensure that the maximum benefits are paid by each Plan.)

COVERAGE UNDER OTHER INSURANCE

The Plan must know what other health insurance coverage you have in order to coordinate benefits with your other carrier(s). This could reduce the out-of-pocket or "not covered" amounts that you are liable for. Therefore, it is in your best interest to provide us with the most up-to-date information about other coverage carried by you and your dependents. If you have any questions, please contact the Customer Care Center at 505.262.7363 or statewide at 1.800.808.7363.

When you end or begin your other health insurance coverage, you must notify the Customer Care Center immediately.

Medicaid

Benefits paid on behalf of a Member of this Plan will be paid to the New Mexico Human Services Department (HSD) when:

1. HSD has paid or is paying benefits on behalf of the Member under the New Mexico Medicaid program;
2. Payment for the services in question has been made by HSD to the Medicaid provider; and
3. Lovelace is notified that the Member receives benefits under the state Medicaid program and that benefits must be paid directly to HSD.

Otherwise, Lovelace will pay Providers for your Covered Services. If you have already paid a Provider for Covered Services, you must seek reimbursement from the Provider. Lovelace is required by state law to make payment to Providers directly.

ENROLLMENT

Who Can Enroll as a Member?

To be eligible for Covered Services, you must be enrolled as a Member. Please note that ALL Members will be enrolled on individual policies. To be eligible to enroll as a Member you must meet the eligibility criteria listed below.

A. To be eligible to enroll as a Member, you must

1. reside in New Mexico;
2. be under the age of sixty-five (65); and
3. continue to meet the criteria indicated within this section of the EOC

B. To enroll a Dependent minor child under the age of eighteen (18) as a Member, you must:

1. submit a separate completed Application for each such child, and our Underwriting Department must approve each Application. He or she must be your natural child, stepchild, adopted child, or a child for whom you are the legal guardian. Any adopted child(ren) that you wish to enroll must be legally placed in your home for adoption by a court of law within the United States. Any child(ren) for whom you are the permanent legal guardian must be supported pursuant to a court order imposed on you (including a qualified medical child support order).

Custodial Parent Rights

Lovelace acknowledges the rights of the custodial parent of children who are covered under an Evidence of Coverage with the Lovelace PPO Plan and enrolled by the non-custodial parent. Custodial parents are able to contact the Plan and obtain and provide necessary information including but not limited to Provider information, claim information and benefit/services information for that child.

Enrollment and Effective Date of Coverage

Eligible individuals may apply for coverage by submitting completed enrollment application forms to Lovelace Insurance Company.

The Lovelace Individual Plan is offered statewide; however, the premiums differ between the "Albuquerque Area" and the "Non-Albuquerque Area". The Albuquerque Area includes all U.S. Postal Service Zip Codes within the following New Mexico counties: Bernalillo, Sandoval, Valencia and Torrance. The Non-Albuquerque Area includes all other New Mexico counties.

Eligible individuals approved by Lovelace Insurance Company as Members, will be effective the 1st of a given month – as indicated by the Underwriting Department – at 12:01 a.m.

SPECIAL ENROLLMENT FOR NEWBORN, ADOPTED AND COURT-ORDERED DEPENDENTS

If you are an existing Member, there are special circumstances in which you may enroll your dependent(s) as a Member after the Effective Date of your enrollment. Your dependent(s) will have a separate Evidence of Coverage from your own. You may submit an enrollment Application (separate Application for each dependent) to Lovelace for any eligible dependent(s) within thirty-one (31) days of the date of the following events:

- Birth of a dependent newborn child
- Adoption of a dependent child or legal placement of a child for adoption
- Issuance of a Court Order assigning you permanent legal guardianship of a minor child.

The Effective Date of coverage under "Special Enrollment for Dependents" will be the day of the event creating eligibility as described below:

- Birth of a Dependent Newborn Child – the Effective Date of coverage is the date of birth.
- Adoption of a Dependent Child - the Effective Date of coverage is the date the child is legally placed with you for adoption.
- Legal Placement of a Child for Adoption – the Effective Date of coverage is the date of legal placement of the child with you for adoption or the date of court-ordered legal guardianship.

If you do not enroll your dependent(s) within the thirty-one (31) days of one of these events, the eligible dependent(s) will be subject to underwriting and, if approved, will NOT be enrolled on the date of the event (birth, adoption, legal placement). An Application must be submitted to Lovelace for each dependent and the request for coverage is subject to denial.

Residency

Eligibility in the Plan requires that you reside within the State of New Mexico.

Full and Accurate Completion of Enrollment Application

Each Member (or parent/legal guardian) must fully and accurately complete the enrollment Application. False, incomplete or misrepresented information provided in any enrollment Application may, in the Plan's sole discretion, cause the coverage of the Member to be null and void from its inception.

Hospitalization on the Effective Date of Coverage

If you are confined in a hospital on the Effective Date of your coverage, you must notify us of such a hospitalization within two (2) days, or as soon as reasonably possible thereafter.

Notification of Change of Status

Any change in a Member's status after the Effective Date of coverage should be reported to the Customer Care Center. Examples include a change from tobacco user to non-tobacco user; a change in address to a new geographic area within New Mexico (e.g., Albuquerque to Las Cruces) that could affect the Member's monthly Premium; or any change in eligibility status such as a move outside of the state of New Mexico that would require termination of coverage.

If you change your address, be sure to notify Lovelace as soon as possible to ensure you receive your Plan ID cards and other Plan mailings.

TERMINATION OF COVERAGE

We may terminate your coverage for any of the reasons stated below:

Termination For Cause

Upon written notice to you, we may terminate a Member's coverage for cause if any of the following events occur:

1. You omit, misrepresent, or provide materially false information in the enrollment Application, in which case, we may render coverage of a covered family unit to be null and void from the Effective Date of coverage;
2. You permit a non-Member to use your Lovelace ID card or to falsely obtain services and supplies;
3. You obtain or attempt to obtain services and supplies by means of false, misleading or fraudulent information, acts or omissions;
4. You fail to pay the monthly Premium;
5. You fail to pay Co-Payments, or any other amount due as a result of receiving services and supplies;
6. Your behavior, in our sole opinion, is disruptive, unruly, abusive or uncooperative to such an extent that we are seriously impaired in our ability to provide services to you or to any other Member; or
7. You threaten the life or well being of any Plan employee, Provider, or another Member.

In no event, however, will we terminate your coverage due to health status, need for health care services, race, gender, age, sexual orientation or utilization of services and supplies. If you feel that your coverage has been unjustly terminated you can appeal the decision to the Superintendent of Insurance. The address and toll-free number are as follows:

New Mexico Public Regulation Commission – Insurance Division
Attn: Superintendent
P.O. Box 1269
Santa Fe, NM 87504-1269
1.800.947.4722

Termination By Reason of Ineligibility

When you fail to meet the eligibility criteria in "Enrollment and Effective Date of Coverage" as a Member, your coverage under this Plan shall cease.

Unless otherwise provided by law, if you fail to meet the eligibility criteria your coverage shall cease at midnight of the day that the loss of eligibility occurs, and we shall have no further obligation to provide services and supplies.

This Agreement may be terminated for any of the following reasons:

1. Termination for Non-Payment of Premium. If Premiums are not paid within thirty (30) days after they are due, coverage under the Individual Plan will be automatically terminated. Termination will be effective retroactive to the last day of the period for which the affected Member's premium was paid. Lovelace will not pay for any Covered Services provided to a Member after the date of termination. Lovelace will not cancel a Member's coverage for non-payment of any fees during any period in which a Member is hospitalized and receiving treatment for a life-threatening Condition. In addition, Lovelace will not cancel a Member's coverage for refusal to follow any prescribed course of treatment.
2. Termination on Notice. The Member (or parent/legal guardian), without cause, may terminate this Agreement upon written notice to Lovelace.

3. Termination for Fraud or Misrepresentation. We may terminate this Agreement retroactive to the Effective Date of coverage upon thirty (30) days prior written notice to the Member if, at any time, we determine that the Member has performed an act or practice that constitutes fraud or has intentionally misrepresented a material fact.

4. Termination Due to refusal to follow Lovelace policies. We may terminate this Agreement as of the date specified for refusal to follow Lovelace's administrative policies or refusal of Lovelace's benefits; provided that written notice is sent to the Member as least thirty (30) days in advance of such termination.

5. Termination Due to Residency Outside of New Mexico. We may terminate this Agreement at the end of the month in which the Member ceases to physically live in New Mexico.

6. We may terminate this Agreement if the Member ceases to be eligible, except that with respect to a child placed for adoption whose placement has been disrupted prior to legal adoption, this Agreement shall terminate as of the date such child is removed from placement.

7. We may terminate this Agreement on the date of entry into active military duty, except for temporary duty of thirty (30) days or less.

8. Termination in Accordance with state and/or federal law. We may terminate this Agreement upon prior notice to the Member in accordance with any applicable state and/or federal law.

Termination Effective Date. Coverage under this Agreement shall terminate at midnight of the date of termination provided in the written notice.

Notice of Termination to Members. If this Agreement is terminated for any reason in this section, Lovelace will notify you of the termination Effective Date and any applicable rights you may have.

Responsibility for Payment. The Member shall be responsible for the payment of all prepayment Premiums due through the date on which coverage ceases. You shall be financially responsible for all services rendered after that date. Lovelace shall be responsible for providing appropriate notice of cancellation to all Members in accordance with applicable state law.

Incontestability Period. No statement (except a fraudulent statement, as explained in this Agreement) made by a Member in any Application for coverage that is more than two years old can void this Agreement or be used to deny a claim for loss incurred under this Evidence of Coverage unless the Application or a true copy of it is incorporated in or attached to the Contract.

Continuation of Coverage

As a Member of the Lovelace Insurance Company Individual Plan, Continuation of Coverage does not apply. You may only be terminated based on the reasons indicated in the Termination of Coverage section of this Agreement.

TERMINATION OF COVERAGE

Medicare

If you become eligible for Medicare Part A and Part B and reside in our Medicare Advantage or Medicare PPO approved service area, you may be eligible to join the Lovelace Senior Plan (LSP) or Premier Choice. You may be eligible for Medicare by reason of age, disability or end stage renal disease. To obtain more information regarding LSP or Premier Choice, contact the Customer Care Center at 505.262.7363 or 1.800.808.7363.

No change will be made to your Individual Plan coverage based on Medicare eligibility unless we receive a written request from you.

Prepayment of Premiums

Prepayment of Premiums is mandatory. Prepayments, as stated in the approval letter or any notice of Prepayment change, are payable in advance by the Member or the financially responsible party. Premium payments will be deducted each month from the Member's or financially responsible party's bank account as stated in the Member approval letter.

Changes in Premium Payments

Lovelace reserves the right to change the Premium Payment amount for the Covered Benefits provided written notice of such change in Premium amount shall be given by Lovelace to the Member at least sixty (60) days prior to the Effective Date of the Premium change. Changes may occur for the following reasons:

- Following a change of residence into or out of the "Albuquerque Area", which is defined as all Zip Codes within the Counties of Bernalillo, Sandoval, Torrance and Valencia;
- Upon change in age, per published Premium age bands, automatically effective the 1st of the month following the Member's birthday; or
- Following a change in which the provisions of the Agreement are amended which result in a Premium change.

Premiums Not Paid On Time

If Premiums are not paid within thirty-one (31) days after they are due, coverage under the Individual Plan will be automatically terminated. Termination will be effective retroactively to the last day of the period for which the affected Member's Premium was paid. Lovelace will not pay for any Covered Services provided to a Member after the date of termination.

Refund Policy

If the Member is not satisfied with the Plan for any reason within the first 31 days of coverage, the Member may request a Cancellation. Lovelace will refund to the Member all Premiums paid for the 1st month of coverage. Lovelace has the right to recover any benefit payments made for claims during the (thirty-one (31) day period.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice is effective on April 14, 2003

Lovelace Insurance Company is committed to maintaining and protecting the confidentiality of our Members' personal and sensitive information. We are required by federal and state law to protect the privacy of your individually identifiable health information and other personal information and to send you this Notice about our policies, safeguards and practices. The term "confidential information' will be used throughout the remainder of this Notice to describe individually identifiable health information maintained and possibly shared. When we use or disclose your confidential information, we are bound by the terms of this Notice or any revised Notice.

How We Protect Your Privacy

Lovelace Insurance Company will not disclose confidential information without your authorization unless it is necessary to provide your health benefits; administer your benefit Plan to support Lovelace Insurance Company programs or services, or as otherwise required or permitted by law. When we need to disclose individually identifiable information, we will follow the policies described in this Notice to protect your confidentiality.

Lovelace Insurance Company protects your confidential information by implementation of processes and procedures for accessing, labeling and storing confidential records. Access to our facilities is limited to authorized personnel. We restrict internal access to your confidential information to the Lovelace Insurance Company employees who need to know that information to conduct our business. Lovelace Insurance Company trains its employees on policies and procedures designed to protect your privacy. Our Privacy Officer monitors how we follow those policies and procedures and educates our organization on this important topic.

How We Use And Disclose Your Confidential Information

We will not use your confidential information or disclose it to others without your authorization, except for the following purposes:

- **Treatment.** We may disclose your confidential information to your health care Provider for its provision, coordination or management of your health care and related services – for example, for coordinating your health care with us or for referring you to another Provider for care.
- **Payment.** We may use and disclose your confidential information to obtain payment of premiums for your coverage and to determine and fulfill our responsibility to provide your Plan benefits, - for example, to make coverage determinations, administer claims and coordinate benefits with other coverage you may have. We also may disclose your confidential information to another Plan or a health care Provider for its payment activities – for example for the other Plan to determine your eligibility or coverage, or for the health care Provider to obtain payment for health care services provided to you.
- **Health Care Operations.** We may use and disclose your confidential information for our health care operations – for example, to provide customer service and conduct quality assessment and improvement activities. We also may disclose your confidential information to another Plan or a Provider who has a relationship with you, so that it can conduct quality assessment and improvement activities – for example, to perform case management.
- **Appointment Reminders and Treatment Alternatives.** We may use and disclose your confidential information for appointment reminders or to send you information about treatment alternatives or

other health-related benefits and services.

- **Disclosure to Lovelace Insurance Company Vendors and Accreditation Organizations.** We may disclose your confidential information to companies with whom we contract, if they need it to perform the services we've requested – for example, vendors who help us provide important information and guidance to Members with chronic Conditions like diabetes and asthma. Lovelace Insurance Company also discloses confidential information to accreditation organizations such as the National Committee for Quality Assurance (NCQA) when the NCQA auditors collect Plan Employer Data and Information Set (HEDIS) data for quality measurement purposes. When we enter into these types of arrangements, we obtain a written agreement to protect your confidential information.
- **Promotional Gifts.** We may use or disclose your confidential information to provide you with a promotional gift of nominal value.
- **Public Health Activities.** We may disclose your confidential information for the following public health activities and purposes: (1) to report health information to public health authorities that are authorized by law to receive such information for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse or neglect to a government authority that is authorized by law to receive such reports; (3) to report information about a product or activity that is regulated by the U.S. Food and Drug Administration (FDA) to a person responsible for the quality, safety or effectiveness of the product or activity; and (4) to alert a person who may have been exposed to a communicable disease, if we are authorized by law to give this notice.
- **Health Oversight Activities.** We may disclose your confidential information to a government agency that is legally responsible for oversight of the health care system or for ensuring compliance with the rules of government benefit programs, such as Medicare or Medicaid, or other regulatory programs that need health information to determine compliance.
- **For Research.** We may disclose your confidential information for research purposes, subject to strict legal restrictions.
- **To Comply with the Law.** We may use and disclose your confidential information to comply with the law.
- **Judicial and Administrative Proceedings.** Under certain circumstances, we may disclose your confidential information in a judicial or administrative proceeding or in response to a legal order.
- **Law Enforcement Officials.** We may disclose your confidential information to the police or other law enforcement officials, as required by law or in compliance with a court order or other process authorized by law.
- **Health or Safety.** We may disclose your confidential information to prevent or lessen a serious and imminent threat to your health or safety or the health and safety of the general public.
- **Government Functions.** Under certain circumstances, we may disclose your confidential information to various departments of the government such as the U.S. military or the U.S. Department of State.
- **Workers' Compensation.** We may disclose your confidential information when necessary to comply with Workers' Compensation laws.

Uses And Disclosures With Your Written Authorization

We will not use or disclose your confidential information for any purpose other than the purposed described in this Notice without your written authorization. For example, we will not supply confidential information to another company for its marketing purposes or to a potential employer with whom you are seeking employment without your signed authorization. You may revoke an authorization that you previously have given by sending a written request to our Privacy Officer, but not with respect to any actions we already have taken.

Your Individual Rights

- **Right to Request Additional Restrictions.** You may request restrictions on our use and disclosure of your confidential information for the treatment, payment and health care operations purposes explained in this Notice. While we will consider all requests for restrictions carefully, we are not required to agree to a requested restriction.
- **Right to Receive Confidential Communications.** You may ask to receive communications of your confidential information from us by alternative means of communication or at alternative locations. While we will consider reasonable requests carefully, we are not required to agree to all requests.
- **Right to Inspect and Copy your Confidential Information.** You may ask to inspect or to obtain a copy of your confidential information that is included in certain records we maintain. Under limited circumstances, we may deny you access to a portion of your records. If you request copies, we may charge you copying and mailing costs.
- **Right to Amend your Records.** You have the right to ask us to amend your confidential information that is contained in our records. If we determine that the record is inaccurate, and the law permits us to amend it, we will correct it. If your doctor or another person created the information that you want to change, you should ask that person to amend the information.
- **Right to Receive an Accounting of Disclosures.** Upon request, you may obtain an accounting of disclosures we have made of your confidential information. The accounting that we provide will not include disclosures made before April 14, 2003, disclosures made for treatment, payment or health care operations, disclosures made earlier than six years before the date of your request, and certain other disclosures that are excepted by law. If you request an accounting more than once during any twelve (12) month period, we will charge you a reasonable fee for each accounting statement after the first one.
- **Right to Receive Paper Copy of this Notice.** You may contact the Customer Care Center at the toll-free number on your Lovelace Insurance Company ID card to obtain a paper copy of this Notice, even if you previously agreed to receive this Notice electronically.

If you wish to make any of the requests listed above under "Your Individual Rights," you must complete and mail us the appropriate form. To obtain the form, please contact the Customer Care Center at the toll-free number on your Lovelace Insurance Company ID card and request the appropriate form. The requested form will be mailed to you. Completed forms should be mailed to the address printed on the forms. After we receive your signed, completed form, we will respond to your request.

Questions or Complaints

If you want more information about your privacy rights, do not understand your privacy rights, are concerned that we have violated your privacy rights, or disagree with a decision that we made about access to your confidential information, you may contact our Privacy Officer. You may also file written complaints with the Secretary of U.S. Department of Health and Human Services. Please contact our Privacy Officer to obtain the correct address for the Secretary. We will not take any action against you if you file a complaint with the Secretary or us.

Privacy Officer

You may contact our Privacy Officer at:

Privacy Officer
Lovelace Insurance Company
PO Box 27107
Albuquerque, NM 87125-7101
Telephone Number: 505.262.7363 (In Albuquerque)
1.800.808.7363 (Outside of Albuquerque)
Fax Number 505.262.7719

We may change the terms of this Notice at any time. If we change this Notice, we may make the new Notice terms effective for all of your confidential information that we maintain, including any information we created or received before we issued the new Notice. If we change this Notice, we will send you the new Notice if you are enrolled in a Lovelace Insurance Company benefit Plan at that time. You also may obtain any new notice by contacting the Customer Care Center at the toll-free number on your Lovelace Insurance Company ID card.

General Policy Provisions

You have selected a preferred Provider organization benefit Plan - Lovelace PPO. The provisions outlined below provide additional information and clarification to Members of Lovelace PPO. If you have any questions about these provisions, please contact the Customer Care Center.

Amendments

This EOC shall be subject to amendment, including exclusion for specific Conditions, modification, Premium rate changes, or termination in accordance with their provisions of this Agreement. By electing coverage or accepting benefits under this Policy, all Members legally capable of contracting, agree to all the terms, Conditions, and provisions of this Policy.

Assignment of Benefits

Lovelace specifically reserves the right to pay the Member directly and to refuse to honor an assignment of benefits in any circumstances. No person may execute any power of attorney to interface with Lovelace's right to pay the Member instead of anyone else.

Notice of Claim

Written notice of claim must be given to Lovelace within 1 year (365 days) after the occurrence or start of the loss on which claim is based. If notice is not given in that time, the claim will not be invalidated, denied or reduced if it is shown that written notice was given as soon as was reasonably possible.

Claim Forms
When Lovelace receives the notice of claim, it will give to the claimant, or to the policyholder for the claimant, the claim forms which it uses for filing proof of loss. If the claimant does not receive these claim forms within fifteen (15) days after Lovelace receives notice of claim, the claimant will be considered to meet the proof of loss requirements of the Policy if the claimant submits written proof of loss within 1 year (365 days) after the date of loss. This proof must describe the occurrence, character and extent of the loss for which claim is made.

Disclaimer of Liability
Lovelace has no control over any diagnosis, treatment, care, or other service provided to a Member by any facility or provider, whether an In-Network, Participating Provider or not, and is not liable for any loss or injury caused by any health care Provider by reason of negligence or otherwise.

Execution of Contract
The parties acknowledge and agree that the Member's (or parent's/legal guardian's) signature or execution of the enrollment application form shall be deemed to be acceptance of the Policy. All statements, in the absence of fraud, made by an Applicant shall be deemed representations and not warranties. No such statements shall void coverage or reduce benefits unless contained in a written Application for coverage.

Entire Contract
The Evidence of Coverage, the Summary of Benefits, the Enrollment Application Form, including medical information, obtained upon enrollment of the Member covered hereunder, the Member Agreement and the issued Lovelace ID Card constitute the Entire Contract between the parties and, as of the Effective Date hereof, supersede all other agreements between the parties.

Governing Law
The Policy is made and shall be interpreted under the laws of the State of New Mexico and applicable federal rules and regulation.

Individual Health Insurance
Individual Health Insurance is that form of health insurance covering persons and issued to an individual.

Identification Cards
Identification (ID) Cards are issued by Lovelace to Members for identification purposes only. Possession of a Lovelace ID Card confers no rights to services or other benefits under this Policy. To be entitled to such services or benefits, the holder of the card must, in fact, be the Member on whose behalf all applicable Policy charges have actually been paid. Any person receiving services or other benefits to which he/she is not then entitled pursuant to the provisions of the Policy shall be charged the prevailing rates. If any Member permits the use of his/her ID card by any other person, all rights of such Member may be immediately terminated at the will of Lovelace.

Legal Actions
No action at law or in equity will be brought to recover on the Policy until at least sixty (60) days after proof of loss has been filed with Lovelace. No action will be brought at all unless brought within 3 years after the time within which proof of loss is required.

Misstatements
All statements, in the absence of fraud, made by the Member, shall be deemed representations and not warranties, and no such statement shall void the insurance or reduce benefits thereunder unless contained in the written Application for such insurance.

Payment of Claims
Claims submitted by a Member for services received will be payable in accordance with the beneficiary designation and the provisions respecting such payments. If no such designation or provision is provided, claims shall be payable to the estate of the insured. Any other claims unpaid at the insured's death may, at the option of the insurer, be paid to such beneficiary. All other claims will be payable to the insured.

Claims submitted by a Provider or facility, which may include hospital, nursing, medical or surgical Providers shall be paid directly to the submitting party at the discretion of the insured at the time of written proof of loss.

Payment to Out-of-Network Providers
This Plan permits a Member to seek care from both In-Network, Participating Providers as well as from Out-of-Network, non-Participating Providers. The Member will be liable directly to the Out-of-Network, non-Participating Provider for payment of the Co-Payment or Co-Insurance, charges above Usual and Customary Charges and non-covered services. Co-Insurance is the percentage of the Provider's Allowable Charges that is specified within the Summary of Benefits section, which is payable by the Member to the provider. A Co-Payment is a fixed dollar amount per service that is payable by the Member to the provider at the time of service.

Policies and Procedures
Lovelace may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Policy.

Premium Increases
Should there be an increase in the Premiums associated with the Lovelace PPO Plan, the Lovelace Insurance Company will provide written notice to policyholders and the increase will not be effective without at least a sixty (60) day prior notice.

Proof of Loss
Written proof of loss must be given to Lovelace within 1 year (365 days) after the date of the loss for which claim is made. If written proof of loss is not given in that time, the claim will not be invalidated nor reduced if it is shown that written proof of loss was given as soon as was reasonably possible. Foreign claim must be translated in English and charges submitted in U.S. currency prior to being submitted to Lovelace for payment.

Physical Examination
Lovelace, at its own expense, will have the right to examine any person for whom claim is pending as often as it may reasonably require.

Reinstatement
Lovelace may reinstate this Policy after termination without the execution of a new Application or the issuance of a new ID Card or any notice to the Member, other than the unqualified acceptance of an additional payment from the Member.

Right to Examine

Lovelace, at its own expense, shall have the right and opportunity to examine the Member when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Time of Payment of Claims

Claims under this Policy for any loss other than loss for which this Policy provides any periodic payments will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued claims for loss for which this Policy provides periodic payment will be paid within sixty (60) days and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Waiver of Agents

No agent or other person, except an officer of Lovelace, has the authority to waive any Conditions or restrictions of the Policy, to extend the time for making payment, or to bind Lovelace by making promise or representation or by giving or receiving any information. No such waiver, extension, promise, or representation shall be valid or effective unless evidence by an endorsement or amendment in writing to this Policy signed by one of the aforesaid officers.

GLOSSARY

The following terms, when used in this EOC, are defined as follows:

Albuquerque Area: All US Postal Service Zip Codes in New Mexico within the Counties of Bernalillo, Sandoval, Torrance and Valencia.

Allowable Charge: The amount Lovelace will pay an In-Network Provider for a Covered Service.

Ambulatory: Health care services that do not require hospitalization of a patient, such as those delivered at a physician's office, clinic, medical center or outpatient facility.

Annual Deductible: The amount a Member must pay for Covered Services each Contract Year before health benefits are paid by Lovelace. It is also referred to as a "Deductible."

Applicant: An adult natural person who applies for enrollment in the Individual Plan OR a dependent child for whom the Application is being submitted by a parent, adoptive parent or legal guardian.

Application: Also known as the "Enrollment Application". The form provided by the Individual Plan which requests certain contact, personal, financial and medical information about Applicants who wish to apply for membership in the Lovelace Individual Plan.

Basic Health Care Benefits: Benefits for Medically Necessary services consisting of preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory and diagnostic and therapeutic radiological services. Your basic health benefits do not include: mental health services; services for alcohol or drug abuse; services for pre-natal or post-natal maternity care or delivery; infertility diagnostic services or testing, infertility treatment or prescriptions or injections for infertility; dental or vision services; or long-term rehabilitation treatment. For information regarding the specific benefits covered under your Lovelace PPO Plan, refer to the "Covered Benefits and Services", and the "Covered Services with Limitations" sections of this EOC, as well as your Summary of Benefits. For information regarding general and specific exclusions under your Lovelace PPO Plan, refer to the "Exclusions" section of this EOC.

Biologicals: Medical compounds prepared from living organisms and their products including serums, vaccines, antigens and antitoxins.

Certified Nurse Midwife: Any person who is licensed by the board of nursing as a registered nurse and who is licensed by the New Mexico Department of Health as a Certified Nurse Midwife.

Certified Nurse Practitioner: A registered nurse whose qualifications are endorsed by the Board of Nursing for expanded practice as a Certified Nurse Practitioner and whose name and pertinent information is entered on the list of Certified Nurse Practitioners maintained by the Board of Nursing.

Condition: A group of related diagnoses dealing with the same organ, system or disease process.

Co-Payment/Co-Insurance: The Member's share of the fee for Covered Services, as described in the Summary of Benefits, which is payable at time of service.

Contract Year: The twelve (12) month period of time that begins on January 1st and ends on Deceember 31st, agreed upon by the Plan and the Member.

GLOSSARY

Covered Services: Benefits, services and supplies, as described in the Summary of Benefits and Authorized by the Plan Medical Director.

Cytological Screening: Pap Smear; a Papanicolaou test and a pelvic exam for symptomatic as well as asymptomatic female patients including tests for Human Papillomavirus.

Deductible: The amount a Member must pay for Covered Services each Contract Year before health benefits are paid by Lovelace. It is also referred to as an "Annual Deductible."

Doctor of Oriental Medicine (D.O.M.): A person who is a Doctor of Oriental Medicine licensed by the appropriate governmental agency to practice acupuncture and oriental medicine.

Effective Date: The date the Member's coverage begins under the Individual Plan. Also known as the Member's "Enrollment Date".

Emergency Medical Condition: A medical Condition which manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent lay person, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1) Serious jeopardy to your health, or, if pregnant, the health of you or your unborn child, 2) Serious impairment to the bodily functions; or 3) Serious dysfunction of any bodily organ or part.

Emergency Services: Covered inpatient or outpatient services that are furnished by a Provider who is qualified to provide emergency services and the services are needed to evaluate or stabilize an Emergency Medical Condition.

Enrollment Date: 12:01 A.M. of the date on which a Member's coverage begins.

FDA: United States Food and Drug Administration

Follow-up Care: Reexamination of or maintenance of contact with a patient at prescribed intervals following diagnosis or treatment of a Condition.

Formulary: A listing of approved drug products. The drugs and medications included have been approved in accordance with parameters established by Lovelace. This list is subject to periodic review and is amended as required.

In-Network Pharmacy: A duly-licensed pharmacy contracted to provide services to Members within the Lovelace PPO network.

In-Network Provider: A Provider who has entered into an agreement/contract with the Lovelace Insurance Company to provide health care services to our Members, with an expectation of receiving payment, other than Co-Payments or Deductibles, directly or indirectly from the Plan. An In-Network Provider is a duly licensed Provider/Practitioner of the healing arts, facility or ancillary Provider, acting within the scope of their license. This provider is also referred to as a "Participating Provider." Facilities include hospitals currently licensed by the Department of Health. Other Providers include: doctors of medicine and surgery, osteopathic medicine and surgery, dentistry, optometry, and podiatry; doctors of oriental medicine, chiropractic and other specialties; psychologists; certified nurse midwives; and registered lay midwives. Providers also include registered nurses in expanded practice.

GLOSSARY

Individual Plan: The individual PPO benefit Plan established by Lovelace and selected by the Member to provide health care to Members, as it exists on the Effective Date of the Policy or as subsequently amended as provided in the Policy.

Lovelace Insurance Company: An insurance company organized under the applicable laws of the State of New Mexico. Lovelace Insurance Company oversees the administration of the PPO Plan, including the provision of Plan benefits.

Medical Director (Plan): The Physician, or his/her designee, charged by the President and Chief Executive Officer of Lovelace to serve as the Medical Director of the Plan and manage the provision of health care services to Members.

Medicaid: Grants to states for medical assistance programs, Title XIX of the Social Security Amendments of 1965, as amended.

Medically Necessary: Medically Necessary means health care services determined by a Provider, in consultation with the Lovelace Insurance Company, to be appropriate or necessary, according to any applicable generally accepted principles and practices of good medical care or practice guidelines developed by the federal government, national or professional medical societies, boards and associations, or any applicable clinical protocols or practice guidelines, or developed by the Lovelace Insurance Company consistent with such federal, national, and professional practice guidelines, for the diagnosis or direct care and treatment of a physical Condition, illness, injury or disease.

Medicare: The program of medical care for disabled persons or persons of age sixty-five (65) or older operated by the federal government under Title XVIII of the Social Security Amendments of 1965, as amended.

Member: Any individual who has been approved by Lovelace Insurance Company to participate in the Plan and for whom the required Premium has been received by the Plan.

Non-Albuquerque Area: All US Postal Service Zip Codes in New Mexico in Counties other than Bernalillo, Sandoval, Torrance and Valencia.

Other Health Professional: An individual other than a physician who is licensed or otherwise authorized under the applicable state law to deliver medical services.

Other In-Network/Participating Health Care Facility: Any facility other than a participating medical hospital, which is operated by or has an agreement with Lovelace to provide services to Members. Other Participating Health Care Facilities include, but are not limited to: licensed skilled nursing facilities and rehabilitation hospitals.

Out-of-Network Pharmacy: A duly-licensed pharmacy that is not contracted with Lovelace Insurance Company.

Out-of-Network Provider: A Provider not contracted with Lovelace Insurance Company. An Out-of-Network Provider is a duly-licensed Provider or Practitioner of the healing arts or a facility or ancillary Provider acting within the scope of their license. Covered Services provided by an Out-of-Network Provider will be covered at the Out-of-Network level of benefits. Emergency care services will be covered as In-Network benefits. Refer to your Summary of Benefits for further information. Facilities include hospitals currently licensed by the Department of Health. Providers include: doctors of medicine and surgery, osteopathic medicine and surgery,

dentistry, optometry, and podiatry; doctors of oriental medicine, chiropractic and other specialties; psychologists; certified nurse midwives; and registered lay midwives. Providers also include registered nurses in expanded practice.

Out-of-Pocket Maximum: The maximum amount a Member pays in Co-Insurance and Co-Payments for Covered Services each Contract Year after the required Deductible is met. Once the Out-of-Pocket Maximum is met, Lovelace will pay 100% of Usual and Customary Charges, subject to the limitations of this Policy.

Participating Provider: A Provider who has entered into an agreement/contract with the Lovelace Insurance Company to provide health care services to our Members, with an expectation of receiving payment, other than Co-Payments or Deductibles, directly or indirectly from the Plan. An In-Network Provider is a duly licensed Provider/Practitioner of the healing arts, facility or ancillary provider, acting within the scope of their license. This provider is also referred to as an "In-Network Provider." Facilities include hospitals currently licensed by the Department of Health. Other Providers include: doctors of medicine and surgery, osteopathic medicine and surgery, dentistry, optometry, and podiatry; doctors of oriental medicine, chiropractic and other specialties; psychologists; certified nurse midwives; and registered lay midwives. Providers also include registered nurses in expanded practice.

Physician: A doctor of medicine and surgery, osteopathic medicine and surgery, dentistry, optometry, podiatry, Practitioner of healing arts, doctors of oriental medicine, chiropractic or other specialties.

Plan: The benefit Plan established by Lovelace and selected by the Member to provide health care to Members, as it exists on the Effective Date of the Policy or as subsequently amended as provided in the Policy.

Physician Assistant: Skilled person who is a graduate of a Physician Assistant or assistant surgeon program approved by a nationally recognized institution, licensed in the State of New Mexico to practice medicine under the supervision of a licensed Physician.

Policy: Refers to this Health Policy and its amendments; the Policy is a contract between Lovelace and the Member for the provision of health care services for the Member.

Pre-existing Condition: A Condition that was present before the Enrollment Date for coverage for the benefits whether or not any medical advice, diagnosis, care or treatment was recommended or received before that date within the six-month period ending on the Enrollment Date. Genetic information is not included as a Pre-existing Condition for the purposes of limiting or excluding benefits in the absence of a diagnosis of the Condition related to the genetic information. Refer to the "Pre-existing Condition Exclusions" section of this EOC for further information.

Premium: The sum of money paid monthly to the Plan by the Member or its designated agent in order for the Member to receive the services and benefits associated with the Plan.

Prescription Drugs: Drugs for which the sale or legal dispensing requires the order of a Physician.

Prior Authorization or Authorized: A system whereby a Provider must receive approval from the Lovelace Insurance Company's Medical Director or designee in order for certain health care services and benefits to be covered. Examples of services requiring Prior Authorization include, but are not restricted to: non-emergency inpatient hospitalization, outpatient surgical procedures, short-term rehabilitation, MRI, and Skilled Care. These services require oversight by the Plan or are a limited benefit and have time limits of when services can be provided.

GLOSSARY

Provider/Practitioner: Any duly licensed hospital, Physician or Other Health Professional authorized to furnish health services within the scope of their license.

Provider Network: A group of Providers who have contracted with Lovelace Insurance Company as a Group. Check with the Customer Care Center for details.

Registered Nurse in Expanded Practice: A registered nurse approved under state law as a certified nurse practitioners, certified nurse anesthetist, certified clinical nurse specialist in psychiatric mental health nursing or a clinical nurse specialist in private practice. The registered nurse must hold a master's degree or doctorate in a defined clinical nursing specialty and be certified by a national nursing organization.

Skilled Care: Services ordered by a Physician which require the skills of professional personnel such as a registered nurse or licensed practical nurse and are provided directly by or under the supervision of such personnel to a patient who needs those services twenty-four (24) hours a day, along with other treatment, for recovery from illness or injury. Skilled Care does not include custodial nursing care.

Specialist: A Physician who has received training and education in a specific area of medicine.

Subscriber Agreement: A document issued by Lovelace Insurance Company that includes information specific to the individual Member, such as the Member Effective Date of coverage, the benefit Plan, monthly Premium amount and other general information.

Subject to Insurability: Medical investigation that will occur during the first twelve (12) months of Member's coverage if a claim is received with a diagnosis included on the Automatic Decline List.

Summary of Benefits: An attachment to the EOC that describes applicable benefits and Co-Payments for the Plan selected.

Technology: New Technology is evaluated against the following criteria: the Technology must have final approval from the appropriate government regulatory bodies. The scientific evidence must permit conclusions about the effect of the Technology on health outcomes. The Technology must improve the net health outcomes. The Technology must be as beneficial as any established alternatives. The improvement must be attainable outside of investigation of setting.

Termination Date: Midnight of the date on which a Member's coverage ends.

Urgent Care: Medically necessary health care services provided at an urgent care facility in emergencies or after a normal business hours for unforeseen Conditions due to illness or injury that are not life-threatening but require prompt medical attention.

Urgent Illness: An unexpected or Urgent Illness is a non-life-threatening situation that requires prompt medical attention. Some examples of urgent situations are: sprains, strains, vomiting, cramps, diarrhea, bumps, bruises, cold, fever, small lacerations, minor burns, severe stomach pain, swollen glands, rashes, poisoning and back pain.

Usual and Customary Charges: The amount normally charged for specific medical procedures and/or office visits by health care Providers. Usual and customary charges are determined at the discretion of Lovelace.

GLOSSARY

Utilization Management: The process of helping individual patients get the right care at the right level by the right Provider, at the right time for the purpose of maximizing patient benefits and ensuring quality health care.

Women's Health Care Provider: Either an obstetrician-gynecologist (an OB/GYN Specialist), a family practitioner, a certified nurse-midwife, another physician specializing in women's health, or a Physician assistant or Certified Nurse Practitioner who specializes in women's health.

Workers' Compensation Policy or Plan: The Workers' Compensation Plan of the 50 United States, the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands, as well as the systems provided under the Federal Employees' Compensation Act and the Longshoreman's and Harbor Workers' Compensation Act, and any other federal, state, county, or municipal Workers' Compensation, occupational disease or other employer liability laws, or other legislation of similar purpose or intent.

Lovelace Insurance Company

4101 Indian School Rd. NE | Albuquerque, NM 87110 | 505.262.7363 | 800.808.7363 | lovelaceiplan.com