



# Individual Plan

## Benefit Comparison Grid

# Individual Plan Benefit Comparison Grid

		Member's Cost, Co-Payment or Co-Insurance			
		In-Network Participating Provider	Out-of-Network Non-Participating Provider	In-Network Participating Provider	Out-of-Network Non-Participating Provider
Annual Deductible	Deductible applies and must be met before Plan payments are made, unless otherwise noted. <sup>3</sup>	Option 1: \$ 1500 Option 2: \$ 2000 Option 3: \$ 4000	\$ 3000 \$ 4000 \$ 8000	Option 4: \$ 250 Option 5: \$ 500 Option 6: \$ 750 Option 7: \$1000 Option 8: \$2000	\$ 500 \$ 1000 \$ 2000 \$ 2000 \$ 4000
Annual Out-of-Pocket Maximum	Includes Co-Insurance only; does not include Deductible, penalty amounts, Co-Payments, charges above Usual & Customary (U&C), premium payments or non-covered charges.	Option 1: \$ 3000 Option 2: \$ 4000 Option 3: \$ 8000	\$ 6000 \$ 8000 \$16000	Option 4: \$1000 Option 5: \$2000 Option 6: \$2000 Option 7: \$2000 Option 8: \$4000	\$ 2000 \$ 4000 \$ 4000 \$ 4000 \$ 8000
Preventive Care Services <sup>5</sup>	Not subject to Deductible Covered services include: <ul style="list-style-type: none"> <li>• Routine physicals</li> <li>• Adult &amp; Child Immunizations</li> <li>• Annual Men's Exam</li> <li>• Annual Women's Exam, including preventive mammogram</li> <li>• Health and Family Planning education</li> <li>• Well Baby/Child Care</li> <li>• Vision and Hearing Screening (members age 17 and under)</li> <li>• Preventive Colonoscopy</li> </ul>	<u>Co-Payment per Non-Specialist Office Visit:</u> Option 1, 2, 3: \$25/visit  <u>Co-Payment per Specialist Office Visit:</u> Option 1, 2, 3: \$35/visit	Not a benefit	<u>Co-Payment per Non-Specialist Office visit:</u> Option 4, 5, 6: \$15/visit Option 7, 8: \$20/visit  <u>Co-Payment per Specialist office visit:</u> Option 4, 5, 6: \$20/visit Option 7, 8: \$30/visit	Not a benefit
Medical Office Visits <sup>5</sup>	In-Network visits not subject to Deductible  Diagnostic and treatment (non-preventive) services rendered in an office setting	<u>Co-Payment per Non-Specialist Office Visit:</u> Option 1, 2, 3: \$25/visit  <u>Co-Payment per Specialist Office Visit:</u> Option 1, 2, 3: \$35/visit	50%	<u>Co-Payment per Non-Specialist Office visit:</u> Option 4, 5, 6: \$15/visit Option 7, 8: \$20/visit  <u>Co-Payment per Specialist office visit:</u> Option 4, 5, 6: \$20/visit Option 7, 8: \$30/visit	40%
Allergy Services	Allergy Services include: <ul style="list-style-type: none"> <li>• Testing, Treatment, Serum extracts and Injections</li> </ul>	30%	50%	20%	40%

Contact a Lovelace Individual Plan sales representative for a more complete description of covered benefits, limitations and exclusions at (505) 232-1982 or (877) 232-1982.

# Individual Plan Benefit Comparison Grid

		Member's Cost, Co-Payment or Co-Insurance			
		In-Network Participating Provider	Out-of-Network Non-Participating Provider	In-Network Participating Provider	Out-of-Network Non-Participating Provider
Outpatient Medical Services	Service provided in an outpatient setting, including:				
	• Outpatient/Ambulatory surgery	30%	50%	20%	40%
	• Injections/Injectable medications	30%	50%	20%	40%
	• Norplant insertion & removal	30%	50%	20%	40%
	• Transfusion of Blood	30%	50%	20%	40%
	• Dialysis & ESRD	30%	50%	20%	40%
• Radiation therapy	30%	50%	20%	40%	
• Chemotherapy	30%	50%	20%	40%	
Lab & Imaging/Radiology Services	Diagnostic testing, including, but not limited to:				
	• Laboratory tests	30%	50%	20%	40%
	• X-Rays, EEGs and EKGs	30%	50%	20%	40%
	• MRI, PET & CT Scans	30%	50%	20%	40%
Outpatient Short Term Rehabilitation & Therapy Services <sup>4</sup>	Physical, Cardiac, Occupational, Speech <sup>2</sup> , Acupuncture and Chiropractic care  60 visits per Contract Year combined maximum	30%	50%	20%	40%
Ambulance Services	Ground & Air Transport	30%	50%	20%	40%
Emergency & Urgent Care	Co-Payments not subject to Deductible				
	• Emergency Room Visit	\$100	\$100	\$100	\$100
	• Urgent Care Visit	\$ 50	50% (Subject to Deductible)	\$ 50	40% (Subject to Deductible)
	• Worldwide Emergency Care	\$100	\$100	\$100	\$100
Inpatient Hospital Services <sup>1</sup>	Service provided during an admission to an Inpatient facility, including:				
	• Semiprivate Room and Board	30%	50%	20%	40%
	• Physician and Surgeon Charges	30%	50%	20%	40%
	• Diagnostic and Therapeutic	30%	50%	20%	40%
	• Lab and X-ray	30%	50%	20%	40%
	• Hemodialysis (member must apply for Medicare benefits)	30%	50%	20%	40%
	• Drugs and Medications	30%	50%	20%	40%
• Operating and Recovery Room	30%	50%	20%	40%	
Inpatient Services at Other Health Care Facilities <sup>1,4</sup>	Skilled Nursing, Rehabilitation & Sub-Acute Facilities  60 days per Contract Year combined maximum	30%	50%	20%	40%
Home Health Services	Prescribed home nursing care, physician and therapy care  100 visits per Contract Year combined maximum	30%	Not a benefit	20%	Not a benefit

Contact a Lovelace Individual Plan sales representative for a more complete description of covered benefits, limitations and exclusions at (505) 232-1982 or (877) 232-1982.

# Individual Plan Benefit Comparison Grid

		Member's Cost, Co-Payment or Co-Insurance			
		In-Network Participating Provider	Out-of-Network Non-Participating Provider	In-Network Participating Provider	Out-of-Network Non-Participating Provider
Hospice Care Services	Specified Hospice Care Services (which are reasonable and necessary for the palliation or management of terminal illness) Combined lifetime maximum benefit for both In & Out of Network is \$7,500	30%	50%	20%	40%
Transplants	Must be received at a Lovelace approved facility For details regarding specific transplant coverage, refer to the EOC & Handbook Lifetime maximum benefit	30% \$500,000	Not a benefit	20% \$500,000	Not a benefit
Durable Medical Equipment	Specified durable medical equipment Maximum per Contract Year	30% \$3,500	Not a benefit	20% \$3,500	Not a benefit
External Prosthetic Appliances	Specified external prosthetic appliances Maximum per Contract Year	30% \$3,500	Not a benefit	20% \$3,500	Not a benefit
Prescription Drugs	Not subject to Deductible  A maximum of a 30-day supply and a maximum of 480ml for liquids, and the customary therapeutic regime for other products. Coverage includes Insulin, glucose test strips, other prescription diabetic supplies, birth control, contraceptive devices and oral contraceptives  Mail Order is double the co-pay for a 90-day supply. If you'd like information and/or to order a Mail Order Rx Kit, contact the Customer Care Center	\$10 per Rx or refill for formulary generic drugs  \$35 per Rx or refill for formulary name brand drugs with no generic equivalent  \$55 per Rx or refill for name brand drugs with a generic equivalent or for non-formulary drugs	Not a benefit	\$10 per Rx or refill for formulary generic drugs  \$35 per Rx or refill for formulary name brand drugs with no generic equivalent  \$55 per Rx or refill for name brand drugs with a generic equivalent or for non-formulary drugs	Not a benefit
Lifetime Maximum	There is no lifetime maximum benefit for In-Network benefits. However, certain benefits have annual limits or maximums. There is a \$1,000,000 lifetime maximum for Out-of-Network benefits.				
Pre-existing Condition Limitation	A condition is pre-existing if it is a physical or mental condition for which medical advice, medication, diagnosis, care or treatment was recommended, or for which a reasonable person would have sought treatment, within a six-month period before the effective date of coverage. No benefits are available for pre-existing conditions for six months after the effective date of coverage.				

Lovelace Insurance Company provides the above benefits when Medically Necessary. Prior authorization is required for certain services. Contact the Customer Care Center for information regarding which services require prior authorization before services are received. Unless otherwise noted, Co-Payments, Deductible and/or Co-Insurance amounts are due at the time of service. This is only a summary that lists the Deductible, Co-Insurance, Co-Payment and Out-of-Pocket amounts, and provides a brief description of the Plan. For detailed benefit information, please refer to the Evidence of Coverage & Handbook.

Contact a Lovelace Individual Plan sales representative for a more complete description of covered benefits, limitations and exclusions at (505) 232-1982 or (877) 232-1982.

# Individual Plan Benefit Comparison Grid

## EXCLUSIONS

Refer to the Plan Evidence of Coverage (EOC) & Handbook for a complete listing of Plan Exclusions. Your Plan provides coverage for Medically Necessary services. Some services require prior authorization by the Plan Medical Director. Your Plan does not provide coverage for the following, except as required by law:

- Services that are not Medically Necessary, except for services authorized by the Plan
- Maternity Care, including pre-natal care and delivery
- Behavioral/Mental Health Services
- Cosmetic Surgery, except as authorized by the Plan or as listed in the EOC/Handbook
- Routine Dental Services (coverage may be available if you select an optional dental benefit package)
- Drugs and medicines purchased without a doctor's prescription. Prescription drugs are covered except as defined in the EOC/Handbook
- Rehabilitative treatment programs for alcoholism or drug addiction, including inpatient detoxification
- Organ transplants, except as provided in this Summary, the EOC/Handbook and unless approved by the Plan Medical Director
- The medical and hospital services of a donor when the recipient of an organ transplant is not a Member or when the transplant procedure is not a covered benefit
- Experimental services, investigational procedures or protocols, including drugs or equipment, except as required by law
- Care for military service-connected disabilities for which the Member is legally entitled to service and for which facilities are reasonably available to the Member
- Custodial care, including but not limited to care primarily to meet personal needs which can be provided by persons without professional skills or training. Some examples are help in walking, getting in and out of bed, bathing, dressing, eating and taking medication
- Eye refraction measurements, eyeglasses, corrective lenses, other eye appliances, hearing aids, or the fitting of either eyeglasses or hearing aids
- Routine physical exams, checkups, medications and inoculations and/or Biologicals required for licensing, employment, marriage, insurance or travel purposes
- Vocational rehabilitation
- 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 surgery; reversal of voluntary sterilization.
- Nursing home care, except skilled nursing services provided in a Plan approved skilled nursing facility with authorization from the Plan
- Long-term rehabilitative therapy
- Expenses which an insured person would not legally have to pay if there were no insurance
- Infertility or artificial conception treatment, services or drugs

## EXCLUSIONS – continued

- Care for conditions that State or local law requires be treated in a public facility or court-ordered services which are not ordered by a Participating Physician and approved by the Plan Medical Director
- Repairs for Durable Medical Equipment (DME), prosthetic or orthotic devices that are owned by the Member
- Orthopedic shoes and arch supports are not covered unless they are Medically Necessary for the treatment of diabetes
- Non-surgical treatment of feet and bunions and routine foot care
- An injury or sickness due to the employment with an employer or self-employment
- Vitamins, minerals, food supplements (except Special Medical Foods as outlined in the EOC/Handbook), dietary nutrition counseling and weight loss or exercise programs of any type

## LIMITATIONS

Refer to the Plan Evidence of Coverage & Handbook for a complete listing of Plan Limitations. Your plan has limited coverage for the following services:

- Acupuncture
- Chiropractic services
- Circumstances beyond the Plan's control
- Consumable medical supplies
- Craniomandibular and temporomandibular joint (TMJ) dysfunction conditions – surgical and non-surgical treatment of TMJ is covered when Medically Necessary and authorized by the Plan Medical Director as required
- Dental care, except as required by law and as written in the EOC/Handbook (an optional dental benefit package may be selected)
- Home health services
- Only Medically Necessary Services by a podiatrist authorized by the plan, are covered
- Family planning evaluation and treatment services are limited to sperm count, hysterosalpingography and endometrial-biopsy; infertility services are not covered.
- Prescription medications
- Private duty nurse
- Private room accommodations
- Routine physical exams
- Substance abuse
- Tobacco cessation
- Rental benefits for medical equipment and other items will not exceed the purchase price of a new unit
- Select services must be performed by Participating Providers only. Some services do not have an Out-of-Network benefit
- After a member reaches the applicable Out-of-Pocket limit, Plan pays 100% of most of the covered In-Network or Out-of-Network charges for the rest of the Contract Year.
- Member is responsible for charges exceeding reasonable or Usual & Customary (U&C) amounts.

Contact a Lovelace Individual Plan sales representative for a more complete description of covered benefits, limitations and exclusions at (505) 232-1982 or (877) 232-1982.

# Individual Plan Benefit Comparison Grid

## FOOTNOTES:

- (1) All Inpatient Hospital Admissions require Pre-Admission Certification and Continued Stay Review. If your admission/stay is not approved there may be a reduction or denial of coverage.
- (2) Speech therapy that is not restorative in nature will not be covered.
- (3) Deductible must be met before benefit payments are made (excluding specified routine, emergent & preventive services). The In-Network and Out-of-Network Deductibles are separate. Payments made for In-Network services contribute to the In-Network Deductible only. Payments made for Out-of-Network services contribute to the Out-of-Network Deductible only.
- (4) Days/visits used under the In-Network Plan will be counted against the maximum days available for Out-of-Network Coverage.
- (5) Co-Payments are for the office visit only; other services received during the visit may be subject to appropriate Deductible and Co-Insurance amounts.

## THESE ARE ONLY HIGHLIGHTS OF THE PLAN'S FEATURES

This summary contains highlights only and is subject to change. The specific terms of coverage, exclusions and limitations are contained in the Evidence of Coverage & Handbook. If you have any questions about a specific service or treatment, contact the Customer Care Center at 262.7363 in Albuquerque, or 800.808.7363 outside of Albuquerque.

Inpatient hospitalization for any Emergency Service requires notification to the Plan within 48 hours of admission. Emergency Services are those services 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.