

The page is framed by a decorative border of twelve stylized flowers, each with a central circle and ten petals. The flowers are arranged in a grid-like pattern: one in the top center, one in the middle left, one in the middle right, one in the bottom left, and one in the bottom center. The text is centered in the middle of the page, overlapping the middle-right flower.

care new mexico
evidence of coverage
handbook

CARE NEW MEXICO – SUMMARY OF BENEFITS

Care New Mexico is a registered trade name of Lovelace Health System, Inc. a licensed New Mexico Health Maintenance Organization (HMO). Care New Mexico is a non-Federally qualified plan offered by Lovelace Health Plan. Under the New Mexico Minimum Health Care Protection Act, Care New Mexico does not include benefits ordinarily required to be offered by Health Maintenance Organizations under the New Mexico HMO Act.

Lovelace Health Plan provides the following benefits when Medically Necessary and only when provided or arranged by a Participating Provider. Coverage is limited to services received at a facility or from a provider contracted with Lovelace Health Plan. There is a maximum limit on the cost of health care services of \$100,000 per Calendar Year. Co-payments are due at the time of service. Office visits are limited to seven (7) visits per Calendar Year, not including maternity care.

Covered Benefit/Service	Description of Service	Cost/Co-Payment for Member
Office Visits – Limitation of seven (7) office visits per Calendar year		
Primary Care	Physician, Nurse Practitioner, and Physician Assistant Services from Participating family practice physicians, general practitioners, internists, pediatricians or obstetricians/gynecologists. A basic level of primary and preventive care including physician, nurse practitioner, nurse midwife or physician assistant office visits. Well-baby and Well-child care, including periodic evaluation of a child’s physical and emotional status, a history, a complete physical examination, a development assessment, anticipatory guidance and appropriate immunizations and laboratory tests. Such evaluation and care shall be covered when performed at approximately the age intervals of birth, two weeks, two months, four months, six months, nine months, twelve months, fifteen months, eighteen months, two years, three years, four years, five years and six years.	\$10 per visit
Speciality Care	Specialty care and consultation when referred by your Primary Care Physician.	\$10 per visit
Urgent Care	Non-appointment, non-emergent medical care provided by a physician, nurse practitioner or physician assistant.	\$10 per visit
Support Services	All necessary services in conjunction with a covered office visit (i.e. laboratory, x-ray).	No charge
Emergency Care	All necessary services and supplies provided in an emergency room for a Medical Emergency Only. Services are covered within the Service Area only. Emergency care received outside the service area is Not Covered.	\$50 per visit
Outpatient Surgery	Services not requiring hospital admission for Medically Necessary surgery at a Participating Provider/Facility.	\$100 per procedure
Hospital Admission	Comprehensive range of medical and surgical services. Including hospital physician care, room and board, general nursing care, private room and private nursing if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room or intensive care at a Participating acute care facility. HOSPITAL ADMISSIONS ARE LIMITED TO 25 INPATIENT DAYS PER CALENDAR YEAR AND MAXIMUM AMOUNT OF \$100,000.00 PER CALENDAR YEAR FOR ALL COVERED INPATIENT AND OUTPATIENT MEDICAL CARE.	\$200 per admission

CARE NEW MEXICO – SUMMARY OF BENEFITS

Covered Benefit/Service	Description of Service	Cost/Co-Payment for Member
Maternity Care	<p>Pre-natal and post-natal care, including one pre-natal office visit per month during the first two trimesters of pregnancy, two office visits per month during the seventh and eighth months of pregnancy and one office visit per week during the ninth month and until term. Each office visit shall also include pre-natal counseling and education, and necessary and appropriate screening, including history, physical examination and the laboratory and diagnostic procedures deemed appropriate by the physician.</p> <p>Hospital Admission for Delivery All physician, certified nurse midwife and hospital services for mother during confinement, including, but not limited to full term delivery or miscarriage.</p>	<p>\$10 per visit</p> <p>\$200 per admission</p>
Newborn Care	<p>Outpatient Care (See office visit)</p> <p>Inpatient Services – Child is covered from birth; however, he/she must be enrolled with the Plan within 31 days of birth. Inpatient hospitalization is limited to 25 inpatient days per Calendar Year.</p>	<p>\$10 per visit</p> <p>\$200 per admission (co-payment waived if baby is released from hospital at the same time as mother)</p>
Women's Health Care	Coverage for Cytologic screening, to include Papanicolaou test and pelvic exam for asymptomatic as well as symptomatic women.	\$10 per visit
Mammography	Low dose screening mammograms for determining the presence of breast cancer, including one baseline mammogram for persons age thirty-five (35) through thirty-nine (39), one biannual mammogram for persons age forty (40) through forty-nine (49) years and one annual mammogram for persons age fifty (50) years and over.	\$10 per visit
Home Health Services	Home Health Services following hospital discharge or in lieu of hospitalization. Prescribed skilled nursing care. Custodial care is not a covered benefit. Home Health care days are included in the 25 day limitation of inpatient hospital days.	\$50 per visit
Health Education	Classes and specialty programs	Some require co-payments

Lovelace Health Plan provides the following benefits when Medically Necessary and only when provided or arranged by a Participating Provider. Coverage is limited to services received at a facility or from a provider contracted with Lovelace Health Plan. Charges are not to exceed \$100,000 per Calendar Year. Co-payments are due at the time of service. Office visits are limited to seven (7) visits per Calendar Year, not including maternity care.

CARE NEW MEXICO – DISCLOSURE STATEMENT

Lovelace Health System, Inc., a licensed New Mexico Health Maintenance Organization (HMO), offers the Care New Mexico Plan to qualified enrollees under the New Mexico Minimum Health Care Protection Act. Care New Mexico is a non-Federally qualified plan and does not provide all the coverage ordinarily required to be offered by Health Maintenance Organizations under the New Mexico HMO Act and regulations or Federal HMO laws and regulations.

For example, the Plan does not cover the following:

1. An unlimited number of office or urgent care visits to health care providers (seven visits per Calendar Year are covered, not including maternity care).
2. Unlimited days of hospitalization (twenty-five days per Calendar Year of hospital and home health care combined are covered).
3. Unlimited outpatient hospital services.
4. Unlimited laboratory, x-ray and other diagnostic services.
5. Short-term outpatient rehabilitation services, including physical therapy, occupational therapy, speech therapy/audiology, respiratory therapy, chiropractic therapy and acupuncture.
6. Out-of-service area emergency care.
7. Mental/behavioral health services.
8. Infertility treatment.
9. Dental care for any purpose.
10. Treatment of craniomandibular (CMJ) or temporomandibular (TMJ) disorders.
11. Transportation for high-risk maternity patients or newborns with birth problems to a tertiary care hospital unit.
12. Home health visits in excess of a total of twenty-five days per Calendar Year for both hospitalization and home health care.
13. Organ transplants or any services related to organ transplants.

The primary and preventive care features of the Plan are:

1. Seven office or urgent care visits per Calendar Year to a Lovelace Health Plan Participating Primary Care Physician or Specialist.
2. Well-baby and well-child care, including history, physical, immunizations and laboratory tests (at age intervals of birth, two weeks, two months, four months, six months, nine months, twelve months, fifteen months, eighteen months, two years, three years, four years, five years and six years).
3. Emergency room services at a Lovelace Health Plan Participating facility.
4. Outpatient surgery from a Participating Provider/facility.
5. Maternity care, including pre-natal office visits once a month during the first two trimesters of pregnancy, two office visits per month during the seventh and eighth months of pregnancy and one office visit per week during the ninth month and until term, with related laboratory and diagnostic tests.

For additional information, please refer to the Summary of Benefits and the detailed benefits explanations in this Evidence of Coverage (EOC) Handbook.

WELCOME TO LOVELACE HEALTH SYSTEM, INC.

Lovelace Health System, Inc., is a Health Maintenance Organization (HMO) organized under the applicable laws of the State of New Mexico and is referred to in this document as “Lovelace Health System, Inc.” and/or the “Lovelace Health Plan.” When we use the words “Lovelace Health Plan,” “we,” “us,” and “our” in this document, we are referring to Lovelace Health System, Inc.

Lovelace Health System, Inc. has entered into an Agreement with your Group to provide you and your covered Dependents with a minimum health care medical plan. For individual Members, the Agreement is between Lovelace and the individual Subscriber and any reference to Group should be ignored.

We insure eligible participants for benefits described in this Evidence of Coverage. 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,” “Enrollees” or “Subscribers.”

How to Use this Book

This EOC Handbook is a legal document. Your EOC Handbook, along with your Summary of Benefits, describes the health care benefits available to you and your covered dependents. The benefits described in the pages to follow are underwritten by Lovelace Health Plan. This EOC Handbook (also called the “policy”) describes the features of the insurance. This EOC Handbook takes the place of any other issued to you on a prior date, which described the insurance.

Your EOC Handbook is designed to make it easy for you to make the most of the benefits and services available. Your EOC Handbook 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.

We encourage you to read this EOC Handbook and your Summary of Benefits carefully. We especially encourage you to review the Benefit Limitations, Exclusions and General Policy Provisions sections of this EOC Handbook. Many of the sections of this EOC Handbook are related to other sections of the document. You may not have all of the information you need by reading just one section.

Capitalized Words

We want to give you information about this document that will help you understand it. Throughout this document, certain capitalized words have special meanings. We have defined these words in the Glossary which appears at the end of this EOC Handbook.

We encourage you to keep this document, as well as the Summary of Benefits and any other attachments or amendments you may receive, for your future reference. Please be aware that your health care providers do not have a copy of your EOC Handbook nor the Summary of Benefits, and are not responsible for knowing or communicating your Covered Benefits.

The Plan

Your Employer Group has chosen Lovelace Health Plan to provide you and your covered Dependents with this medical insurance Plan, which is a Health Maintenance Organization (HMO) Plan.

WELCOME TO LOVELACE HEALTH SYSTEM, INC.

By enrolling in this Plan you have agreed to the terms of the Agreement between Lovelace Health Plan and your Employer Group. This EOC Handbook and the Summary of Benefits include a summary of that Agreement. The Summary of Benefits is sent to all new and renewing Subscribers following the enrollment period. Lovelace Health Plan and your Employer Group may change the benefits described in this EOC Handbook. If that happens, either Lovelace Health Plan or your Employer Group will notify you of any changes that will affect you or your covered Dependents. If there is any difference between the EOC Handbook or Summary of Benefits and the Agreement, the Agreement will be followed. You may ask for a copy of the Agreement from your Employer Group benefits administrator.

Medical benefits of your Plan are described in this EOC Handbook. As a Member, you are expected to receive Medical Services from Participating Providers. The Premiums for this insurance have been based on services being provided by Participating Providers. If you receive services from Non-Participating Providers, Lovelace Health Plan will pay in only two cases. These are 1) medical Emergency services provided in the service area or 2) if there was an authorization from Lovelace Health Plan prior to the visit. These services and benefits are detailed in this EOC Handbook.

Care New Mexico

The New Mexico Minimum Health Care Protection Act allows health maintenance organizations and insurers to offer minimum health coverage at lower rates to residents who can not obtain more comprehensive health care. The Care New Mexico Plan is a prepaid medical plan offered by Lovelace Health Plan to serve residents of Albuquerque, Santa Fe and portions of the surrounding communities in New Mexico. This Plan does not cover all the health care services and benefits which the State of New Mexico usually requires a health care maintenance organization to cover. Care New Mexico is a minimum benefit plan and does not provide you with catastrophic medical coverage. CARE NEW MEXICO IS A REGISTERED TRADE NAME OF LOVELACE.

If you need more information about your Lovelace Health Plan coverage or need copies of your Summary of Benefits, please contact the Lovelace Health Plan Customer Care Center.

Lovelace Health Plan
Customer Care Center
505.232.1881 or 800.808.7363*
TTY Services provided by Relay New Mexico 800.659.8331

Lovelace Health Plan
Consumer Assistance Office
505.232.1870 or 800.808.7363*

*Outside of Albuquerque

Physical Address:

Lovelace Health Plan
Altura Office Complex
4101 Indian School Road NE #110 South
Albuquerque NM 87110-3988

Mailing Address:

P. O. Box 27107
Albuquerque NM 87125-7107

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RIGHTS AND RESPONSIBILITIES

Thank you for making the Lovelace Health Plan your choice for health care benefits. We are pleased that you have chosen this health plan and we look forward to being your partner in health. You have the rights described below. You also assume certain responsibilities when you use this coverage. It is important that you fully understand both your rights and your responsibilities.

You have a right:

- To be given detailed information about your coverage, maximum benefits, the 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 Participating Providers and Member Rights and Responsibilities.
- To affordable health care with information on your out-of pocket expense limitations, the right to seek care from a Non-Participating Provider, and an explanation of your financial responsibility when services are provided by a Non-Participating Provider or without the required pre-authorization.
- To be treated in a manner that respects your privacy and dignity as a person.
- To participate with Participating Providers 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 Participating Plan 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 Participating Provider 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 Lovelace Health Plan or its regulatory bodies about Lovelace Health Plan or the coverage 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 our Member Rights and 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 Lovelace Health 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, except:
 - When clinical data is needed by health care Providers for your care.
 - When Lovelace Health Plan is bound by law to release information.
 - When we prepare and releases data but without identifying names of Members.
 - When necessary, to support Lovelace Health Plan’s programs or operations that evaluate 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 Primary Care Physician (PCP). He or she will discuss alternate treatment plans with you; however, you will make the final decision.
- To select a PCP for yourself and each covered Member of your family. If for any reason you wish to change your PCP, contact the Lovelace Health Plan Customer Care Center to choose another.
- To a complete explanation of why care is denied. You will be guided through the Grievance procedure if you are not satisfied with the Lovelace Health Plan’s decision.

RIGHTS AND RESPONSIBILITIES

- To adequate access to qualified health care professionals. This access must be within Lovelace Health Plan's Service Area (near where you live or work).
- To always have available and accessible urgent and emergency medical services twenty-four (24) hours a day, seven (7) days a week.
- To know, upon request, of any financial arrangements or provisions between Lovelace Health Plan and its Participating Providers which may restrict referrals or treatment options or limit the services offered to you.
- To receive information about how services are authorized or denied. You have the right to know how new Technologies for covered services are evaluated. You can also request and receive information about Lovelace Health Plan's quality assurance plan and utilization review methods.
- To have access to a current list of Participating Providers in the Lovelace Health Plan 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 reading and referring to the EOC Handbook and your Summary of Benefits. Contact the Lovelace Health Plan Customer Care Center when you have questions or Concerns about your Plan.

You have a responsibility:

- To provide honest, complete, to the extent possible, information to those providing care.
- To follow your Primary Participating Providers' advice, plans and instructions that you have agreed on with the provider and consider the likely results if you do not.
- To question your Participating Provider 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 Lovelace Health Plan ID card before you receive care.
- To consult your PCP 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 the Participating Provider's office promptly.
- To pay all charges or Co-Payment amounts, including those for missed appointments. This also applies to non-Covered Benefits and Services.
- To establish an ongoing and satisfactory relationship with your PCP. If you choose a new PCP, you are to schedule a new-patient appointment with him/her.
- 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 Lovelace Health Plan Customer Care Center or your Participating Provider.
- To inform your employer of any changes in family size, address, phone number or membership status. This is to be done within thirty (30) calendar days of the change.
- To make Premium payments on time if they are not paid directly by your Employer Group.
- To pay all Co-Payment amounts at the time service is received.
- To notify the Lovelace Health Plan of other insurance coverage.
- To follow the Lovelace Health Plan's Appeal and Grievance process when displeased with the Lovelace Health Plan's actions or decisions.
- To understand your health problems and participate in developing mutually agreed upon treatment goals to the degree possible.

RIGHTS AND RESPONSIBILITIES

Consumer Advisory Board

The Lovelace Health Plan 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 Lovelace Health Plan. As a Member of Lovelace Health Plan, 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).

PROTECTING YOUR CONFIDENTIALITY

At Lovelace Health Plan, we're committed to maintaining the confidentiality of your personal and sensitive information. You and your family members trust us to collect and maintain the information we need to administer your Plan in a way that protects your privacy. In addition, we are subject to state and federal laws regarding confidentiality. That's why we have policies and safeguards in place to protect the confidentiality and security of your personal information.

To help you better understand how we protect your confidentiality, we're providing you with answers to some common questions about our confidentiality policies.

What Types of Information Do We Receive?

We receive information needed to administer your Plan, including information from Members who apply for coverage or who submit a claim, and information from medical providers and employers.

How do we Protect Confidential Information?

Lovelace Health Plan employees and organizations that act on behalf of Lovelace Health Plan are required to keep our Members' personal information confidential. Here's what we are doing to help ensure the policy is followed:

- We've established a Lovelace Health Plan Privacy Program Office, which is responsible for monitoring our compliance with confidentiality policies, and for educating the organization on this important topic.
- Whenever possible, we provide only aggregate information that doesn't identify any individual. If we need to share individually identifiable information, we have policies that protect confidentiality.
- Our employees may not disclose information to other employees except when it is needed to conduct Lovelace Health Plan business.
- We require a written agreement from companies and organizations, including Plan sponsors, who receive confidential information from us. These companies and organizations agree that they will use any individually identifiable information only to administer the benefits Plan in accordance with applicable laws.
- Sometimes we require a Member's written authorization before we disclose confidential information. For example, a request from a research organization or from a Member's attorney would require an authorization signed by the Member. Requests for confidential information for a minor or for an adult, who is unable to exercise rational judgment or give informed consent, require an authorization from the Member's parent or legal guardian.
- We protect the confidentiality of information for former Members, just as we do for current Members.

We've also taken the following steps to make sure Lovelace Health Plan facilities have policies to protect confidential information:

- Access to our facilities is limited to authorized personnel.
- Lovelace Health Plan locations that maintain confidential information have procedures for accessing, labeling and storing confidential records.
- We have additional policies and procedures to protect confidential information when Lovelace Health Plan Participating Providers provide medical treatment.

PROTECTING YOUR CONFIDENTIALITY

What Types of Information Do We Disclose And To Whom?

Lovelace Health Plan will not release confidential information unless it is necessary to administer the benefits of your Plan or to support Lovelace Health Plan programs or services, such as our care management and wellness programs. We may disclose information relating to claims and the processing of claims to:

- Medical Providers; Plan sponsors and insurers that provide reinsurance or excess (stop loss) insurance to an Employer Group;
- Lovelace Health Plan affiliated companies such as contracted entities providing medical services for Lovelace Health Plan Members;
- Regulatory agencies (such as New Mexico Public Regulation Commission Insurance Division and Centers for Medicare and Medicaid Services (CMS)) and accreditation organizations (such as the National Committee for Quality Assurance);
- Courts or attorneys who serve us with a subpoena;
- New insurers or claim administrators who assume responsibility for administering the benefit Plan;
- Companies that assist Lovelace Health Plan in recovering overpayments;
- Companies that pay claims or perform Utilization Review services for Lovelace Health Plan;
- Companies that assist Lovelace Health Plan in recovering benefits that were paid for claims incurred as a result of third-party negligence, and companies not affiliated with Lovelace Health Plan that perform other services for Lovelace Health Plan.

How Can Members Access Their Confidential Information?

All Members have a right to review their Medical Records, and can submit a written request to the physician or other health care provider who created the record. Lovelace Health Plan strives to make sure that information is accurate and complete. If a Member finds an error and wishes to correct it, he or she can contact the Provider who created the record.

How Do We Let Members Know About Our Confidentiality Policy?

Often, Members are informed about our confidentiality policies and practices during enrollment. However, we also strive to inform all prospective and current Members about our confidentiality policies and practices through and pre-enrollment materials, newsletters and this EOC.

HOW THE PLAN WORKS

As a Member of an HMO Plan, you are selecting our medical care program to provide your health care coverage. Being a member of the Lovelace Health Plan Care New Mexico plan means that you will be getting most or all of your health services from the doctors, hospitals, and other health care providers that are part of the Lovelace Health Plan Network. These doctors, hospitals, and other Participating Providers are contracted with Lovelace Health Plan to provide your care, so they are the ones you must use except in special situations such as emergencies. When you and your covered family members use Participating Providers, the provider will receive payment from Lovelace Health Plan for covered services, except for any applicable Co-Payment amounts that you are responsible for paying. As a Member, you agree to obtain your medical care from a Participating Provider.

When you need care, you can feel confident knowing that the Lovelace Health Plan's network of Participating Providers is close to where you live and work. For more information, please review the Lovelace Health Plan's Online Provider Directory at lovelacehealthplan.com or contact our Lovelace Health Plan Customer Care Center to request a printed copy.

Primary Care Physicians

The Lovelace Health Plan believes a strong relationship with your Primary Care Physician (PCP) will help you and your family make the most of your Plan benefits. As a Lovelace Health Plan Member, you can select a PCP for yourself and each covered member of your family. You may consult our Online Provider Directory by visiting our website at lovelacehealthplan.com, or contact the Lovelace Health Plan Customer Care Center to assist you in selecting a PCP who is a part of the Lovelace Health Plan network.

If you do not select a PCP at the time of your enrollment, a PCP near your home will be selected for you by Lovelace Health Plan. An identification card with the PCP's name will be generated and sent to you by mail. You may change your PCP at any time by using our interactive Online Member website at lovelacehealthplan.com or by contacting the Lovelace Health Plan Customer Care Center.

PCPs include, but are not limited to, family practice physicians, general practitioners, internists, pediatricians or obstetricians/gynecologists (OB/GYN). Female members may choose to have an OB/GYN as their Primary Care Physician, if desired. Your PCP is responsible for providing you primary care services. These include annual examinations, routine immunizations and treatment of non-emergency acute illnesses and injuries.

If you are a new Member and have a medical problem or are on medication, you should contact your PCP's office and arrange for an appointment as soon as possible. Routine check-ups are often scheduled several weeks in advance.

Specialists

A Specialist is a doctor who provides health care services for a specific disease or part of the body. Examples include internists (who care for diseases of internal organs in adults), oncologists (who care for patients with cancer), cardiologists (who care for patients with heart Conditions), and orthopedists (who care for patients with certain bone, joint, or muscle Conditions).

HOW THE PLAN WORKS

Specialist as PCP

A Specialist may act as a PCP for Members with a severe chronic medical Condition. This is permitted if the Specialist provides all basic health care services and they are contracted with Lovelace Health Plan as a Primary Care Physician. Contact the Lovelace Health Plan Customer Care Center to find out which Providers serve in both roles.

Lovelace Health Plan Customer Care Center

The Lovelace Health Plan values your questions and comments about your Plan or your health care. Our Lovelace Health Plan Customer Care Center staff will work with you to resolve any problems that you may experience during your membership. It is our goal to resolve any Concerns you have as quickly and as satisfactorily as possible.

Online Member Options

Our interactive website is a valuable source of information. As a member enrolled in Lovelace Health Plan, you can verify eligibility, check status of a claim, send secure messages to Lovelace Health Plan Customer Care Center staff or search for a Participating Provider and much more. Please visit our website at lovelacehealthplan.com for more information.

Why Contact the Lovelace Health Plan?

Lovelace Health Plan Customer Care Center Representatives are available to assist you with the following:

- PCP selection and change
- Enrollment information
- Questions about Covered Services
- Procedures for obtaining care
- Complaints or Concerns
- Information about Authorizations
- Appeals and Grievance procedures
- Status of claim payment

When to Contact the Lovelace Health Plan

If you have a question or Concern, contact the Lovelace Health Plan Customer Care Center at 505.232.1881 (In Albuquerque) or 800.808.7363 (outside of Albuquerque). The Center is open Monday through Friday. Office hours are 8:00 a.m. to 5:00 p.m. (Mountain Standard Time). Contacts received after hours or on weekends will be directed to a voice-mail message system. These calls will be returned within the next business day. TTY services are available though Relay New Mexico at 800.659.8331.

Language Line

Sé hablá Español. We have translation services available upon request for over 140 languages. We also have on staff bilingual Spanish-speaking representatives. Need translation services during your visit to your physician's office? Contact our Lovelace Health Plan Customer Care Center and we will assist during your appointment as well.

HOW THE PLAN WORKS

Nurse Advice New Mexico

If your question is in relation to a medical Condition, you can contact this Nurse Information line: 877.725.2552, available twenty-four (24) hours a day, seven (7) days a week. Registered Nurses are available to answer your questions.

Your Plan ID Card

You have been issued a Plan ID card (two cards per couple or family). If additional cards are needed, contact the Lovelace Health Plan Customer Care Center. Always carry your Plan ID card with you. The Plan ID card lists some of those benefits to which you and your Dependents are entitled that may require Co-Payment amounts. Additional Co-Payment amount information can be found in your Summary of Benefits. If you are unsure of the benefits covered under your Plan or the Co-Payment amounts, contact the Lovelace Health Plan Customer Care Center for assistance. The Co-Payment amounts found on your Plan ID card do not constitute an all-inclusive list.

ID Card Rules

You are entitled to Plan services and benefits if all applicable Premiums and Co-Payment amounts have been paid and you are eligible to receive Plan benefits. Possession of a Plan ID card alone 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 and that of your covered Dependents may be terminated. Contact the Lovelace Health Plan Customer Care Center immediately if your Plan ID card is lost or stolen.

Co-Payments

The applicable Co-Payment amount required for each type of service is listed in the Summary of Benefits. All Co-Payments are due at the time of service. You may be charged a collection fee by your Provider if your Co-Payment is not paid at the time of service. These charges are your responsibility and not reimbursable by the Plan.

What They Are

Co-Payments are a fixed dollar amount that you must pay each time you obtain a particular Covered Service. Review your Summary of Benefits to see what your Co-Payment amounts are.

When They Are Due

Co-Payments amounts are due for every visit, even if you have more than one appointment in one (1) day. Keep your receipts as proof of payment. If you are in doubt as to whether a Co-Payment is due, contact the Lovelace Health Plan Customer Care Center before your visit. (NOTE: If a Member is readmitted to the hospital within seventy-two (72) hours after discharge, no additional Co-payment amount will be required.)

Precertification/Prior Authorization/Retrospective Review

Precertification/Prior Authorization is a review process where Lovelace Health Plan physicians, nurses, and/or pharmacists work with your Provider to determine whether a procedure, treatment or service is a Covered Benefit under your Plan. Lovelace Health Plan does not restrict your Participating Provider from discussing various treatment options with you, even if the treatment is not covered under your Plan. Please confirm

HOW THE PLAN WORKS

that a treatment, Provider or service will be covered by contacting the Lovelace Health Plan Customer Care Center or ask your Provider to request an authorization from Lovelace Health Plan. A referral, recommendation or order from your Physician is not a guarantee of Plan coverage.

How Does The Process Work?

Lovelace Health Plan requires that Precertification be obtained for all non-emergent hospital admissions and selected outpatient services. When a request for Precertification comes into Lovelace Health Plan from your Participating Provider, a Lovelace Health Plan nurse evaluates the request using nationally recognized guidelines to assist in the review. These guidelines are consistent with sound clinical principles and processes and have been developed with involvement from actively practicing health care providers. Lovelace Health Plan nurses determine what services are covered based on your plan benefits and using these guidelines. When guidelines do not exist, clinical resource tools based on clinical evidence are used.

Anytime a Lovelace Health Plan nurse is unable to approve coverage for clinical reasons, the case is referred to a Lovelace Health Plan Medical Director, a physician who considers each case on an individual basis. The Lovelace Health Plan Medical Director may speak with your physician to obtain additional information. You and your physician will be notified in writing if a request for Precertification cannot be approved based on the information we received and your Plan benefits.

When Does The Review Occur?

Participating Providers are responsible for contacting Lovelace Health Plan and obtaining approval before Members receive services requiring Precertification. You are responsible for contacting Lovelace Health Plan before receiving services from a non-Participating Provider, except for emergencies. Only in limited circumstances, and with Precertification, are services provided by non-Participating Providers a covered benefit. Your Provider must submit clinical information specific to your case in order for Lovelace Health Plan to determine whether the requested service is Medically Necessary and a covered benefit under your Plan. These services may also require oversight by Lovelace Health Plan or are limited benefits and have specific time frames when services can be provided.

This review process can occur at three stages:

- **Prior authorization** is when Lovelace Health Plan receives a request before you receive care. Standard/Non-urgent service determinations are made within five (5) business days of Lovelace Health Plan receiving the request. Notice of coverage decisions will be given to you and your Provider in writing.
- **Concurrent review** is when Lovelace Health Plan receives a request while you are receiving care, for example, in a hospital, skilled nursing facility or rehabilitation facility. Determinations are made within five (5) business days of receipt of the request. Notice of coverage decisions will be given to you and your Provider in writing.
- **Retrospective review** is when Lovelace Health Plan receives a request after you have received care. Determinations related to these services are made within thirty (30) days after receiving all necessary information. Notice of coverage decisions will be given to you and your Provider in writing.

HOW THE PLAN WORKS

Precertification for Urgently Needed Care

If your medical Condition or situation requires that a determination be made right away, Lovelace Health Plan will perform an expedited review. This determination will be completed within one (1) calendar day of Lovelace Health Plan receiving a request for expedited review.

Receiving Prior Authorization is not a guarantee of payment. Coverage includes verification of Benefit Plan Coverage, Limitations and Exclusions and Eligibility Requirements. If Prior Authorization is not obtained when required, services may not be covered under your Plan. To ensure a necessary Prior Authorization has been obtained, contact the Lovelace Health Plan Customer Care Center.

Prior Authorization Coverage Decisions

Licensed physicians will determine coverage denials when clinical reasons are the rationale for the denial. Denial letters will explain the reason for the decision and details on how to submit additional information and/or proceed through Lovelace Health Plan's formal Appeals Process, should you disagree with the coverage decision.

If your physician is part of the Lovelace Health Plan network, then he or she is responsible for contacting Lovelace Health Plan to initiate the Precertification process. If you use a physician who is not part of the Lovelace Health Plan network, then you are responsible for contacting Lovelace Health Plan to initiate the Precertification process.

It is important for you to review your benefit Plan or contact the Lovelace Health Plan Customer Care Center Plan to obtain information about which services require Prior Authorization.

Second Opinions

A second opinion may be obtained from a Participating Provider without a Prior Authorization. Any request for a second opinion outside Lovelace Health Plan network of Participating Providers requires a Prior Authorization from Lovelace Health Plan.

Treatment Refusal

A Member may refuse treatment that Participating Providers recommend. In these cases, the Participating Providers may decide not to continue the physician-patient relationship as it is impeding proper medical care. If the Participating Provider believes no acceptable alternative to the refused treatment exists, neither Lovelace Health Plan nor any Participating Providers will be responsible for treating the Condition or for any resulting complications. This is true as long as a Member refuses treatment determined appropriate.

HOW THE PLAN WORKS

Service Area

The following are the postal zip codes for the Service Area covered under the Plan:

ALBUQUERQUE SERVICE AREA

87001	87035	87068	87190
87002	87042	87101 thru	87191
87004	87043	87125	87192
87006	87047	87131	87194 thru
87008	87048	87148	87199
87010	87052	87153	87538
87015	87053	87154	87540
87016	87056	87158	87560
87022	87057	87174	87562
87023	87059	87176	87565
87031	87060	87184	87568
87032	87061	87185	87569
87062	87573		

SANTA FE SERVICE AREA

87041	87523	87545	87574
87501 thru	87532	87552	87578
87506	87533	87565	87583
87509	87535	87566	87701
87511	87537	87567	87742
87522	87544	87569	87745

If you do not live within the areas covered by the zip codes, you are not eligible to enroll in this Plan. When a Subscriber and/or the Subscriber's Dependents move away from the Service Area, coverage under this Plan will be terminated on the last day of the month in which the move occurred.

Transition of Care

For New Members

If you are new to Lovelace Health Plan and are currently in an active on-going course of treatment with a Provider who is not in the Lovelace Health Plan network of Participating Providers, you may be permitted to continue to receive care for a transitional period of time. The transitional period will not be less than thirty (30) days. Members with certain Conditions, including Members in their second and third trimester of pregnancy, may submit a request for Transition of Care to the Plan within thirty (30) days of enrollment. For those Members in their third trimester, the transitional period will continue through delivery, including post-partum care related to the delivery.

For Existing Members

Transition of care services may also be available for existing Lovelace Health Plan Members with certain medical Conditions and those in their second and third trimester of pregnancy, so that they can have continued access to their Participating Provider if the Provider's contract with Lovelace Health Plan ends.

HOW THE PLAN WORKS

The Member does not need to request continued care since the care is coordinated through the Plan. The Plan makes Transition of Care determinations for new and existing Members based on established criteria. The transitional period will not be less than thirty (30) days.

Claims Payment Process

When you receive medical services from a Participating Provider, your claims will be filed automatically on your behalf. To help ensure claims are paid in a timely and appropriate manner, Members must present their Lovelace Health Plan ID card to Providers at the time of service. Lovelace Health Plan pays Participating Providers directly for Covered Benefits and Services provided to our Members. A Member should not be required to pay additional amounts to any Participating Provider except for required Co-payments amounts as indicated on your Summary of Benefits. Members will be responsible for any charges for missed appointments or appointments cancelled without adequate notice.

If you believe you are being asked to pay an amount to a Participating Provider that you do not agree with, you may contact the Lovelace Health Plan Customer Care Center for assistance. Members are not liable to a Participating Provider for any amounts owed to the Provider by Lovelace Health Plan.

Claims for Emergency Services

When Lovelace Health Plan receives claims for Emergency benefits, it pays the Participating Providers directly. If a Member receives Emergency Services from Non-Participating/Non-Contracted Providers, he or she may be required to pay for the services up front or submit a claim to Lovelace Health Plan in order for services to be paid. This must be done within 1 year (365 days) after the first Emergency Services are provided. If the Member could not reasonably do this, a valid claim will not be denied. However, the itemized statement must be submitted to Lovelace Health Plan as soon as possible.

Services Provided by Non-Participating/Non-Contracted Providers

Members who receive Covered Benefits or Services from an approved Non-Participating Provider may be required to make full payment to that Provider at the time services are rendered. In order for the Member to be reimbursed, the Member must submit satisfactory evidence to Lovelace Health Plan that indicates such payment was made to the Non-Participating Provider. For non-emergent or non-urgent services provided by non-Participating Providers, a Prior Authorization for those services is also required. Members will need to submit itemized bills and receipts to Lovelace Health Plan. The submission must contain an itemized statement of treatment, expenses, and diagnosis, including an explanation for the services and the identification information from your Plan ID card. Once reviewed and approved, the Plan will reimburse the Member for Covered Services, based upon Reasonable and Customary Charges, less any required Co-payment amount the Member would have been required to pay if the services had been obtained from a Lovelace Health Plan Participating Provider. The Member will be responsible for charges not specifically covered by Lovelace Health Plan. Claims or charges for services rendered by a Non-Participating Provider must be submitted to the Plan within one year (365 days) from the date of service.

Claims Department

Attention: "Member Submitted Claims" Team

4101 Indian School Rd, NE

Albuquerque, New Mexico 87110

HOW THE PLAN WORKS

If payment is denied, you will receive notice of the decision, including the reasons for the denial and your Appeal rights. Lovelace Health Plan is not liable or obliged to pay for any services received once a claim has been denied, unless an appeal overturns the original denial. For additional information or if you have questions regarding this process, please refer to the section of this EOC handbook on Appeals and Grievances or contact the Lovelace Health Plan Customer Care Center.

Fraud & Abuse

The Lovelace Health Plan Fraud & Abuse Program is dedicated to detecting, investigating, and preventing all forms of suspicious activity related to possible health insurance fraud or abuse, including any reasonable belief that insurance fraud has or may be 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 Lovelace Health Plan, 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 Lovelace Health Plan.

How to Report Potential Fraud, Abuse, or Suspicious Activity

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

- Call the Lovelace Health Plan Fraud & Abuse Telephone Hotline: (505) 232-1884
- Fax information to the Lovelace Health Plan Fraud & Abuse Dept: (505) 262-3010
- Mail to:

Lovelace Health Plan
Attn: Fraud & Abuse Department
4101 Indian School Rd
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 Lovelace Health Plan and recovery of any overpayments, as applicable.

HOW TO OBTAIN HEALTH CARE

It is important for you to read the information in this section as it explains from which providers you may obtain care and how to ensure that the care you receive is covered by Lovelace Health Plan.

Provider Directory

The Provider Directory includes a listing of physicians, hospitals, pharmacies, medical equipment Providers, laboratory, x-ray, and other network Participating Providers contracted with Lovelace Health Plan. The Provider Directory is subject to change as new Providers contract with us and some Participating Provider contracts end. A Provider's listing in the directory does not guarantee that the Provider is still contracted with Lovelace Health Plan or accepting new patients. The most current contracting status of any Participating Provider may be obtained by accessing Lovelace Health Plan's Online Provider directory via our website at lovelacehealthplan.com or by contacting the Lovelace Health Plan Customer Care Center.

This section of your EOC Handbook will provide you with information on how and where you can obtain care. Refer to your Summary of Benefits for Co-Payment amount information.

Physicians' Qualifications

To obtain professional qualification information regarding Participating PCPs and Specialists, contact the Lovelace Health Plan Customer Care Center at 505.232.1881 or toll-free 800.808.7363. This information may include medical school attended, residency completed and Board Certification status.

Routine Services

You can obtain the following services from a PCP or Specialist on your own, without a referral or approval in advance. You will be required to pay the applicable Co-Payment amount for these services:

- Routine women's health care, which includes breast exams, mammograms (x-rays of the breast), pap tests, and pelvic exams. This care is covered without a referral only if you receive services from a Participating Provider.
- Flu shots and pneumonia vaccinations (as long as you receive them from a Participating Provider).
- Emergency Services in the service area, whether you get these services from Participating Providers or non-Participating Providers.
- Urgently needed care that you receive from non-Participating Providers when you are in the Service Area but, because of unusual or extraordinary circumstances, the Participating Providers are temporarily unavailable or inaccessible.
- Access to Participating Specialists.

PLEASE NOTE: Some Plan Covered Services and Supplies provided in a Provider's office may require Prior Authorization from Lovelace Health Plan. Contact the Lovelace Health Plan Customer Care Center for more information.

Office Visits

With the exception of maternity care, Office Visits are limited to seven visits per Calendar Year. Each time you have a health problem, call or make an appointment with your Physician. Have your Plan Identification (I.D.) card available when you call.

HOW TO OBTAIN HEALTH CARE

To avoid personal liability for the Office Visits entitled to you under this Plan, when you arrive for your appointment, identify yourself as a Care New Mexico Plan Member and present your I.D. card to the receptionist. If a particular benefit requires a Co-Payment amount, you must pay it before receiving services. If you are unable to keep an appointment, cancel as soon as possible.

If you need a same day appointment or have an Urgent Illness, call your PCP's office to make an appointment. You may be offered an appointment with a different Physician, Nurse Practitioner or Physician Assistant. After normal work hours, you can call the Nurse Advice Line available twenty-four (24) hours a day, seven (7) days a week. The number is 877.725.2552. Registered Nurses can help you determine the kind of care most appropriate to your specific needs.

Interpreter Services

Lovelace Health Plan has over-the-phone interpreters for those Members needing special assistance. To access these services, contact the Lovelace Health Plan Customer Care Center at 505.232.1881 or toll-free 800.808.7363.

Diagnostic Tests

All diagnostic tests must be performed by a Participating Provider. Many diagnostic tests require Prior Authorization by Lovelace Health Plan. This requirement does not apply to Emergency Services.

Urgently Needed Care

This section refers to Covered Services obtained to treat the onset of a sudden, unforeseen illness, injury or Condition. 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 Participating PCP.

If your Condition permits, call the Nurse Advice Line, which is available twenty-four (24) hours a day, seven (7) days a week. The number is 877.725.2552.

Registered Nurses can help you decide the kind of care most appropriate to your specific needs.

Emergency Services

Emergency care coverage by Lovelace Health Plan is very specific. Please read this section carefully. Be sure that you know what steps to take when an emergency arises.

Emergencies require quick action

Emergency Services include: medical, surgical, hospital, related health care services and testing to treat emergency medical conditions. Emergency Services are those required to treat an accidental injury or the sudden onset of what reasonably appears 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 disfigurement to a person. Some problems are an emergency because, if not treated promptly, they might become more serious. Some examples include: deep cuts

HOW TO OBTAIN HEALTH CARE

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 Health Plan may determine as an emergency medical condition.

Reimbursement for emergency care will not be denied if you, in good faith and with average knowledge of health and medicine, seek emergency care for an illness or injury that you believe requires immediate medical attention. Emergency care does not require Prior Authorization. Lovelace Health Plan 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 with your PCP;
- The time of day the care was provided;
- The presenting symptoms; and
- Any circumstances that prevented you from seeking emergency care from a Plan Provider under established Plan guidelines.

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

You may have questions about acute illness other than an emergency. You should contact your PCP before going to the emergency room if at all possible.

Emergency Services Within the Service Area

In an emergency situation, go to an emergency room contracted with Lovelace Health Plan. These facilities are open twenty-four (24) hours a day, seven (7) days a week. If, in a potentially life-threatening emergency, you are unable to access one of these facilities, go to the nearest hospital emergency room. If necessary, dial 911 for help. If you are able, tell the emergency room personnel that you are a Lovelace Health Plan Member. They can then contact Lovelace Health Plan for you.

In an emergency, benefits are sometimes available for care from Non- Participating Providers. This is true only if delay in reaching a Participating Provider in the service area would result in death, disability or significant jeopardy to your Condition. Emergency Services obtained from Non-Participating Providers will be reviewed by Lovelace Health Plan.

Emergency Services Outside the Service Area

EMERGENCY SERVICES REQUIRED OUTSIDE OF THE SERVICE AREA ARE NOT COVERED UNDER THE CARE NEW MEXICO PLAN.

Notification of Emergency

If a Member must be hospitalized for any Emergency Service, Lovelace Health Plan must be notified and give authorization within forty-eight (48) hours of admission. If it is not reasonably possible for a Member to do this immediately, a valid claim will not be denied. However, Lovelace Health Plan must be notified as soon as reasonably possible by the Member, a Member's representative or the treating Provider.

There are limits to coverage for Emergency Services received from Non- Participating Providers. In this instance, the services must be included in those the Member is entitled to under his or her Plan. The cost of these services will be reimbursed at the rates that prevail in the area where the services were provided.

HOW TO OBTAIN HEALTH CARE

What benefits are covered as Emergency Services:

- Emergency care at a doctor's office
- Emergency care at an Urgent Care center
- Emergency care as an outpatient or inpatient at a hospital, including physician's services.

What benefits are NOT covered as Emergency Services:

- Elective care or non-emergency care, including Follow-up Care
- Services provided outside of the Service Area

Emergency Hospitalizations

In an emergency, Lovelace Health Plan must be notified within forty-eight (48) hours of you or your covered dependents being admitted to a hospital. If admitted from the emergency room, your emergency room co-payment will be waived and you will be responsible for the Inpatient Hospital Co-payment

HOSPITAL ADMISSIONS ARE LIMITED TO 25 INPATIENT DAYS PER CALENDAR YEAR (INCLUDING HOME HEALTH CARE DAYS FOLLOWING HOSPITALIZATION). AN ELECTIVE, NON-MEDICALLY NECESSARY HOSPITALIZATION IS NOT A COVERED SERVICE.

COVERED BENEFITS & SERVICES

IMPORTANT NOTICE: COVERAGE UNDER THIS PLAN IS LIMITED TO APPROVED SERVICES RECEIVED FROM A PLAN PROVIDER AND THERE IS A MAXIMUM LIMIT ON THE COST OF HEALTH CARE SERVICES OF \$100,000 PER CALENDAR YEAR

Any specific service listed as a Covered Benefit or Service will be provided if it is Medically Necessary for the prevention, diagnosis, or treatment of your illness or condition. No oral statement of any person will modify or otherwise affect the benefits, limitations and exclusions of this EOC, convey or void any coverage, increase or reduce any benefits under this Plan or be used in the prosecution or defense of a claim under this Plan.

To be considered a Covered Benefit, services must be prescribed and performed by a Participating Provider. For some services to be Covered, Lovelace Health Plan must also authorize them. Please refer to the Prior Authorization section in this EOC Handbook or contact the Lovelace Health Plan Customer Care Center. Lovelace Health Plan is not liable and has no obligation to pay for any service or benefit received without Lovelace Health Plan's prior approval, for those services that require a Prior Authorization.

You are responsible for Co-Payment amounts and certain other charges. Please refer to your Summary of Benefits or you may contact the Lovelace Health Plan Customer Care Center for more information.

Medical Office Visits

With the exception of maternity care, Office Visits are limited to seven visits per Calendar Year. Medical office visits include services that are reasonably required to maintain good health. The following services conducted during a medical office visit may include, but are not limited to:

- Routine and non-routine/Urgent Care from Participating Providers
- Diagnostic and/or treatment services from Participating Providers. This includes, but is not limited to, pap smears and mammograms
- Well-child care and routine immunizations in accordance with accepted medical practices
- Periodic/Preventive health assessments/services
- Consultation and minor surgical procedures
- Family planning education and services.
- Vision and hearing screening for members through the age of 17.

Preventive Health Services

The following services are available to Members when the Primary Care Provider (PCP) has determined Medical Necessity:

- Periodic tests to determine blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level or, alternatively, a fractionated cholesterol
- Routine physical exams - covered one (1) time per Calendar Year.
- A periodic glaucoma eye test for all persons thirty-five (35) years of age or older
- Annual stool examination for the presence of blood
- Colon examination including left-sided colon examination
- As needed, 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

COVERED BENEFITS & SERVICES

- Double contrast barium enema every five (5) years
- Colonoscopy every ten (10) years
- Immunization for all adults as recommended by the Advisory Committee on Immunization Practices (ACIP)
- An annual consultation physical, for persons twenty (20) years of age or older and as deemed Medically Necessary or recommended by the PCP
- Other preventive health services, under the PCP's supervision, including reasonable health appraisal examinations and laboratory and radiological tests on a periodic basis
- Voluntary family planning services. Reversal of prior voluntary sterilization surgery is not covered
- Educational materials or consultation with a Participating Provider to promote a healthy lifestyle

Outpatient Surgical Services

Outpatient surgical services include those hospital or facility services that can be reasonably provided on an outpatient or Ambulatory basis. Some of these services must be authorized, requested or directed by Lovelace Health Plan, your PCP or other Participating Provider. Covered services include:

- Certain surgical procedures, anesthesia, administration of blood and blood products and recovery room services.
- Facility administered drugs, medications, Biologicals, and fluids.

Diagnostic and Therapeutic Services

Diagnostic laboratory and/or diagnostic and therapeutic radiology services are covered, including but are not limited to:

- Electrocardiograms (EKGs)
- Electroencephalograms (EEGs)
- Radiation therapy
- Most outpatient blood and urine studies
- Other diagnostic and therapeutic procedures

Inpatient Hospital Services

HOSPITAL ADMISSIONS ARE LIMITED TO 25 INPATIENT DAYS PER CONTRACT YEAR (INCLUDING HOME HEALTH CARE DAYS FOLLOWING HOSPITALIZATION). AN ELECTIVE, NON-MEDICALLY NECESSARY HOSPITALIZATION IS NOT A COVERED SERVICE.

Inpatient hospital services require authorization by Lovelace Health Plan. These services are for treatment and evaluation of certain Conditions that are not appropriate on an outpatient basis. Inpatient hospital services include:

- Semi-private room and board
- Care and services in an intensive care unit
- Physician and surgeon services
- Medications, Biologicals, fluids and chemotherapy
- Meals
- Special diets and nutritional supplements when Medically Necessary
- Dressings and casts

COVERED BENEFITS & SERVICES

- General nursing care and special duty nursing when Medically Necessary
- Use of operating room and related facilities
- Administration of blood and blood products
- X-rays, laboratory and other diagnostic services
- Anesthesia and oxygen services
- Rehabilitation therapies
- Other such services customarily provided in an acute care hospital
- Durable Medical Equipment (DME) (Note: Covered under this Plan only during an authorized hospitalization).

If a Member is readmitted to the hospital within seventy-two (72) hours of their discharge, no additional co-payment will be required.

Family, Infant and Toddler (FIT) Program

This Plan provides coverage (up to \$3500 annually, per eligible child) to those children who qualify for services through the FIT Program. The program provides intervention services for children from birth through three (3) years of age who have or are at risk for early developmental delays and/or disabilities. Children must be enrolled in the FIT Program with the New Mexico State Department of Health and receive services from designated FIT Program Providers. Coverage and services are provided as defined in the requirements for the Family, Infant and Toddler Program Early Intervention Services (Title 7, Chapter 30, Part 8).

Home Health Services

Home health services are covered for a Member who requires Skilled Care and is unable to receive medical care on an Ambulatory outpatient basis. The Member does not need to be confined in a hospital or other health care facility. Home health services must be provided by a Participating Provider.

Home health services include:

- Visits by professional nurses and other participating health professionals (including home health aides)
- Consumable medical supplies administered by professional staff or used during authorized home health visits
- Medical social services
- Covered Drugs and medications prescribed by a Participating Provider for the duration of Home Health Services

These services are subject to periodic review for the continuation of coverage. **Home health care days are included in the 25-day limitation per Calendar Year and must be provided immediately following an inpatient hospitalization or in lieu of a hospitalization.** The services must also be authorized by Lovelace Health Plan.

Women's Health Care

Women's Health Care includes the following services:

- Prenatal care, including Medically Necessary nutritional supplements prescribed by a Physician
- Mammograms for screening and diagnostic purposes including, but not limited to, low-dose mammography screenings performed at designated Participating imaging facilities

COVERED BENEFITS & SERVICES

- Cytologic 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
- Services related to the diagnosis, treatment, and appropriate management of osteoporosis when determined to be Medically Necessary by the PCP in consultation with Lovelace Health Plan
- Direct access to obstetric and gynecological care by qualified women's health care Participating Providers (Some obstetric and gynecological care Providers also choose to participate as PCPs)
- 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
- Direct access to obstetric and gynecological care to female Dependents age thirteen (13) or older

Maternity Care

Medical, surgical and hospital care during the term of pregnancy, upon delivery and during the postpartum period for normal delivery, spontaneous abortion (miscarriage) and complications of pregnancy are covered.

Coverage for a mother shall be available for a minimum of forty-eight (48) hours of inpatient care following a vaginal delivery and a minimum of ninety-six (96) hours of inpatient care following a Cesarean section. Any decision to shorten the period of inpatient care for the mother or the newborn must be made by the attending Physician in consultation with the mother.

Newborn and Adopted Children Coverage*

Newly born and adopted children of a Member will be covered from the moment of birth/adoption given the newborn/adopted child is enrolled with Lovelace Health Plan. **Newborns and adopted children are not automatically enrolled and must meet the eligibility requirements of your Plan.** Please refer to the "Who May Enroll" section of this EOC Handbook for enrollment information.

Coverage of a Member's newly born natural and adopted children includes coverage of injury or sickness and circumcision for newborn males. This also includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

*Includes children in "Placement for Adoption" status

Consumable Medical Supplies

Consumable medical supplies are covered during hospitalization. They are also covered during an office visit or authorized home health visit. Lovelace Health Plan does not cover these supplies when used at other times by the Member or Member's 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

COVERED BENEFITS & SERVICES

- Are ordered or prescribed by a Participating Provider
- Examples include, but are not limited to, bandages and dressing supplies

Rehabilitation Therapy

Rehabilitation therapy including, but not limited to: physical, speech, occupational, respiratory, cardiac and pulmonary therapy. Coverage is limited to therapy received as an Inpatient during an authorized medical hospitalization. Rehabilitation Therapy after a medical discharge is not a Covered Service.

Rehabilitation Therapy is available for rehabilitation during hospitalization following injuries, surgeries or acute medical Conditions, such as a stroke. Related occupational therapy is provided for purposes of training Members to perform the activities of daily living. The therapy must be performed by a Participating Licensed Provider and requires prior authorization by Lovelace Health Plan.

Smoking Cessation Treatment

Quitting isn't easy, but we are here to help you through the process. Lovelace Health Plan's Stop Tobacco for Optimal Prevention program, known as the *S.T.O.P.* program, is offered with your Plan through the Lovelace Health Plan Disease Management Department.

The *S.T.O.P.* program consists of the following:

- Diagnostic services necessary to identify tobacco use, use-related Conditions and dependence.
- A series of one-on-one phone counseling sessions with a trained health care provider. These sessions will help you make a plan and provide you with guidance and support.
- A self-help packet of materials, including tips on how to quit. These tips will help you prepare for quitting, cope with the urge to smoke or chew tobacco, and deal with slip-ups if they occur.
- Prescription medications including Zyban, Nicotrol Inhaler or Nicotine Nasal Spray may be available with a Co-Payment amount. If your Employer Group has chosen an outpatient Prescription Drug benefit, you will find information about it in the Summary of Benefits.
- If you prefer a group setting rather than phone counseling, we can refer you to multi-session group classes in your area. The coverage for prescription medications also applies if you choose group classes instead of the *S.T.O.P.* Program.

Benefit limitations:

- You may only go through the *S.T.O.P.* program once or multi-session group classes twice per Calendar Year.
- Coverage for medications/pharmacotherapy is limited to three (3) consecutive months (ninety [90] days), twice per Calendar Year.
- Medication is limited to a 30-day supply with two refills. Each 30-day supply requires a Co-Payment amount.

Please contact the Stop Tobacco for Optimal Prevention (*S.T.O.P.*) program for specific benefit coverage information. Call 505.232.1844 or toll-free 877.480.9368 to speak with a *S.T.O.P.* counselor.

COVERED BENEFITS & SERVICES

Special Medical Foods

Special medical 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. A 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 Lovelace Health Plan.

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
- Essential to optimize growth, health and metabolic homeostasis
- Must be obtained from Lovelace Health Plan's Participating Vendor/Provider

Foods obtained from a grocery store or internet provider will not be covered as Special Medical Foods.

EXCLUSIONS

Any services and benefits that are not described in the Covered Benefits & Services section are not covered by this Plan. This is also true of any optional benefits not chosen by your Employer Group. The following are examples of excluded services and benefits:

- Any treatments, procedures, services, facility, equipment, drugs, drug usage, devices or supplies that the Lovelace Health Plan Medical Director determines are not Medically Necessary, except for those authorized by Lovelace Health Plan
- Alternative treatments including, but not limited to, aromatherapy, massage therapy or hypnotherapy
- Ambulance or other transportation services including transportation for high risk maternity patients or newborns with birth problems.
- Amniocentesis, ultrasound, or any other procedures requested solely to determine the sex of a fetus. An exception is made if it is Medically Necessary to determine the existence of a sex-linked genetic disorder
- Artificial aids including, but not limited, to hearing aids, ear molds, devices or computers to assist in communication or speech, except as required by law
- Assistance in the activities of daily living. Examples include: eating, bathing, dressing. Homemaker services and non-skilled nursing care are not covered
- Autopsies and/or transportation costs for deceased Members
- Benefits and services not specified as Covered Benefits/Services in this EOC Handbook or the Summary of Benefits
- Care for disabilities connected to military service. This Plan does not cover these services if the Member is legally entitled to these services at facilities that are available to the Member
- Care by Non-Participating Providers, except for service authorized by Lovelace Health Plan or emergencies or urgently needed care. Emergency services provided by Non-Participating Providers are limited to those services the Member is entitled to under this Plan.
- Care received in any facility outside of the Service Area.
- Charges that are determined to be unreasonable by Lovelace Health Plan
- Conditions for which state or local law mandates treatment in a public facility, or court-ordered services. These are not covered unless they are ordered by the PCP and approved by Lovelace Health Plan
- Cosmetics and health and beauty aids
- Cosmetic therapy, drugs/medications or procedures for the purpose of changing appearance. Cosmetic surgery is limited to surgery that is Medically Necessary for the treatment of a functional or organic disorder.
- Custodial, domiciliary or respite care
- Dental care or 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
- Diapers and incontinence supplies
- Dietary supplements and nutritional formulae taken by mouth or feeding tubes are not covered except as defined under Limitations (Special Medical Foods)
- Durable Medical Equipment including replacement and repair, except during an authorized hospital stay
- Equipment that basically serves the comfort or convenience of the patient or the person caring for the patient
- Foot care including, but not limited to, cutting or removal of corns/calluses, nail trimming, cutting or debriding, unless Medically Necessary
- Hearing aids, ear molds, or fitting of hearing aids or ear molds for adults.
- Infertility and reproductive related services, procedures, and medications
- Immunizations, inoculations, exams and other related services required for licensing, employment, marriage, insurance or travel purposes

EXCLUSIONS

- Infant or baby food/formula or breast milk or other regular grocery products that can be processed for oral or tube feedings
- Home Births
- Homemaker services
- Hospice Care/program services
- Long-term rehabilitative therapy
- Mental/behavioral health services
- 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
- Medical, surgical or other health care procedures and treatments that are experimental or investigational. This is determined by the Lovelace Health 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
 - 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
- Membership costs or fees associated with health clubs and weight loss clinics, including personal trainers and the use of club swimming pools for therapy
- Non-medical ancillary services such as vocational or educational rehabilitation, behavioral training, sleep therapy, job counseling, psychological counseling and training, or educational therapy for learning disabilities or mental impairment
- 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
- Nursing home care, including skilled and intermediate care
- Orthopedic shoes and foot orthotics
- Organ transplants and any services related to an organ transplant
- Outpatient Prescription and non-Prescription Drugs and medications.
- Outpatient physical, occupational, speech, respiratory, cardiac, pulmonary, or chiropractic therapy
- Outpatient renal dialysis
- Penile implants
- 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
- Private hospital rooms and/or private duty nursing unless determined to be Medically Necessary by Lovelace Health Plan's Medical Director
- Prosthetic devices, including replacement and repair
- Rehabilitation therapy after a medical discharge
- Repairs for Durable Medical Equipment (DME), prosthetic or orthotic devices
- 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, and laser vision correction, or the fitting of eyeglasses

EXCLUSIONS

- 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
- Services and benefits related to treatment of mental illness and substance abuse Conditions
- Services and inoculations for reasons other than health. Examples include those required for: jobs, marriage, insurance, or travel
- Services and procedures for sexual transformation
- Services which other coverage is required to provide or reimburse, including but not limited to workers' compensation, automobile insurance or similar coverage
- Services of a provider which are not within his/her scope of practice
- 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
- Services not primarily medical in nature, or supplies or equipment that are primarily and customarily used for a non-medical purpose as determined by Lovelace Health Plan's Medical Director
- Services primarily for rest, domiciliary or convalescent care
- Travel, lodging and other related expenses
- Treatment for sexual dysfunction, including but not limited to medications, counseling and clinics
- Treatment for mandibular or maxillary prognathism, micrognathism or malocclusion, surgical augmentation for orthodontics, or maxillary constriction.
- Treatment or care provided by a member of your family or other close relative
- Treatment or services provided in connection with or to comply with involuntary commitments, police detention, court orders or other similar arrangements
- Vision/eye refractive services and optical appliances, except as required by law and as written in this EOC Handbook
- Vocational rehabilitative services
- Weight loss, physical conditioning programs or exercise programs of any type
- Services/supplies received prior to, and after, dates of coverage under the Plan

If you are uncertain whether a particular treatment or service is considered experimental contact Lovelace Health Plan before the treatment or service is provided. Any services and benefits not described in this EOC Handbook or attached Summary of Benefits are not covered under this Plan.

MEMBER APPEAL AND GRIEVANCE PROCEDURE

Lovelace Health Plan's Appeal and Grievance process is overseen by the Lovelace Health Plan Appeals and Grievance Department. Its purpose is to resolve issues from Members who disagree with Lovelace Health Plan's decision to deny a service for coverage or lack of Medical Necessity, called an Adverse Determination. You may also disagree with Lovelace Health Plan's administrative practices, called an administrative grievance. That is, those decisions that appear to affect the availability, delivery or quality of health care services, including but not limited to claims payment, termination of coverage, and quality of care or service. We will provide you a written copy of our appeal and grievance process upon request. We will never retaliate against a Member in any way for filing a Grievance or Appeal. 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.

When You Have a Concern or Complaint

We want you to be completely satisfied with this Plan and the care and/or services you receive. That's why we've established a process for working to research and resolve your Concern or Complaint.

Start with the Lovelace Health Plan 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 Lovelace Health Plan Customer Care Center in Albuquerque at 505.232.1881 or toll-free outside of Albuquerque at 800.808.7363 (TTY Services provided by Relay New Mexico 800.659.8331). One of our Lovelace Health Plan Customer Care Center representatives can assist you and address your Concern.

A Lovelace Health Plan Customer Care Center representative will make every effort to resolve the Concern or Complaint to a Member's satisfaction the first time it is brought to our attention.

If the Lovelace Health Plan Customer Care Center representative is unable to resolve your Concern or Complaint to your satisfaction, you can file an Appeal or Grievance.

File a formal complaint (Appeal or Grievance)

In addition to speaking to one of our Customer Care Representatives by phone, you can also express your Concerns by walk-in interview or arranged appointment at the following address:

Lovelace Health Plan
4101 Indian School Rd, NE
Albuquerque, NM 87110

Or you may submit your Concerns in writing to:

Lovelace Health Plan
P.O. Box 27107
Attn: Appeals and Grievance Department
Albuquerque, NM 87125-7107
Fax: 505.262.7307

All requests received will be thoroughly reviewed to determine the best course of action. If your concern involves clearly divisible administrative and adverse determination grievances, we will process such complaints separately.

MEMBER APPEAL AND GRIEVANCE PROCEDURE

Processing Your Complaint

Once a member sends written notification or verbally files an Appeal or Grievance, the member's request is forwarded to the Appeal and Grievance Department. An acknowledgement letter is sent to the member and the formal resolution process begins.

Initial Determinations

When you or your Participating Provider requests a service, Lovelace Health Plan shall initially determine whether the service being requested is covered by your Plan and is Medically Necessary. This decision will be made either within twenty-four (24) hours of receiving the request (if there are medical reasons that require an expedited decision) or within five (5) working days for a standard review. Lovelace Health Plan may extend the review period for a maximum of ten (10) working days if we can: 1) demonstrate reasonable cause beyond our control for the delay; 2) can demonstrate that the delay will not result in increased medical risk to you; 3) provides a written progress report to you and the related provider within the original five (5) working day review period. If Lovelace Health Plan approves (also known as certifying) a request for services, we will notify you and your Provider by written or electronic communication within two (2) working days of the date the service was certified, or sooner if medical reasons make it necessary to do so. If Lovelace Health Plan makes a decision to deny, reduce or terminate coverage for requested health care services, this is called an Adverse Determination. We will notify you and your Provider 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. We will also provide you with instructions and forms, if required, for appealing our decision.

When we make an adverse determination, you have the right to request an Appeal of the adverse determination. Lovelace Health Plan has two levels of Appeal, Level I and Level II. To initiate a Level I Appeal, you may submit a request for an Appeal to Lovelace Health Plan within 1 year (365 days) of receipt of a denial notice. You should tell us the reason why you feel the denial should be overturned and include any information supporting your Appeal. We will acknowledge in writing within one (1) working day that we have received your request for an Appeal. The acknowledgement letter will contain the name, address, and direct telephone number of an individual at Lovelace Health Plan who may be contacted regarding the grievance.

Appeals of Adverse Determinations

Timeframes for Processing Appeals of Adverse Determinations

Appeals involving the review of a denial of services based on coverage or Medical Necessity, and before they are received (pre-service), will be completed within twenty (20) working days of receipt of a standard Appeal request. Appeals involving the review of a denial of services after they are received (post-service) will be completed within forty (40) working days. Lovelace Health Plan may extend the review period for a maximum of ten (10) working days for pre-service requests and twenty (20) working days for post-service requests if we can: 1) demonstrate reasonable cause beyond our control for the delay; 2) can demonstrate that the delay will not result in increased medical risk to you; 3) provides a written progress report to you and the related provider within the thirty (30) or sixty (60) days review period. Members must agree, in writing, to our request to extend a deadline.

MEMBER APPEAL AND GRIEVANCE PROCEDURE

Some appeals of pre-service denials are processed on an expedited basis. Expedited decisions are made when your life or health, or ability to regain maximum function, would be jeopardized by following the standard Appeal process and time frames. In cases that require an expedited decision of a pre-service request, based at the request of your Participating Provider, a decision will be made within seventy-two (72) hours of the request. We do not conduct expedited appeals for services already provided ("post service") to a member. If you as a member request an expedited decision, a Lovelace Health Plan Medical Director will review your request. If the Medical Director determines that your request for an expedited appeal is medically necessary, a decision will be made within seventy-two (72) hours of the request. All required information will be transmitted between Lovelace Health Plan, your provider and you by the quickest means possible. If the Medical Director determines that your request for an expedited appeal is not medically necessary, Lovelace Health will notify you and then process your appeal within the standard five (5) working days.

Internal Review of Appeal of Adverse Determination by Medical Director - Level I

Your Appeal will be reviewed by a Medical Director not involved in the initial determination. He/she will re-review the request to determine whether the requested health care services are Medically Necessary and covered under the health benefits Plan.

NOTICE OF DECISION ON APPEAL OF ADVERSE DETERMINATION BY MEDICAL DIRECTOR

If the Medical Director decides to reverse the initial adverse determination, the Medical Director will approve the services. You and your Provider will be notified by mail or electronic means (fax, e-mail, etc.) within two (2) 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 written or electronic means within one (1) working day of the telephone notification. You will be given the choice of whether or not to pursue a Level II Appeal by an Internal Panel Review Committee, made up of persons not involved in previous decisions regarding the requested service. If you do not wish to pursue the Appeal, we will mail to you written notification of the Medical Director's decision and confirmation of your decision not to pursue the Appeal within three (3) working days of the medical director's decision.

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. Included in the notification will be a self-addressed stamped response letter which asks whether you want to pursue the Level II Appeal by asking you to check "yes" or "no" within the letter. If you do not return the letter within ten (10) working days, we will again try to contact you by telephone.

If you do not respond to our telephone calls or do not return the response letter within twenty (20) working days of the written notification to uphold the initial decision, we will close the file, documenting that you have not responded.

If we verify with you either by telephone or the response letter that you want to file a Level II Appeal, an Internal Panel Review Committee will be selected to further review the adverse determination.

MEMBER APPEAL AND GRIEVANCE PROCEDURE

If your Appeal was processed on an expedited basis, then an Internal Panel Review will automatically proceed. This review will be completed within seventy-two (72) hours. If an expedited review is conducted during a member's stay or course of treatment, health care services will be continued without cost (except for applicable co-payments) to the member until Lovelace Health Plan makes a decision and notifies you. If you do not make an immediate decision to pursue a second level of appeal, or you request additional time to supply supporting documents or information, the timeframes previously described for completing an appeal will be extended to include the additional time you need.

Internal Panel Review of Adverse Determination – Level II

INTERNAL PANEL REVIEW COMMITTEE

The Internal Panel Review Committee will consist of Lovelace Health Plan staff and one or more health care or other professionals. At least one of the health care professionals selected will practice in a specialty that would typically manage the case that is the subject under appeal or be mutually agreed upon by the grievant and the health care insurer. Panel members must be present physically or by video or telephone conferencing to hear the grievance. A panel member who is not present to hear the grievance either physically or by video or telephone conferencing shall not participate in the decision.

NOTICE OF INTERNAL PANEL REVIEW HEARING

We will notify you in writing of the date, time, and place of the Internal Panel Review hearing. The notice will also advise you of your rights. Your rights include: attending and participating in the internal panel review; presenting your case to the Internal Panel Review Committee; submitting supporting material both before and at the Internal Panel review; asking questions of any representative of Lovelace Health Plan; asking questions of the healthcare professionals on the Internal Panel Review Committee; and being assisted or represented by a person of your choice, including legal representation. You may hire a specialist to participate in the Internal Panel Review at your own expense. PLEASE NOTE: This specialist may not participate in making the decision.

If you choose to have legal representation with you at the hearing, please notify the Appeals Department representative prior to the hearing. Failure to notify may require rescheduling of the hearing within the timeframe allowed to complete your appeal. If we have an attorney present to protect our interests, a notice will advise you of such, and that you may wish to obtain legal representation of your own. We will notify you of this at least three (3) working days before the hearing.

Lovelace Health Plan will accept a member's reasonable request for postponement. Timeframes previously described for completing an appeal will be extended during the period of any postponement.

TIMEFRAMES FOR INTERNAL PANEL REVIEW

No fewer than three (3) working days prior to the internal panel review, we will provide to you with: your pertinent medical records; your treating Provider's recommendation; the Summary of Benefits and/or Evidence of Coverage (EOC) for your Plan; a copy of our notice of the adverse determination; uniform standards relevant to your medical condition used by the internal panel in reviewing the adverse determinations; information provided to or received by any medical consultants retained by Lovelace Health Plan; all other evidence or documentation relevant to reviewing the adverse determination.

MEMBER APPEAL AND GRIEVANCE PROCEDURE

The Internal Panel Review Committee will complete its review for EXPEDITED cases within seventy-two (72) of receipt of the request if the member's life or health would be jeopardized or the member's ability to retain maximum function would be jeopardized. The Internal Panel Review Committee will complete its review of a STANDARD appeal within timeframes previously noted days. We will notify you and your treating Provider of the Internal Panel Review Committee's decision by telephone within twenty-four (24) hours of making a decision, and in writing r by electronic means within one (1) working day of the telephone notice.

NOTICE OF DECISION OF INTERNAL PANEL REVIEW

The written notice will contain the following: the names, titles, and qualifying credentials of the persons on the Internal Panel Review Committee; a statement of the Internal Panel Review Committee's understanding of the nature of the Appeal and all pertinent facts; a clear explanation of the clinical or other rationale for the Internal Panel Review Committee's decision; for coverage determinations, identification of the Plan provision relied upon in reaching the decision. The notice will also explain why each provision did or did not support the panel's decision regarding coverage of the requested service. For Medical Necessity determinations, it will include the uniform standards relevant to the grievant's medical condition and an explanation whether each supported or did not support the panel's decision regard the Medical Necessity of the coverage decision; reference to evidence or documentation considered by the Internal Panel Review Committee in making the decision. The notice will also explain if your right to request an external review by the New Mexico Superintendent of Insurance. The notice will explain the procedures and timeframes of an external review, including contact information and copies of forms needed when requesting an external review. The contact information is: Managed Health Care Bureau – External Review Request, New Public Regulation Commission, P.O. box 1269, 1120 Paseo de Peralta, Santa Fe, New Mexico 87504-1269 or by phone at 1-505-827-3928 or toll free at 1-888-4ASKPRC.

External Review by the New Mexico Superintendent of Insurance

Filing a Request for External Review

If you are not fully satisfied with the decision of the Internal Panel Review, you may request an external review by the New Mexico Superintendent of Insurance. You must request an external review within twenty (20) working days from receipt of the written notice of the Internal Panel Review Committee's decision. The Superintendent may extend the filing deadline if good cause is shown. The request may be:

- Mailed to the Superintendent of Insurance: ATTN: Managed Health Care Bureau – External Review Request, New Mexico Public Regulation Commission, P.O. Box 1269, 1120 Paseo de Peralta, Santa Fe, New Mexico 87504-1269; or
- Emailed to mhcb.grievance@state.nm.us, subject: External Review Request; or
- Faxed to the Superintendent of Insurance, ATTN: Managed Health Care Bureau – External Review Request at 505.827.4734; or
- Completed on-line with a NM PRC, Division of Insurance Complaint Form available at <http://www.nmprc.state.nm.us>.

MEMBER APPEAL AND GRIEVANCE PROCEDURE

If the medical circumstances require, you or your requesting provider may telephonically request an expedited review by calling the Managed Health Care Bureau at 1-505-827-3928 or toll free at 1-888-4ASKPRC.

Members may contact the Superintendent's office for help with requests for information and answers to questions about external reviews by calling 1.888.4.ASKPRC. All requests for assistance shall be directed to the Managed health Care Bureau as the assigned Insurance staff for assistance in the external review process. If a member wants to file an expedited external review, he/she may contact the Division of Insurance's Managed Health Care Bureau at 505.827.3928 or toll free at 1-888-4ASKPRC.

You must file the following with your external review request: a copy of the notice of Lovelace Health Plan's internal review decision; a fully executed form authorizing the Superintendent to obtain any necessary medical records from Lovelace Health Plan or any other relevant provider. You may also file any other supporting documents or information you wish to submit to the Superintendent for review.

For Appeals involving experimental or investigational treatment, the Insurance Division staff shall review the request to determine if coverage reasonably appears to be a covered benefit under your plan except for our determination that the health care service is experimental or investigational for a particular medical condition; and is not explicitly listed as an excluded benefit under your plan. The Insurance Division staff shall review the request to determine if Medical Necessity considerations specific to experimental or investigational treatment are valid. The Superintendent requires that the treating provider certify the appropriateness of this treatment, as compared to that of conventional, i.e. non-experimental or investigational in nature. Your treating provider must certify that (a) standard health care services have not been effective in improving your condition; (b) standard health care services are not medically appropriate; (c) there is no standard health care service covered by Lovelace Health Plan that is as beneficial as or more beneficial than the recommended or requested health care service; and (d) your treating provider, who is a licensed, board certified or board eligible physician qualified to practice in the areas of medicine appropriate to treat your condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service requested by you is likely to be more beneficial to you than available standard health care services.

If you wish to supply supporting documents or other information after you have filed your request for external review, the timeframe for completing the review will be extended up to 90 days from the receipt of your request form, or until you submit all supporting documents, whichever comes first.

Acknowledgement of Request for External Review

Upon receipt of your request for external review, the Superintendent will immediately send you an acknowledgement that the request has been received and send Lovelace Health Plan a copy of the request for external review. Lovelace Health Plan will provide the Superintendent documents, including, but not limited to: 1) a summary of benefits; 2) member handbook/Evidence of Coverage; 3) medical records; 4) other documents and information relevant to the member's appeal; 5) any other documents, records and information relevant to the adverse determination and the internal review decision or intended to be relied on at the external review hearing. Lovelace Health Plan will provide this information to the Superintendent within five (5) working days upon receipt of the request. If we do not comply with the requirements regarding acknowledgement of requests for external review, the Superintendent may reverse the adverse determination. The Superintendent may waive the requirements if required by the medical circumstances of the case.

MEMBER APPEAL AND GRIEVANCE PROCEDURE

Timeframes for External Reviews of Adverse Determinations

The Superintendent will complete an external review in accordance with the medical urgency of your case. The review will not exceed seventy-two (72) hours whenever your life or health would be jeopardized or your ability to regain maximum function would be jeopardized.

Initial Review by Insurance Division Staff

Insurance Division staff will complete an initial review of the request within ten (10) working days from receipt of your request for an external review. If a hearing is held, the Superintendent will complete the external review within thirty (30) working days from receipt of a complete request for an external review. The Superintendent may extend the external review period for up to an additional ten (10) days when the Superintendent has been unable to schedule the hearing within the required timeframe and the delay will not result in increased medical risk to you. Insurance Division staff will review the request for external review to ensure it meets criteria established by New Mexico law.

The staff shall determine if: 1) you provided the required documents previously described; 2) you are or were a covered person under Lovelace Health Plan at the time the health care service was requested or provided; 3) you have exhausted our internal review procedures and any applicable grievance review procedure of an entity that purchases or is authorized to purchase health care benefits according to the New Mexico Health Care Purchasing Act; and 5) the health care service that is the subject of the grievance reasonably appears to be a covered benefit under your plan.

If the request for external review is incomplete, insurance division staff shall immediately notify you and require you to submit the information required by the Superintendent within a specified period of time.

If the request does not meet criteria, the Superintendent will notify Lovelace Health Plan and you. You will have a right to request a hearing within thirty-three (33) days from the date the notice to deny a hearing was mailed.

If the request does meet criteria, the Superintendent will notify Lovelace Health Plan and you that the request has been accepted by the Superintendent and that an informal hearing will be scheduled to determine if, as a result of our adverse determination, you were deprived of medically necessary covered services. Prior to a hearing, Insurance Division staff will attempt to informally resolve the grievance. If the grievance cannot be resolved informally, then a hearing will be held.

External Review Hearing

The Superintendent will provide notice of the hearing to Lovelace Health Plan and you, no later than eight (8) working days prior to the hearing date. The Superintendent will not unreasonably deny a request for postponement of the hearing made by Lovelace Health Plan or you.

The hearing notice will include the date, time, and place of the hearing and the matters to be considered. Both Lovelace Health Plan and you have the right to attend the hearing or designate someone to attend the hearing on your behalf; be assisted by an attorney or other person; and call, examine, and cross-examine witnesses. The Superintendent may designate hearing officers to include a licensed attorney to regulate the proceeding and ensure efficient conduct of the hearing and two (2) co-hearing officers who shall be licensed health care professionals. If the Superintendent designates 2 co-hearing officers, at least

MEMBER APPEAL AND GRIEVANCE PROCEDURE

one of them shall practice in a specialty that would typically manage the case that is the subject of appeal. Testimony at the hearing shall be taken under oath. The hearing officers may call and examine Lovelace Health Plan representatives, you and other witnesses.

The Superintendent or attorney hearing officer shall regulate the proceeding and perform all acts and take all measures necessary or proper for the efficient conduct of the hearing. The Superintendent or attorney hearing officer may: 1) require the production of additional records, documents and writing relevant to the subject of the grievance; 2) exclude any irrelevant, immaterial, or unduly repetitious evidence; and 3) if you or Lovelace Health Plan fails to appear, proceed with the hearing or adjourn the proceeding to a future date, giving notice of the adjournment to the absent party.

Insurance staff may attend the hearing, ask questions and otherwise solicit evidence from the parties, but shall not be present during deliberations among the Superintendent or his designated hearing officer and any independent co-hearing officers. The hearing shall be stenographically recorded at the Division of Insurance's expense. Both you and we have the right to: 1) attend the hearing (we shall designate a person to attend on our behalf and you may designate a person to attend on your behalf if you choose not to attend personally); 2) be assisted or represented by an attorney or other person; and 3) call, examine and cross examine witnesses. You and Lovelace Health Plan must state, on the record, that the hearing officers shall be released from civil legal liability for all communications, findings, opinion, and conclusions made in the course and scope of the external review.

Superintendent's Decision Following Hearing

At the close of the hearing, the hearing officers shall review and consider the entire record and make a recommended decision. Within the timeframe allotted for external review, the Superintendent will issue an order. If the order requires action on the part of Lovelace Health Plan, the Order shall state the timeframe for complying with the order. The Order shall be binding on Lovelace Health Plan and you.

Administrative Grievances

You have the right to file a Grievance if you are dissatisfied with any aspect of your health benefits plan, other than a request for health care services, including, but not limited to: administrative practices of Lovelace Health Plan that affect the availability, delivery or quality of health care services; claims payment, handling or reimbursement for health care services; and terminations of coverage. 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 to your satisfaction, you may file a formal grievance. The issue will be sent to the Grievance Department to initiate the formal Grievance process.

Initial Internal Review – Level I

Once the request has been received, Lovelace Health Plan will send you written acknowledgement of your Grievance within three (3) working days after receipt. The letter will contain the name, address and direct telephone number of a Lovelace Health Plan employee who may be contacted regarding the administrative grievance. The review of your grievance will be conducted by a Lovelace Health Plan employee authorized to take action on the grievance, if applicable, and allow you to provide any information relevant to the grievance.

MEMBER APPEAL AND GRIEVANCE PROCEDURE

Lovelace Health Plan will mail a written response to you within fifteen (15) working days of receipt of the grievance. We may extend the fifteen (15) day timeframe when there is a delay in obtaining documents or records necessary for the review of your grievance, provided that Lovelace Health plan notifies you in writing of the need and reasons for the extension and the expected date of resolution, or by mutual written agreement of the health care insurer and the grievant.

Our response letter to you shall contain: the name, title and qualifications of the person conducting the initial review; a statement of the reviewer's understanding of the nature of the administrative grievance and all pertinent facts; a clear and complete explanation of the reason for the reviewer's response/decision; the health benefits plan provisions relied on in reaching the response; a statement that the initial decision will be binding unless you submit a request for reconsideration within twenty (20) working days of the receipt of the initial response; and a description of the procedures and deadlines for requesting reconsideration, including any necessary forms.

Reconsideration of Internal Review – Level II

If you are not satisfied with the outcome of the Initial Review, Lovelace Health Plan will appoint a Reconsideration Committee consisting of Lovelace Health Plan employees who have not participated in the initial internal review, to review your grievance. You must request this committee hearing within days after receiving your response letter, or the Initial Review decision will be final.

RECONSIDERATION REVIEW COMMITTEE

Upon receipt of your request for a Reconsideration Committee hearing, Lovelace Health Plan will schedule and hold a meeting within fifteen (15) working days after receiving your request for reconsideration. The hearing will be held during regular business hours at a location reasonably accessible to you. You will have the opportunity to participate at the committee meeting in person, by conference call, video conferencing or other technology, at our expense. Lovelace Health Plan will not unreasonably deny your request for postponement of the hearing.

RECONSIDERATION COMMITTEE HEARING

We will notify you in writing of the hearing date, time and place of the Reconsideration Committee hearing at least ten (10) working days in advance. The notice will advise you of your rights: to attend the hearing; to present your case to the committee; to submit supporting material both before and at the hearing; to ask question of any representative of Lovelace Health Plan; and be assisted or represented by a person of your choice that may or may not be a legal representation. If Lovelace Health Plan will have an attorney to represent our interests; the notice will advise you of this and that you may wish to obtain legal representation of your own.

If you choose to have legal representation with you at the hearing, please notify the Grievance Department representative prior to the hearing. Failure to notify may require rescheduling of the hearing within the timeframe allowed for administrative grievances.

No fewer than three (3) working days prior to the hearing, Lovelace Health Plan will provide you with all the documents and information that the Reconsideration Committee will rely on in reviewing your grievance.

MEMBER APPEAL AND GRIEVANCE PROCEDURE

DECISION OF RECONSIDERATION COMMITTEE

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 grievance; a clear and complete explanation of the rationale for the committee's recommendation; the health benefits plan provision(s) relied on in reaching the decision; references to the evidence or documentation relied on in reaching the decision; a statement that the initial decision will be binding unless the grievant submits a request for external review by the Superintendent of Insurance within twenty (20) working days of receipt of the Reconsideration Committee's decision letter; and a description of the procedures and deadlines for requesting external review by the Superintendent of Insurance, including any necessary forms. The notice shall contain the toll-free telephone number and address of the Superintendent's office.

External Review of Administrative Grievance

Filing Requirements

If you are still not satisfied with the Lovelace Health Plan's decision on your administrative grievance, you may request an external review by the New Mexico Superintendent of Insurance. You must file your request within twenty (20) working days of receipt of the Reconsideration Committee's written notice of its decision. You may file the request for external review on the forms provided to you by Lovelace Health Plan. You may also file any other supporting documents or information you wish to submit to the Superintendent for review. The request shall be:

- Mailed to the Superintendent of Insurance: ATTN: Managed Health Care Bureau – External Review Request, New Mexico Public Regulation Commission, P.O. Box 1269, 1120 Paseo de Peralta, Santa Fe, New Mexico 87504-1269; or
- Emailed to mhcb.grievance@state.nm.us, subject: External Review Request; or
- Faxed to the Superintendent of Insurance, ATTN: Managed Health Care Bureau – External Review Request at 505.827.4734; or
- Completed on-line with a NM PRC, Division of Insurance Complaint Form available at <http://www.nmprc.state.nm.us>.

If you wish to supply supporting documents or other information after you have filed your request for external review, the timeframe for completing the review will be extended up to 90 days from the receipt of your request form, or until you submit all supporting documents, whichever comes first.

Acknowledgement of Request for External Review

Upon receipt of a request for external review, the Superintendent shall immediately send you an acknowledgment that the request has been received. The Superintendent shall also send Lovelace Health Plan a copy of your request for external review. Upon receipt of the copy of the request for external review, Lovelace Health Plan will provide the Superintendent within five (5) working days all necessary documents and information considered in arriving at the administrative grievance decision.

External Review of Administrative Grievance

The Superintendent shall review the documents submitted by Lovelace Health Plan and you, and may conduct an investigation or inquiry or consult with you, as appropriate. The Superintendent shall issue a written decision on the administrative grievance within twenty (20) working days of receipt of the complete request for external review.

MEMBER APPEAL AND GRIEVANCE PROCEDURE

Non-Binding Arbitration Required

Information regarding non-binding arbitration is for those plans not subject to the Employee Retirement Income Security Act of 1974 (ERISA). Any controversy between the Lovelace Health Plan and a Member (including any legal representative acting on behalf of a Member), arising out of or in connection with this Plan shall be submitted to arbitration upon written notice by one party to another. Such arbitration, if requested by either party, shall be a prerequisite to litigation and shall be governed by the provisions of the Commercial Arbitration Rules of the American Arbitration Association, to the extent that such provisions are not inconsistent with the provisions of this section. If despite good faith efforts by both parties, the arbitration process has not been completed within four (4) months of the demand for arbitration, either party may bring a lawsuit.

If the parties cannot agree upon a single arbitrator within thirty (30) days of the effective date of the written notice of arbitration, each party shall choose one arbitrator within fifteen (15) working days after the expiration of such thirty (30) day period and the two (2) arbitrators so chosen shall choose a third party arbitrator, who shall be an attorney duly licensed to practice law in the applicable state. If either party refuses or otherwise fails to choose an arbitrator within such fifteen (15) working day period, the arbitrator chosen shall choose a third arbitrator in accordance with these requirements.

The arbitration hearing shall be held within thirty (30) days following appointment of the third arbitrator, unless otherwise agreed to by the parties. If either party refuses to or otherwise fails to participate in such arbitration hearing, such hearing shall proceed and shall be fully effective in accordance with this section, notwithstanding the absence of such party.

The arbitrator(s) shall render his (their) decision within thirty (30) days after the termination of the arbitration hearing. The decision of the arbitrator, or the decision of any two (2) arbitrators if there are three (3) arbitrators, shall be binding upon both parties, unless either party rejects the arbitrator's decision and opts to pursue other legal remedies. If neither party rejects the arbitrators' decision, it shall be enforceable in any court of competent jurisdiction.

The arbitration decision shall be in writing, including findings of fact and conclusions of law. The costs of arbitration shall be borne by the parties in such proportions as the arbitrator(s) may determine.

No party to the Agreement shall have a right to cease performance of services or otherwise refuse to carry out its obligations under the Agreement pending the outcome of arbitration in accordance with this section, except as otherwise specifically provided under the Agreement.

Legal Action

No legal action shall be brought to recover on this plan by the Group or a Participant prior to the expiration of sixty (60) days after written proof of loss has been furnished, in accordance with the requirements of state law. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

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. Lovelace Health Plan has the right of subrogation. If a Member is injured through the wrongful act or omission of another person, Lovelace Health Plan is entitled to allowable charges billed 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, underinsured motorist benefits carrier or legal settlement.

Lovelace Health Plan also receives an assignment of any and all claims for uninsured or underinsured motorist benefits to repay allowable billed charges for the benefits given. Lovelace Health 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 Health Plan's Subrogation Services right away at:

Healthcare Recoveries
250 N. Sunny Slope Rd. #150
Brookfield, WI 53151
800-443-0671
Fax: 262-796-9863

We will work with you or your lawyer to protect Lovelace Health 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 Lovelace Health Plan. To settle or agree to a release without informing Lovelace Health Plan may destroy its subrogation rights. Then you will be obligated to repay Lovelace Health 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 Lovelace Health Plan provided benefits, you must notify Lovelace Health Plan Subrogation 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 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

Lovelace Health Plan must know what other health insurance coverage that 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. When you end or begin your other health insurance coverage, you must notify the Lovelace Health Plan Customer Care Center immediately. If you have any questions, please contact the Lovelace Health Plan Customer Care Center at 505.232.1881 or atoll-free 800. 808.7363.

Medicaid

Lovelace Health Plan sometimes pays the New Mexico Human Services Department (HSD) directly. These direct payments are for medical assistance benefits paid under the State's Medicaid program. This applies if you are eligible for Medicaid and if:

- HSD has paid or is paying benefits on behalf of you or your Dependents
- HSD has paid or is paying a Participating Provider for medical care to you or your Dependents
- HSD has notified the Plan that benefits must be paid directly to HSD

Otherwise, Lovelace Health Plan will pay the Participating Provider for your covered medical care. If you have already paid a Participating Provider for emergency care Lovelace Health Plan must pay the Participating Provider. This is done in accord with State law. You must seek reimbursement from the Participating Provider.

Medicare

If you become eligible for Medicare Part A and Part B and reside in our Medicare Advantage approved Service Areas, you may be eligible to join the Lovelace Senior Plan (LSP) offered by Lovelace Health System, Inc. or Lovelace Premier Choice offered by Lovelace Insurance Company. You may be eligible for Medicare by reason of age, disability or end stage renal disease. To find out if you are eligible to enroll in LSP or Premier Choice, you should contact the Lovelace Health Plan Medicare Sales Department at 505.262.3757 or toll-free 800.262.3757.

WHO MAY ENROLL

To become eligible and maintain eligibility for coverage under this Plan, the following must be met:

- You must reside in the Service Area.
- The current monthly Premium must be paid.
- You must meet the definition of a Subscriber or Dependent.
- This Plan may be offered to individuals, families or Groups of fewer than twenty individuals formed for purposes other than obtaining insurance coverage.
- The individual, family or Group obtaining coverage under the Plan has been without health care coverage for the six-month period immediately preceding the effective date of their coverage. Groups in existence for less than six months, which have been without health care coverage since the formation of the Group, are eligible.
- This Plan may be offered to individuals who have had medical coverage within six months prior to enrollment in the Plan, provided:
 - The individual is an employee whose health coverage has been terminated by their employer; or
 - The individual is a Dependent who no longer qualifies as a Dependent under the terms of a medical plan; or
 - The individual or the Dependent of an individual who no longer has health coverage as a result of termination or change in employment of the individual or by reason of death of a spouse or dissolution of marriage.
- You have not had medical coverage previously terminated for cause.

Adding Dependents

As a Subscriber, you may enroll a legally acquired new Dependent within 31 days after you acquire the Dependent by notifying the Lovelace Health Plan, completing and submitting any necessary enrollment forms and proof of dependency to the Plan, and paying any necessary additional Premium, all within the 31-day period. If you perform these obligations within the 31-day period, then:

- Your newborn, natural child will be covered for 31 days after birth provided any applicable Premium has been paid. The child must be enrolled during the 31-day period for coverage to continue. If the Premium is not paid or the newborn is not added to the Plan within the 31-day period, the newborn coverage will be canceled on the mother's discharge date.
- Your adopted child will automatically become a Member upon the date of placement with you or your spouse for purposes of adoption, if the child is enrolled within 31 days after the date of placement. A copy of the court or agency order granting placement for purposes of adoption must be provided to the Plan Administrator within the 31-day period.
- A child for whom you or your spouse obtains legal custody, or becomes a legal guardian may be enrolled in the Plan. The child must be enrolled within 31 days after the date of the court order granting custody or guardianship. A copy of the court order must be provided to the Plan Administrator within 31 days after the order is filed for record with the clerk of the court. The child will become a Member on the date the order is filed with the clerk of the court.

WHO MAY ENROLL

- A child for whom the Subscriber or the Subscriber's spouse is required by a court or administrative order to provide health coverage may be added at any time. The non-custodial parent, or the state Medicaid agency or child support enforcement agency must provide the Plan Administrator with a copy of the order. Dependent coverage will become effective for the child on the date specified by the court or administrative order. Payment of any necessary additional Premium will be required at the time of enrollment. The Dependent can reside outside of the Service Area.
- After expiration of the 31-day period for initial eligibility, you may enroll legally acquired new Dependents only during a subsequent open enrollment period. The only exception is for a child of a non-custodial parent who is a Member and who is required by a court or administrative order to provide health coverage and the parent is eligible for family coverage.

Change of Status

Changes in Dependent status, marital status, place of work or residence (in or out of the Service Area), or leaving a Group may affect your Plan coverage. You must notify the Plan Administrator about such changes as soon as they occur. If you are enrolled in the Plan through a Group, please request that they notify the Plan Administrator immediately. If you are enrolled in the Plan through an individual Agreement, please call a Lovelace Member Services Representative.

Continuing Enrollment

Subscribers and their Dependents already enrolled in the Plan through a Group on the effective date of a new Contract Year may be automatically re-enrolled for the year beginning on that effective date, unless the Subscriber notifies the Group of his or her intent to cancel membership. Contact the Group's benefit administrator's office for specific procedures. Subscribers and their Dependents enrolled individually are automatically re-enrolled month to month, unless the Subscriber notifies the Plan Administrator of his or her intent to cancel membership.

If You are a New Member

You will become a Member of the Plan on the date your enrollment application is accepted by the Plan Administrator. You will be covered for only those Covered Services provided or arranged by your PCP and authorized by the Plan Medical Director or designee. Your PCP will be responsible for your care, refer you to Specialists as needed when Medically Necessary, and will arrange and direct any hospital care. If you or a covered Dependent is hospitalized on the date your coverage becomes effective, you must notify the Plan Administrator so that your care can be transferred to a Plan Provider.

Pre-Existing Conditions

Lovelace Health Plan does not does exclude coverage for pre-existing conditions, nor does Lovelace Health Plan impose any waiting period for those enrolling in this Plan, either as individuals or members of a group, as the result of a Pre-Existing Condition.

TERMINATION

Term

Individual membership will continue in effect for each subsequent monthly coverage period for which a Premium is paid, except as provided below.

Termination

You may terminate your membership in the Plan by:

- Notifying the Plan Administrator in writing 30 days in advance;
- Notify your Group; or
- Failure to make a Premium payment

Non-Group Members who terminate Plan coverage for themselves and their covered Dependents are not eligible for any COBRA continuation, individual conversion or extended benefits offered by Lovelace.

You must check with your Group or refer to the Agreement regarding re-enrollment procedures. Any Subscriber or their Dependents who terminate their membership in the Plan are eligible to re-enroll only in accordance with the terms of the Agreement.

The Plan Administrator may terminate your membership and that of your Dependents for cause, upon 15 days written notice, or with written notice effective immediately for gross misconduct. Cause for termination or a Subscriber and covered Dependents may include any of the following:

- Failure to pay Premiums.
- Failure to pay Co-payments.
- Failure to pay for non-Covered Services.
- Permitting an unauthorized person to use your Plan I.D. card (unless you notified the Plan Administrator that your card was lost or stolen).
- Repeated failure to keep appointments for medical care.
- Refusal of Plan benefits.
- Abuse of Plan coverage by such actions as providing false information on applications or forms.
- Failure to follow Plan rules and regulations.
- Verbal or physical threats to a Lovelace employee or Plan Provider.
- Fraudulent receipt of Plan services for non-Members.
- Failure to comply with subrogation rules.

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; refusal to follow a prescribed course of treatment; and if you are hospitalized with a life-threatening condition. 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

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Members terminated for cause are not eligible for any COBRA continuation, individual conversion or extended benefits provided by Lovelace or the Plan.

For Members who move outside of the Service Area, coverage will end on the last day of the month of the move (except for the Dependent child of a non-custodial parent who is required by a court or administrative order to provide health coverage).

If your Group chooses not to continue Plan coverage or if the Plan Administrator terminates your Group for cause, Plan benefits end on the effective date of termination. You or your Dependents will be billed at the Plan Provider's usual and customary fees for health care services received after termination of your membership. If you learn that your Group will cease to offer coverage under this Plan and you or your covered Dependent is either hospitalized or pregnant, please call the Plan Administrator immediately to arrange for Premium payment and benefit continuation.

Group Continuation Privileges Under COBRA

Some Groups are required to offer continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended. Please check with your Group to determine if these privileges are available to you. If so, these privileges will be available regardless of your health status unless:

- Your Group stops offering any health coverage to its employees;
- You terminate your Group Plan membership; or
- The Plan Administrator terminates your membership for cause.

For you or your Dependents to be eligible for continuation of coverage under COBRA, one or more of the following conditions must be met:

- Death of the covered employee.
- Termination of the covered employee for reasons other than gross misconduct.
- Reduction in a covered employee's hours of employment which resulted in loss of eligibility for Group coverage.
- Disability of the covered employee or a Dependent.
- Divorce or legal separation of the covered employee from the employee's spouse.
- Covered employee becoming entitled to Medicare coverage.
- Cessation of a Dependent child's coverage under the terms of the Agreement.
- Bankruptcy is initiated against the employer of a retired employee, causing the retired employee or Dependents to lose coverage.

If COBRA continuation coverage is elected by you or your Dependent, the continuation coverage begins on the date that Group coverage ends. For widowed spouses, divorced spouses, spouses of Medicare eligible employees, and Dependent children who become ineligible for Group coverage under the Plan, the continuation coverage may be provided up to 36 months. Coverage for terminated employees or employees whose work hours are reduced, and their eligible Dependents may be provided for up to 18 months.

Coverage for disabled employees or their disabled Dependents may be provided for up to 29 months. Coverage for retired employees and Dependents who lose coverage because of bankruptcy of the employer of the retired employee may be continued until the death of the retired employee or (for Dependents) until 36

TERMINATION

months after the death of the retired employee.

No COBRA coverage however, will be provided if:

- You fail to make timely payments to the Group benefit administrator;
- You or your Dependent becomes a covered employee under another group health plan and is not subject to preexisting condition clauses;
- Your spouse remarries and becomes covered under another group health plan and is not subject to preexisting condition clauses;
- Your spouse or Dependent becomes entitled to Medicare benefits; or
- Your employer ceases to provide any health plan to its employees.

A monthly Premium will be charged for COBRA continuation coverage. The Premium will be determined at the time of eligibility and may be subject to change.

If you or your Dependent becomes aware of a qualifying event (such as divorce, legal separation, or a Dependent reaching the age of 25), you or your Dependent must notify the Group benefit administrator within 60 days of the event, and obtain and complete an election form. This form must be completed and returned by the date shown on the form.

At the end of the continuation period, you, your spouse and other eligible Dependents will have the option of converting your COBRA coverage to the individual conversion option provided by Lovelace.

If you have questions about this benefit, you should consult your Group benefit administrator.

Individual Conversion Privileges

If enrollment through your Group is no longer available to you, you may continue your Plan coverage by converting your membership to individual coverage. You must notify your Group benefit administrator and the Plan Administrator within 30 days after termination of your Group membership. If you or your covered Dependents are on COBRA continuation status, you have 60 days before your coverage ends to notify the Plan Administrator of your intention to convert to individual membership. The Plan Administrator will then send an individual conversion application directly to you. The effective date of individual conversion coverage will be the date your eligibility for Group coverage ends.

For you or any of your Dependents who become eligible for Medicare, individual conversion privileges will be limited to membership in the Lovelace Senior Plan (LSP).

Discontinuance of the Plan

Lovelace reserves the right to discontinue the Care New Mexico Plan, at any time and for any reason in the sole discretion of Lovelace, and to terminate coverage for all Members upon 90 days notice. Notwithstanding any other provisions in this Brochure, if Lovelace discontinues the Plan, all rights of Members to benefits, including any continuation or conversion rights or any rights to extended benefits, will cease on the effective date of termination by Lovelace of the Plan.

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 became effective on April 14, 2003.

Lovelace Health Plan 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 Health Plan will not disclose confidential information without your authorization unless it is necessary to provide your health benefits, administer your benefit Plan, to support Lovelace Health Plan 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 Health Plan 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 Health Plan employees who need to know that information to conduct our business. Lovelace Health Plan 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 health plan or a health care Provider for its payment activities – for example for the other health 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 health 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.

NOTICE OF PRIVACY PRACTICES

- **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 your Employer as Sponsor of Your Plan.** We may disclose your confidential information to your employer or to a company acting on your employer's behalf, so that it can monitor, audit and otherwise administer the employee health benefit Plan in which you participate. Your employer is not permitted to use the confidential information we disclose for any purpose other than administration of your health benefit Plan. Your employer's health benefit Plan documents will say whether your employer receives confidential information and will identify the employees who are authorized to receive your confidential information.
- **Disclosure to Lovelace Health Plan 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 Health Plan also discloses confidential information to accreditation organizations such as the National Committee for Quality Assurance (NCQA) when the NCQA auditors collect Health 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.

NOTICE OF PRIVACY PRACTICES

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 Privacy 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 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 Lovelace Health Plan Customer Care Center at the toll-free number on your Lovelace Health Plan 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 Privacy Rights,” you must complete and mail us the appropriate form. To obtain the form, please contact the Lovelace Health Plan Customer Care Center at the toll-free number on your Lovelace Health Plan 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.

NOTICE OF PRIVACY PRACTICES

For More Information 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:

Lovelace Health Plan

Privacy Officer

PO Box 27107

Albuquerque, NM 87125-7101

Telephone Number: 505.232.1881 (In Albuquerque)

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 Health Plan benefit Plan at that time. You also may obtain any new notice by contacting the Lovelace Health Plan Customer Care Center at the toll-free number on your Lovelace Health Plan ID card.

GENERAL PROVISIONS

Affirmation Statement Regarding Plan Decisions

Lovelace Health Plan only makes utilization management decisions based on appropriateness of care, service and existence of coverage. Lovelace Health 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.

Amendments

This EOC shall be subject to amendment, including exclusion for specific conditions, modification, premium rate changes, or termination in accordance with their provisions or by mutual agreement in writing between Lovelace Health Plan and the Employer Group(s).

Circumstances beyond the Plan's Control

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

Evaluating New Technology for Inclusion as a Covered Benefit

Lovelace Health Plan excludes coverage of diagnostic tests, medications, medical procedures and other health care services that are considered by Lovelace Health Plan to be experimental or investigational in nature. We have a process to evaluate health services that might be considered experimental or investigational. If Lovelace Health Plan determines the procedure or service is experimental or investigational, the service will not be covered by this Plan. If you agree to receive these services, you may be responsible for the charges.

The Medical Director will perform a search of the published, peer-reviewed medical literature to see if there is support for a particular health care service. This support will generally be in the form of prospective, randomized, controlled clinical trials that support the safety and effectiveness of the health care service in question. If the Medical Director is not able to locate support, he/she may consult with an outside vendor that the Plan uses to help us evaluate new technologies. Finally, Lovelace Health Plan has a Technology Assessment Committee that can assist us 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.

Governing Law

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

Independent Contractors

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

GENERAL PROVISIONS

Medical Records

Lovelace Health Plan keeps medical and other information private. It is used for administering the Plan and for medical research or education. Information may also be used to determine subrogation issues and to coordinate benefits with other insurance coverages. The information may also be needed to review a disputed claim. To get a copy of your own medical records maintained by Lovelace Health Plan, you will need to sign a special form.

Misrepresentation of Information

If Lovelace Health Plan determines that information was intentionally omitted from a Member's coverage application or is inaccurate, there are serious consequences. If this is discovered within two (2) years 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.

Non-Member Custodial Parent Rights

Lovelace Health Plan acknowledges the rights of Custodial Parent of children who are covered under a Non-Custodial Parents policy. Custodial parents are able to contact Lovelace Health Plan and obtain and provide necessary information including but not limited to provider information, claim information and benefit/services information for that child.

Notice of Claim

Written notice of claim must be given to Lovelace Health Plan within 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, including those claims submitted by a member's beneficiary.

Premium Increases

Should there be an increase in the premiums associated with this plan, Lovelace Health Plan will provide written notice to policyholders and the increase will not be effective without at least a sixty (60) day prior notice.

Recovery of Excess Benefits

An "excess benefit" is a service or benefit not covered by this Plan, but provided by Lovelace Health Plan. Lovelace Health Plan shall have the right to recover the excess benefit. If the excess benefit is a service, recovery shall be based upon the usual and customary 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 Health Plan's alone. It is used at Lovelace Health Plan's sole discretion. If Lovelace Health Plan asks, you (or your legal representative if you are a minor or legally incompetent) will give to Lovelace Health Plan what is needed to secure these recovery rights.

GLOSSARY

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

Administrative Grievance: An expression of dissatisfaction with any aspect of your health benefits plan, other than a request for health care services, including, but not limited to: administrative practices of Lovelace Health Plan that affected the availability, delivery or quality of health care services; claims payment, handling or reimbursement for health care services; and terminations of coverage.

Agreement (Individual or Group): The legal contract for the provision of the Plan between Lovelace and the Group or the legal contract for the provision of the Plan between Lovelace and the Subscriber.

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.

Appeal of Adverse Determination: A complaint involving the review of a denial of services based on coverage or Medical Necessity.

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

Calendar Year: The period of time beginning January 1 and ending December 31 of any given year.

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.

Concern/Complaint: The first contact with the Lovelace Health Plan Customer Care Center expressing dissatisfaction from a Member.

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

Continuous Quality Improvement: An ongoing and systematic effort to measure, evaluate, and improve a managed health care plan's process in order to continually improve the quality of health care services provided to its enrollees.

Co-Payment: 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 period of time for which the Agreement is in effect.

Court Ordered Dependent: A dependent for which an employee or Subscriber has been ordered by the courts to provide health insurance.

GLOSSARY

Covered Benefit/Services: Benefits, services and supplies as described in the EOC Handbook and/or the Summary of Benefits. In order for a member to receive coverage for Benefits and Services, member must meet eligibility requirements and services must be Medically Necessary. Some Covered Services require Prior Authorization by the Plan.

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

Emergency Medical Conditions: 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 his or her health, if pregnant the health of themselves or their unborn child, 2) Serious impairment to the bodily functions; 3) Serious dysfunction of any bodily organ or part; or 4) Disfigurement to the person.

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.

Enrollee: Any individual who is entitled to receive health care benefits; an individual who has enrolled in a Lovelace Health Plan and whom has met all the enrollment and eligibility requirements as defined.

Evidence of Coverage: This document is the Evidence of Coverage (EOC); it is a clear and conspicuous written document of the essential features and medical services covered by the Plan and is given to the enrollee or subscriber by the Plan. It includes the Summary of Benefits.

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

Grievance: Any expression of dissatisfaction from any Member, Provider or their duly appointed representative.

Group: The employer or contract holder; a Group consists of fewer than twenty individuals, including self-employed individuals formed for purposes other than obtaining insurance coverage, provided that the Group meets the Plan eligibility criteria.

Health Care Facility: An institution providing health care services, including a hospital or other licensed inpatient center; an ambulatory surgical or treatment center; a skilled nursing center; a residential treatment center; a home health agency; a diagnostic, laboratory or imaging center; and a rehabilitation or other therapeutic health setting.

Health Care Professional: An individual other than a physician who is licensed or otherwise authorized under the applicable state law to deliver medical services, within the scope of his/her license, and who has an agreement with Lovelace Health Plan to render services to Members.

Health Plan: A health maintenance organization organized under the applicable laws of the State of New Mexico and known as the "Lovelace Health Plan." The Health Plan oversees the administration of the Plan benefits and the delivery of health care coverage. (Also referred to as the health care insurer.)

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Health Care Services: includes, to the extent offered by the Member's Plan, physical health or community-based mental health or developmental disability services, including services for developmental delay.

Health Maintenance Organization (HMO): any person who undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for co-payments or deductibles. An HMO is a type of Managed Care Organization that provides a form of health insurance coverage that is fulfilled through hospitals, doctors, and other providers with which the HMO has a contract.

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

Home Healthcare: means health services provided on a part-time, intermittent basis to an individual confined to his or her home due to physical illness.

Hospital: means a facility which is maintained by the state or any political subdivision of the state or any place which is currently licensed as an acute care hospital by the department of health and has accommodations for resident bed patients, a licensed professional registered nurse always on duty or call, a laboratory and an operating room where surgical operations are performed, but the term does not include convalescent, nursing or rest homes or facilities primarily for the treatment of substance abuse.

Independent Quality Review Organization (IQRO): means an organization independent of the health care insurer or managed health care plan that performs external quality audits of managed health care plans and submits reports of its findings to both the managed health care plan and to the Department of Insurance.

Independent Utilization Review Organization: means a board independent of Lovelace Health Plan and appointed by the Superintendent of Insurance, consisting of two physicians and one attorney, all of whom are duly licensed in the State of New Mexico, who will hear utilization management grievances in accordance with regulations adopted by the Superintendent of Insurance.

Mandatory Medical Support Order: A document from a State or Federal governmental agency ordering an individual to provide health insurance coverage for specific dependents.

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

Medical Necessity or Medically Necessary: Health care services determined by a Lovelace Health Plan, in consultation with a Participating Provider, 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, or boards and associations. Applicable clinical protocols or practice guidelines, developed by Lovelace Health Plan are consistent with the diagnosis or direct care and treatment of the condition for which they are required. Services must be required for purposes other than the comfort and convenience of the Member or their Participating Provider.

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.

GLOSSARY

Member: Any Subscriber or Dependent who elects the Plan coverage and for whom the required Premium has been received by Lovelace Health Plan.

Non-Participating/Non-Contracted Provider: A physician, facility or ancillary Provider not contracted with the Lovelace Health Plan. Services provided by a Non-Participating/Non-Contracted Provider will not be covered except in urgent or emergency situations or as authorized by Lovelace Health Plan.

Obstetrician/Gynecologist: A physician who is board eligible or board certified by the American Board of Obstetricians and Gynecologists or by the American College of Osteopathic Obstetricians and Gynecologists.

Participating Provider: Duly licensed individual Provider/Practitioner, or institutional provider of health care services, which has entered into an agreement/contract with Lovelace Health Plan to provide healthcare services to its Members. May include, but is not limited to, hospitals, physicians, dentists, pharmacies, facilities or ancillary Providers of the healing arts, acting within the scope of their license. Participating Providers have an expectation of receiving payment, other than Co-Payments, directly or indirectly from Lovelace Health Plan. May also be referred to as Plan Provider, Contracted Provider or Network Provider.

Participating Physician: Any doctor of medicine, osteopathy, dentistry, optometry, and podiatry, Practitioner of healing arts, doctors of oriental medicine, chiropractic or other specialties contracted with Lovelace Health Plan to provide services to its Members.

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.

Plan: The Plan established by Lovelace to provide health care to Members by Plan Providers, as the Plan exists on the effective date of the Agreement or as subsequently amended.

Precertification (see also Prior Authorization): A system whereby a Provider must receive approval from the Lovelace Health Plan's Medical Director before a Member receives specialty care in order for certain health care services and benefits to be covered. These services require oversight by Lovelace Health Plan or are a limited benefit and have time limits on when services can be provided.

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

Primary Care Physician (PCP): A Plan Physician who is responsible for a Member's care, providing appropriate services and referrals to Specialists as needed. (Formal referrals are not required by Lovelace Health Plan.) PCPs are able to take care of any basic problem including but not limited to behavioral health, preventive care, chronic disease, OB/GYN care, orthopedic, and dermatology services. PCPs include but are not limited to physicians who practice: family/general practice, internal medicine, pediatrics, and obstetrics/gynecology.

Prior Authorization (see also Precertification): A system whereby a Provider must receive approval from the Lovelace Health Plan's Medical Director before a Member receives specialty care in order for certain health

GLOSSARY

care services and benefits to be covered. These services require oversight by Lovelace Health Plan or are a limited benefit and have time limits on when services can be provided.

Provider/Practitioner: Any duly licensed hospital or other facility, physician or other health professional authorized to furnish health services within the scope of their license.

Provider Network: Those Providers who have contracted with Lovelace Health Plan individually or as groups to provide care and service to Lovelace Health Plan Members. Certain referral requirements may apply. Check with the Lovelace Health Plan Customer Care Center for details.

Quality of Care Issue: Complaint regarding allegations of inappropriate medical care that may include but are not limited to improper treatment, surgical complications or continuity of care.

Quality of Service Issue: Complaint regarding dissatisfaction with delivery of services pertaining to accessibility in appointment scheduling, wait time for appointment, attitude of staff or physicians, and issues of facility cleanliness, parking or waiting areas.

Registered lay midwife means any person who practices lay midwifery and is registered as a lay midwife by the New Mexico Department of Health.

Screening mammography: A radiologic examination utilized to detect unsuspected breast cancer at an early stage in asymptomatic persons and includes the x-ray examination of the breast using equipment that is specifically for mammography, including the x-ray tube, filter, compression device, screens, film, and cassettes, and that has an average radiation exposure delivery or less than one rad mid-breast. Screening mammography includes two views for each breast. Screening mammography includes the professional interpretation of the film, but does not include diagnostic mammography.

Service Area: The Service Area is the geographical area, approved by the appropriate State agency, within which Plan Providers are accessible to Members.

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: An active employee of an Employer Group, or entitled as a retiree or otherwise to participate in the medical benefits arranged by the Employer Group, or any other individual, who meets the established eligibility requirements and is entitled to membership on his or her own behalf and not as the Dependent of another person.

Summary of Benefits: An attachment to the EOC Handbook that describes applicable benefits and Co-Payment amounts for the Plan selected by the Employer Group for the Members of the Employer Group.

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

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about the effect of the Technology on health outcomes. The Technology must improve the net health outcome. The Technology must be as beneficial as any established alternatives. The improvement must be attainable outside of investigational settings.

Tertiary Care Facility: A hospital unit, which provides complete perinatal care and intensive care of intrapartum and perinatal high-risk patients with responsibilities for coordination of transport, communication, education and data analysis systems for the geographic area served.

Transition of Care: A process whereby new Members in an active, on-going course of treatment, with approval from a Lovelace Health Plan Medical Director, may be permitted to continue to receive care from their current health care Provider for a transitional period of time, even though the Provider may not be a Member of the Lovelace Health Plan's Provider Network. This process also permits new Members who, at the effective date of enrollment, have entered their third trimester of pregnancy to continue receiving care from their current health care Provider to include post-partum care directly related to the delivery. New Members must submit the request for Transition of Care to Lovelace Health Plan within thirty (30) days of enrollment.

Transition of care services may also be available for existing Members with certain medical Conditions and those in their second and third trimester so they can have continued access to their Provider when the Provider's contract ends. The Member does not need to request continued care since the care is coordinated through Lovelace Health Plan Health Plan. Lovelace Health Plan makes Transition of Care determinations for new and existing Members based on established criteria.

Urgent Care Services: Medically Necessary health care services provided for urgent illnesses after a PCP's normal business hours for unforeseen Conditions due to illness or injury that are not life-threatening but require prompt medical attention.

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

Usual and Customary Charges: The amount determined by Lovelace Health Plan to be payable under the Plan for services rendered to Members by non-Participating Providers. Payable amounts are based on the following criteria: fees that a Provider usually charges for a given service; fees which fall within the range of usual charges for a given service filed by most professional Providers who have similar training and experience in the same locality; fees which are usual and customary or which would not be considered excessive in a particular case because of unusual circumstances.

Utilization Review/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.

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.

Physical Address:

Altura Office Complex
4101 Indian School Road NE #110 South
Albuquerque NM 87110-3988

Mailing Address:

P. O. Box 27107
Albuquerque NM 87125-7107

- Lovelace Health Plan Customer Care Center 505.232.1881 or 1.800.808.7363*
 - Behavioral Health Services 505.816.6605 or 888.684.0461*
 - Subrogation Services 505.262.3742 or 1.800.808.7363*
 - Nurse Advice Line 1.877.725.2552
(Available twenty-four [24] hours a day, seven [7] days a week)
 - Telecommunication Device for the Deaf (TDD) 800-659-8331
TTY Services provided by Relay NM
 - Consumer Assistance Office 505.232.1870 or 1.800.808.7363*
 - Disease Management LifeLong Steps..... 505.232.1844 or 1.877.480.9368*
- *Outside of Albuquerque

Visit our web site at: lovelacehealthplan.com

Please refer to the Provider Directory for a listing of Participating Providers and/or facilities.

We look forward to providing services to you and assisting you in using your benefits.

Thank you for selecting the Lovelace Health Plan.

