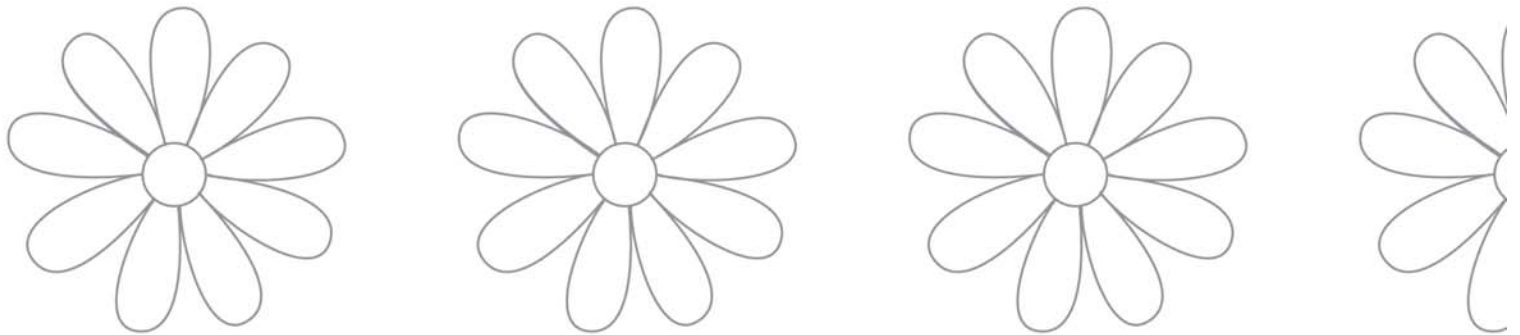
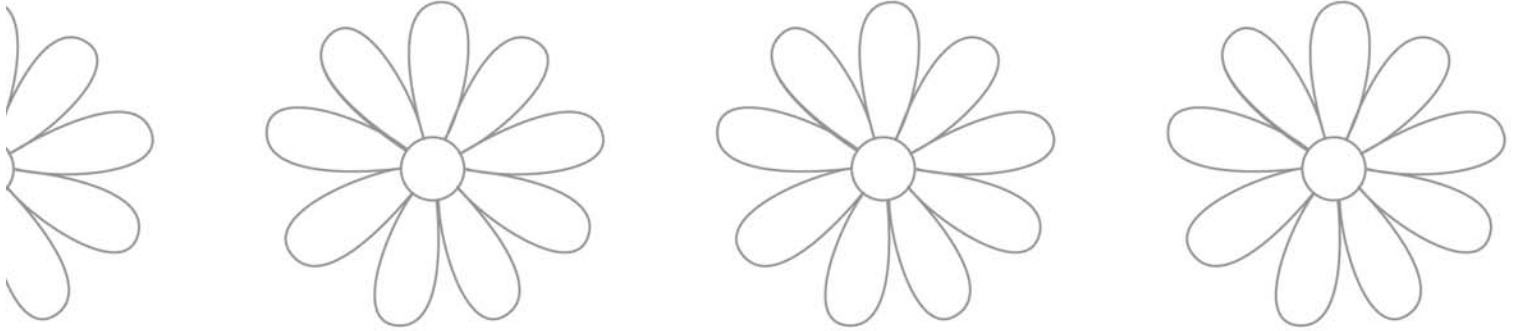


# **nmhia hmo coverage**

evidence of coverage 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.

We insure eligible participants (as determined by the New Mexico Health Insurance Alliance), 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, the Summary of Benefits (also called the "certificate") describes the features of 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, the Summary of Benefits 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 the 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 or the Summary of Benefits and are not responsible for knowing or communicating your Covered Benefits.

## **The Plan**

Lovelace Health Plan offers HMO Plans. Please read this section carefully, as well as your Summary of Benefits to fully understand the specific plan option you've chosen for you and any covered dependents. You may also contact our Customer Care Center at 505.727.5700 (In Albuquerque) or 800.808.7363 (outside of Albuquerque) if you have questions or need more information.

In order to receive the full value of this Plan, it is important to understand the terms, conditions and benefits. These services and benefits are detailed in this EOC Handbook and your specific Summary of Benefits.

By enrolling in this Plan you have agreed to the terms of the Agreement between Lovelace Health Plan and the New Mexico Health Insurance Alliance. 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 the New Mexico Health Insurance Alliance may change the benefits described in this EOC Handbook. If that happens, either Lovelace Health Plan or the New Mexico Health Insurance Alliance will notify you of any changes that will affect you or your covered Dependents. If there is any difference between the EOC Handbook and the Summary of Benefits and the Agreement, the Agreement will be followed.

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

**Lovelace Health Plan  
Customer Care Center  
505.727.5700 or 800.808.7363  
TTY Services provided by Relay New Mexico 800.659.8331**

**Lovelace Health Plan  
Consumer Assistance Office  
505.727.5700 or 800.808.7363  
Outside of Albuquerque**

**You may also visit our web site at: [www.lovelacehealthplan.com](http://www.lovelacehealthplan.com) for more useful information about your benefits and services.**

**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

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## RIGHTS AND RESPONSIBILITIES

Thank you for making Lovelace Health System, Inc. (Lovelace Health Plan) your choice for health care benefits. We are pleased that you have chosen a quality Health Care Insurer and we look forward to being your partner in health. We are committed to providing our Members high-quality health care insurance. 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, Lovelace Health Plan's policies and procedures regarding products, services, providers, appeal procedures and other information about Lovelace Health Plan and the benefits we provide under your plan. In addition, your rights include access to information about 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 Prior Authorization.
- To be treated in a manner that respects your privacy and dignity as a person.
- To participate with Providers in making decisions about your health care.
- To be given by your provider, in language you understand, an explanation of your medical condition; recommended treatment; risks of the treatment; expected results; and reasonable medical alternatives. If you are not able to understand the information, an explanation shall be given to your next of kin, guardian or another authorized person. Information shall be documented in your medical record.
- To choose a Primary Care Provider within the limits of covered benefits and plan network.
- To be informed by your Participating Provider about your treatment; to request your consent (agreement) to the treatment; to refuse treatment, including medication; to be told of the possible consequences of refusing such treatment. This right exists even if treatment is not a covered benefit or Medically Necessary, according to the Plan under which you are covered. The right to consent or agree to treatment may not be possible in a medical 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 us and/or the coverage we provide. A Member also has the right to receive an answer 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. 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 Lovelace Health Plan prepares and releases data but without identifying Members.
  - When necessary to support Lovelace Health Plan's programs or operations, including for payment and to evaluate quality and service.
- To be promptly informed of termination or changes in benefits, services or Participating Providers.
- To a complete explanation of why a benefit is denied; the opportunity to appeal the decision to Lovelace Health Plan; the right to a second level of appeal with Lovelace Health Plan; and the right to request help from the New Mexico Superintendent of Insurance.
- 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 adequate access to qualified health care professionals near where you live or work within the Lovelace Health Plan service area.

- To always have available and accessible services when medically necessary and covered services, including 24 hours per day, 7 days per week for urgent and emergency care services, and for other health care services as defined by the evidence of coverage or the Summary of Benefit and Rider(s) if applicable.
- To receive information about how benefits are authorized or denied. You have the right to know how new Technology 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 receive detailed information about all requirements that you must follow for prior authorization and utilization review.
- 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. You should carefully read and refer to this EOC Handbook and your Summary of Benefit and Rider(s) if applicable. 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 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 physician before receiving medical care, unless your Condition is life threatening.
- If you will be delayed or unable to keep an appointment, you should notify the Provider's office promptly.
- To pay all charges or Co-Payment/Co-Insurance amounts, including those for missed appointments. This also applies to deductibles and non-Covered Benefits and Services.
- To express your opinions, Concerns or Complaints in a constructive way to the Lovelace Health Plan Customer Care Center or your Provider.
- To inform your employer of any changes in family size, address, phone number or Membership status 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 notify the Lovelace Health Plan of other insurance coverage.
- To follow our Appeal and Grievance process when displeased with the Lovelace Health Plan's or Providers' actions or decisions.
- To understand your health problems and participate in developing mutually agreed upon treatment goals to the degree possible.

**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 505.727.5700 or 1.800.808.7363 (outside of Albuquerque) or TTY 800.659.8331.

## **PROTECTING YOUR CONFIDENTIALITY (GRAHAM, LEACH, BLILEY ACT)**

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?**

Our employees and organizations that act on our behalf 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 our 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, including electronic records.

### **What Types of Information Do We Disclose And To Whom?**

We 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:

- Providers, Plan Sponsors, and insurers that provide reinsurance or excess (stop loss) insurance;
- 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 we keep 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.

### **Notice of Confidentiality of Domestic Abuse Information**

There is a state confidentiality law that protects our Member's confidential information if they have been involved in domestic abuse. In processing your application for insurance or a claim for insurance benefits, Lovelace Health Plan may receive confidential domestic abuse information from sources other than you. If this happens, we are prohibited from using this or any other confidential abuse information or your status as a victim of domestic abuse as a basis for denying, refusing to insure, renew, or reissue or canceling, or otherwise terminating your health care coverage. We are also prohibited from restricting or excluding coverage or benefits or charging a higher premium for health coverage based on domestic abuse information.

As a health plan Member you have a right to access and correct all confidential domestic abuse information that we may have about you. A full or more comprehensive notice and explanation of confidential domestic abuse information practices as required by the law will be provided to you upon your request. If you are or have been a victim of domestic abuse you have the right to inform us of your wish to be designated as a protected person. As a protected person, confidential abuse information, which includes your address and telephone number, will remain confidential and will be disclosed and transferred only in accordance with state and federal laws.

If you wish to be designated as a protected person, please contact Lovelace Health Plan Customer Care Center, (505) 727-5683 or 1-800- 808-7363

## **NOTICE OF PRIVACY PRACTICES (HIPAA PRIVACY)**

**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 was effective February 17, 2010.

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, genetic information and other personal information and to send you this Notice about our policies, safeguards and practices. The term "genetic and 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. However, we are prohibited from using or disclosing genetic information to make any underwriting determinations, such as eligibility or rate setting. However, we are prohibited from using or disclosing genetic information to make any underwriting determinations, such as eligibility or rate setting. 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 for fraud and abuse detection, for disease management and/or 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.
- **Appointment Reminders and Treatment Alternatives:** We may use and disclose your confidential information for appointment reminders or send you information about treatment alternatives or other health-related benefits and services. If you receive anything of value for making these communications, we will notify you of this fact and you will have an opportunity to opt out of future communications.

- **Coverage Information and Treatment Alternatives.** We may use and disclose your confidential information to send you information about your coverage, 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 and may not use your confidential information for employment related actions or decisions or in connection with other benefits plans sponsored by your employer. 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 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 use and disclose your confidential information for public health activities authorized by law, such as preventing or controlling disease, reporting births and deaths, reporting child or adult abuse or neglect to government authorities, reporting reactions to medications, notifying people of recalls of products and alerting those who may have been exposed to a communicable disease
- **Individual involved in your care:** We may disclose your confidential information to close friends or family members who are involved in or help pay for your care. We may also advise your family members or close friends about your condition or location (such as that you are in the hospital).
- **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 as required by law.
- **Judicial and Administrative Proceedings.** We may disclose your confidential information in response to a court or administrative order and, under certain circumstances, a subpoena, warrant, discovery request or other lawful process.
- **Law Enforcement Officials.** We may disclose your confidential information to the police or other law enforcement officials, as required by law in compliance with a court order warrant or other process or request authorized by law to report a crime or as otherwise permitted 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 or other person.
- **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. State law may further limit the permissible ways we use or disclose your confidential information. If an applicable state law imposes stricter restrictions, we will comply with that state law.

## Uses and Disclosures with Your Written Authorization

We will not use or disclose your confidential information for any purpose other than the purposes described in this Notice without your written authorization. For example, we will not disclose psychotherapy notes, use or disclose your confidential information for marketing or sell your confidential information unless you have signed an authorization or applicable law permits the use or disclosure.

## 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. Except for disclosures to another health plan when you have paid in full out-of-pocket for your care.
- **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, if you believe that communication through normal business practices could endanger you. While we will consider reasonable requests carefully, we are not required to agree to all requests. Your request must specify how or where you wish to be contacted.
- **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 consistent with applicable law. If your information is stored electronically and you request an electronic copy, we will provide it to you in a readable electronic form and format.
- **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, except for 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 our 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.

## 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 Office. If we discover a breach involving your unsecured confidential information, we will notify you of the breach by letter or other method permitted by law. You may also file written complaints with the Secretary of U.S. Department of Health and Human Services ([www.hhs.gov/ocr/privacy](http://www.hhs.gov/ocr/privacy)). Please contact our Privacy Office 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	Telephone Number: 505.727.5700 (In Albuquerque)
Privacy Officer	800.808.7363 (Outside Albuquerque)
PO Box 27107	Fax Number: 505.727.5510
Albuquerque, NM 87125-7101	

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 issue 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 Customer Care Center.

## HOW YOUR PLAN WORKS

### When a Participating Provider Coordinates Your Care

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 means that you will be getting most or all of your health care 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, Co-Insurance or Deductible 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. From your neighborhood health care center to acute care hospitals, our statewide network of contracted physicians, hospitals and other Participating Providers means you're covered all across New Mexico. For more information, please review the Lovelace Health Plan's Online Provider Directory at [www.lovelacehealthplan.com](http://www.lovelacehealthplan.com) or contact our Lovelace Health Plan Customer Care Center to request a printed copy.

### Primary Care Practitioners

The Lovelace Health Plan believes a strong relationship with your Primary Care Practitioner (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 [www.lovelacehealthplan.com](http://www.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. You may change your PCP at any time by using our interactive Online Member website at [www.lovelacehealthplan.com](http://www.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. Female members may choose to have an OB/GYN as their Primary Care Practitioner, if desired. Your PCP is responsible for providing your 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).

### 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 Practitioner. Contact the Lovelace Health Plan Customer Care Center to find out which Providers serve in both roles.

## **Lovelace Health Plan Provider Directory**

Before joining our network, Participating Providers must meet our standards through a process called credentialing. We regularly review Providers' credentials to help ensure they continue to meet these standards.

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 our Online Provider directory via our website at [www.lovelacehealthplan.com](http://www.lovelacehealthplan.com) or by contacting the Customer Care Center.

## **Providers' Qualifications**

To obtain professional qualification information regarding Participating PCPs and Specialists, contact the Customer Care Center. This information may include medical school attended, residency completed and Board Certification status.

## **Customer Care Center**

We value your questions and comments about your Plan or your health care coverage. Our Customer Care Center staff will work with you to resolve any problems that you may experience. 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 with Lovelace Health Plan, you can verify eligibility, check status of a claim, send secure messages to Customer Care Center staff or search for a Participating Provider and much more. Please visit our website at [www.lovelacehealthplan.com](http://www.lovelacehealthplan.com) for more information.

## **Why Contact one of our Representatives?**

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

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

## **Where to Contact Us**

If you have a question or Concern, contact the Customer Care Center at 505.727.5700 (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). Most calls 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. Calls related to a request for a request for urgent services or an appeal of a denial of a request for urgent services are processed differently. Please see the EOC section, "MEMBER APPEAL AND GRIEVANCE PROCEDURE" for more information.

## 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 Customer Care Center and we will assist during your appointment as well.

## 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 help 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 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/Co-Insurance amounts. Additional Co-Payment/Co-Insurance amount information can be found in your Summary of Benefits and Rider, if applicable. If you are unsure of the benefits covered under your Plan or the Co-Payment/Co-Insurance amounts, contact the Customer Care Center for assistance. The applicable Co-Payment/Co-Insurance amounts found on your Plan ID card are not an all-inclusive list.

## Abbreviations of Applicable Co-Payment and Co-Insurance

The following is a list of abbreviations used on Plan ID cards:

PHYSICIAN SERVICES	= Non-Specialist/Primary Care Provider Office Visit amount
SPECIALIST	= Specialist Office Visit amount
ER	= Emergency Room amount
URGENT CARE	= Urgent Care amount
HOSPITAL	= Hospital Admission amount
OP SURGERY	= Outpatient Surgery amount

## ID Card Rules

You are entitled to Plan benefits for Covered Services if all applicable Premiums, Deductibles and Co-Payment/Co-Insurance 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 Customer Care Center immediately if your Plan ID card is lost or stolen.

## **COST SHARING FEATURES**

Depending on the Plan you are enrolled in, the Co-Payment, Co-Insurance, Deductible (if applicable) and Out-of-Pocket maximum amounts required under your Plan are listed in the Summary of Benefits.

### **Co-Payments**

Co-Payments are a fixed dollar amount that you must pay each time you obtain a particular Covered Service. Co-Payments are due for every Provider visit, even if you have more than one appointment in one day. These charges are not reimbursable by us. Members pay the applicable Co-Payment and the Plan pays the remainder of the benefits. Review your Summary of Benefits for all applicable Co-Payments.

### **Co-Insurance**

Co-Insurance is the amount of the Allowable Charge that is partially paid by the Plan and partially paid by you on a percentage basis. The Co-Insurance percentage will be applied to the total Allowable Charges for the service. Co-Insurance is in addition to the Calendar Year Deductible you are responsible for and continues to be your responsibility after the Calendar Year Deductible is met. Refer to your Summary of Benefits and Rider for more information.

Co-Insurance is due after a service is rendered, when the related claim has been processed and the Co-Insurance calculated based on total amount of the claim paid. After a claim is processed, an explanation of benefits (EOB) will be mailed to you, notifying you of the Co-Insurance amount you owe to the treating Provider. It is then your responsibility to make payment to the Provider for the full Co-Insurance amount. Keep your receipts as proof of payment.

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

### **Annual Deductibles**

An Annual Deductible is the amount you and your covered Dependents must pay each Calendar Year before Covered Services or benefits are paid for by Lovelace Health Plan, except for those services listed as not subject to the Deductible in the Summary of Benefits or Rider, if applicable. Those services will be covered by Lovelace Health Plan even when the Annual Deductibles have not yet been met. Please refer to your Summary of Benefits for your Plan's deductible amounts.

#### *Per-Person Deductible*

For Subscribers who have selected single or couple coverage, each Member must meet his or her individual, per-person Calendar Year deductible amount. Once each has met the per-person Deductible, Lovelace Health Plan will pay benefits for Covered Services for that Member.

#### *Family Deductible*

For Subscribers who have selected family coverage (or coverage for more than three (3) or more individuals) there are total Calendar Year family deductibles that must be met. Each family Member's individual Deductible is applied toward a family Deductible, but only until the per-person Deductible is met. For example, if the Per-Person Deductible is \$500, then up to \$500 per Member can be applied to the family Deductible.

Refer to your Summary of Benefits for the amount of your Per-Person Deductible and your Family Deductibles.

### **Annual Out-of-Pocket Maximums**

To protect you and your covered Dependents from the high cost of catastrophic illness, there is a maximum on the Co-Payment and Co-Insurance amounts you must pay in a Calendar Year for certain Covered Benefits and Services.

This amount is referred to as an Out-of-Pocket Maximum. This amount differs depending upon your Plan. Please refer to your Summary of Benefits for your Plan's Out-of-Pocket Maximums.

Co-Payments made for Core Medical Benefits accumulate to your annual Out-of-Pocket Maximums. Once your Deductible is met (if applicable), Co-Insurance expenses for Core Medical Benefits accumulate toward your annual Out-of-Pocket Maximums. Co-Payments and Co-Insurance amounts associated with Additional Benefit Riders, such as Vision and Prescription Drug Riders (if applicable), do not count towards your annual Out-of-Pocket Maximums. Annual Deductibles; penalty amounts (if applicable); charges above Usual, Customary and Reasonable Charges; Premium payments; or charges for non-covered services also do NOT contribute towards annual Out-of-Pocket Maximums.

Annual Out-of-Pocket maximums are calculated on a Calendar Year basis. After your annual Out-of-Pocket Maximum is reached, Lovelace Health Plan will pay 100% of the Covered Services up to the Allowable Charge for In-Network Covered Services from Participating Providers for the remainder of that Calendar Year with the exception of Durable Medical Equipment (DME), External Prosthetic Appliances (EPA) and Infertility Services. These benefits remain the same and will be administered as stated in the Summary of Benefits. Additionally, charges in excess of Usual, Customary and Reasonable do not apply and remain the Members' responsibility for payment. Annual or Lifetime, where allowed, benefit maximums will be applied.

#### *Per-Person Maximum*

For Subscribers who have selected single or couple coverage, each Member must meet his or her individual Per-Person Maximum. Once the Per-Person Maximum is met, Lovelace Health Plan will pay 100%, up to the Allowable Charge or Usual, Customary and Reasonable Charges, for Covered Services for that Member as stated above.

#### *Family Maximum*

For Members who have selected family coverage (coverage for three (3) or more individuals), there is a total Family Maximum. Each covered family Member's individual payments for Covered Services are also counted toward the Family Maximum, but only until the per-person maximum is met.

To inquire about your specific Out-of-Pocket Maximum amount, visit our website at [www.lovelacehealthplan.com](http://www.lovelacehealthplan.com) and click on the Online Member Options site.

### **Annual Coverage Limits and “Essential Benefits”**

Under the Patient Protection and Affordable Care Act (PPACA), Lovelace Health Plan is allowed to set annual limits for “Essential Benefits” no lower than \$750,000. This minimum limit will be raised to \$1.25 million beginning September 23, 2011, and to \$2 million beginning on September 23, 2012. These limits apply to all employer plans and all new individual market plans. For plans issued or renewed beginning January 1, 2014, all annual dollar limits on coverage of essential benefits will be prohibited. Essential Benefits under PPACA refer to coverage for the following services:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity/newborn
- Behavioral Health/Substance Abuse conditions
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Lab services
- Preventive/wellness services
- Chronic disease management
- Pediatric services (including oral and vision care).

### **Lifetime Maximum Benefit Provision**

A Lifetime Maximum is the maximum amount of Benefits payable for all Covered Benefits/Services incurred during the entire time a Member is covered under this Plan. Some Covered Benefits/Services have specific benefit lifetime maximums. For your Lifetime Maximum amounts please refer to your Summary of Benefits and Rider, if applicable. If a Member terminates coverage and re-enrolls one or more times in the Plan, the Benefits paid for any period of enrollment are applied toward the Lifetime Maximum Benefit. The Plan will not pay any further Plan Benefits for a Member once the Plan has paid the Lifetime Maximum Benefit for that Member.

### **No Lifetime Limits on “Essential Benefits”**

Under the Patient Protection and Affordable Care Act (PPACA), Lovelace Health Plan is not allowed set lifetime limits for Essential Benefits. Essential Benefits under PPACA refer to coverage for the following services:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity/newborn
- Behavioral Health/Substance Abuse conditions
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Lab services
- Preventive/wellness services
- Chronic disease management
- Pediatric services (including oral and vision care).

## **PRIOR AUTHORIZATION**

Prior Authorization is a review process whereby Lovelace Health Plan physicians, nurses, and/or clinical staff work with your Provider to determine whether a procedure, treatment, or service is a Medically Necessary Covered Benefit under your Plan. Lovelace Health Plan does not restrict your Provider from discussing various treatment options with you, even if the treatment is not covered under your Plan. However, please confirm that a treatment or service will be covered by carefully reviewing this EOC Handbook, your Summary of Benefits or Rider, if applicable, or by contacting the Customer Care Center.

A referral, recommendation or order from your Provider is not a guarantee of Plan coverage. In addition, receiving Prior Authorization for a service 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 that a necessary Prior Authorization has been obtained, contact the Customer Care Center prior to obtaining services.

### **Who Is Responsible For Obtaining Approval from the Plan**

Participating Providers (those Providers contracted with Lovelace Health Plan) are responsible for contacting Lovelace Health Plan and obtaining approval before Members receive services for services requiring Prior Authorization. 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.

To ensure that you obtain the necessary Prior Authorization, call the Customer Care Center at the toll-free number on your Plan ID card at least fourteen (14) days before a scheduled service, or as soon as possible. Our Customer Care Center representatives can inform you which services require from the Plan. The requested treatment or service may require that our clinical staff discuss the details with your treating Provider to determine if the services are covered under your Plan and are medically necessary.

### **Failure to obtain Prior Authorization may result in a denial of claims.**

#### **How Does The Process Work?**

Lovelace Health Plan requires that Prior Authorization be obtained for hospital admissions and selected outpatient services. When a request for Prior Authorization comes into Lovelace Health Plan from your Provider, a Lovelace Health Plan nurse or pharmacist 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 or pharmacists or other clinical staff determines 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. These services may also require oversight by Lovelace Health Plan or are limited benefits and have specific time frames when services can be provided.

Examples of services requiring /Prior Authorization include, but are not limited to:

- Inpatient hospitalization
- MRI, PET Scan, CT Scan
- DME (Durable Medical Equipment)
- Skilled Care
- Some Prescription drugs

Anytime a Lovelace Health Plan nurse or pharmacist or other clinician 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 Medical Director may speak with your Provider to obtain additional information. You and your

Provider will be notified in writing if a request for Prior Authorization cannot be approved based on the information we received and your Plan benefits.

### **When Does The Review Occur?**

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.

### **Prior Authorization for Immediately Needed (Expedited) 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) calendar day of Lovelace Health Plan receiving a request for expedited review.

### **Prior Authorization Coverage Decisions**

Our medical directors 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 formal Appeals Process, should you disagree with the coverage decision.

**It is important for you to review this EOC or contact the Customer Care Center to obtain information about which services require Prior Authorization.**

### **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 a Participating Provider, you may be permitted to continue to have those services paid at your In-Network level of coverage for a transition period of not 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 at the time a provider is no longer affiliated, meaning a Participating Provider with Lovelace Health Plan, 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 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 (at the In-Network level of coverage) if the Provider's contract with Lovelace Health Plan ends. The Member does not need to request continued care since the care is coordinated through the Plan. This includes coverage of post partum care related directly to the delivery. 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 Covered 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 pay any Participating Provider only for required Co-Payments, Deductible and/or Co-Insurance amounts as indicated on your Summary of Benefits and Rider, if applicable.

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 Customer Care Center for assistance. Members are not liable to a Participating Provider for any amounts owed to the Provider by Lovelace Health Plan

## **Affirmation Statement**

Lovelace Health Plan only makes claims' processing decisions based on appropriateness of care, service, and existence of coverage. Lovelace Health Plan may not provide payment to, or make employment decisions regarding a reviewer who processes claims on the likelihood that the individual will support a denial of benefits.

## **Services Provided By Non-Participating Providers**

**Under limited circumstances, this Plan will pay for services provided by Non-Participating Providers: emergency and urgent care and non-emergency care with a Prior Authorization from Lovelace Health Plan.**

In the event medically necessary covered services are not reasonably available through Lovelace Participating Providers, Lovelace Health Plan shall refer a Member to a Non-Participating Provider and shall fully reimburse the Non-Participating Provider at the usual, customary, and reasonable rate or at an agreed upon rate. Before Lovelace Health Plan may deny a referral to a Non-Participating Provider, Lovelace Health Plan must make sure the request is reviewed by a specialist similar to the type of specialist to whom a referral is requested.

Members who receive Covered Benefits or Services from a 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 an itemized statement of treatment, expenses, and diagnosis, including an explanation for the services and the identification information from your Plan ID card.

Itemized bills must be submitted on billing forms or the Provider's letterhead stationery and must show:

- Name and address of the Physician or other health care Provider;
- Full name of the patient receiving treatment or services; and
- Date, type of service, diagnosis, and charge for each service separately.

Canceled checks, balance due statements, cash register receipts or bills you prepare yourself are not acceptable. Please make a copy of all itemized bills for your records before you send them because the bills are not returned to you. Itemized bills are necessary for your claim to be processed so that all benefits available under this Plan are provided.

If your itemized bill(s) include services previously filed, identify clearly the new charges that you are submitting. Medical records of treatment/service may also be required. Members may also use Lovelace Health Plan Claim Forms. Member Claim Forms are available from the Lovelace Health Plan Web site at [www.lovelacehealthplan.com](http://www.lovelacehealthplan.com) or from a Customer Care Representative.

Claims for services rendered by a Non-Participating Provider must be submitted to the Plan within one year (365 days) from the date of service. If your Non-Participating Provider does not file a claim for you, you are responsible for filing the claim within the one-year deadline. Claims submitted after the deadlines are not eligible for benefit payments. If a claim is returned for further information, you must resubmit it, with the information requested, within 90 days of receipt.

Please mail the claim forms and itemized bills to:

**Claims Department**  
**Lovelace Health Plan**  
**P.O. Box 549**  
**Buckeystown, MD 21717**

Once received, reviewed and approved, the Plan will reimburse the Member for Covered Services, less any required Deductibles and Co-Insurance or Co-Pay amount the Member is required to pay as stated in the Summary of Benefits and Rider(s), if applicable. The Member will be responsible for charges not specifically covered by the Plan.

### **Usual, Customary and Reasonable Charges**

Covered Benefits and Services you receive from an Out-of-Network Provider are covered only up to your Plan's "Usual, Customary and Reasonable" amounts. "Usual, customary and reasonable rates" means health care services, medical supplies and payment rates for health care services provided by a health care practitioner at or near the median rate paid for similar health care services within a surrounding geographic area where the charges were incurred. Surrounding geographic area may be determined by the type of service and access to that service in the geographic area. Since Providers that are outside of the Lovelace Health Plan Network have not contracted with us or agreed to accept our discounted rates, the Member will be fully responsible for the amount an Out-of-Network Provider may charge in excess of the Usual, Customary and Reasonable Charges.

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

### **Claims for Emergency Services Received Outside the United States**

Even overseas, this Plan's coverage travels with you. If you need Urgent or Emergency Hospital or Physician care outside of the United States, claims should be handled the same way as described in the section ***Services Provided by Non-Participating Provider***. Members who obtain services from Providers outside the United States will normally be required to pay that Provider at that time and then submit a claim to Lovelace Health Plan for reimbursement. Members are responsible for ensuring that claims and/or records are appropriately translated and that the monetary exchange rate is clearly identified when submitting claims for services received outside the United States. Medical records of treatment/service may also be required.

### **Fraud & Abuse**

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

### *Definitions of Fraud & Abuse:*

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

Abuse- Provider or Member practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to health plans, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes Provider or Member practices that result in unnecessary costs to the health plan.

### *How to Report Potential Fraud, Abuse, or Suspicious Activity*

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

- Fraud & Abuse Telephone Hotline: (505) 727-5384
- Fax Info to the Fraud & Abuse Dept: (505) 727-5510
- 
- Mail: 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 the Plan and/or recovery of any overpayments, as applicable.

### **Second Opinions**

Second opinions or specialist consultations can be obtained from in network providers without need for prior authorization. If the Health Plan determines, in consultation with a network provider, that a second opinion is not available in network, coverage is limited to one out of network consultation per diagnosis. An out of network second opinion requires prior authorization by the Health Plan. Any additional services beyond a consultation office visit require additional prior authorization by the Health Plan, and are subject to benefit and medical necessity review. Before we may deny such a referral to a Non-Participating Provider, the request must be reviewed by a specialist similar to the type of specialist to whom a referral is requested.

### **Service Area**

The Service Area is the geographical area encompassing the state of New Mexico.

### **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 TO OBTAIN HEALTH CARE

This section explains how to access Participating Providers to obtain care and how to help ensure that the care you receive is covered by the Plan.

In order for Lovelace Health Plan to provide your Plan benefits in a timely fashion, you should follow these basic steps:

Contact your physician or other Participating Provider when you have a health care need;

- Identify yourself as a Member. Have your Plan I.D. card on hand when making appointments;
- Upon arriving for a scheduled appointment, show your Plan I.D. card to the receptionist
- Obtain Prior Authorization for the services described in the Prior Authorization; Covered Benefits and Services; and Covered Services with Limitations sections of this EOC;
- Notify Lovelace Health Plan of an Emergency admission within forty-eight (48) hours after such an admission;
- Submit all claims within 1 year (365 days) after the date of service; and
- Call the Customer Care Center if you have a question, concern or complaint.

### Medical Office Visits

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

If you need a same day appointment or have an Urgent Illness, call your Provider's office to make an appointment. You may be offered an appointment with another provider in the office. .

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

### After Hours

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 available over-the-phone interpreters for those Members needing special assistance. To access these available services, contact the Customer Care Center at the phone number listed at 505.727.5700 or toll-free 800.808.7363.

## **URGENT AND EMERGENCY 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 by making an appointment with a Participating Provider.

### **Urgent Care**

Urgent Care means Medically Necessary Health care Services provided in non-life threatening situations, or after a Primary Care Practitioner's normal business hours for unforeseen conditions due to illness or injury that are not life threatening, but require prompt medical attention.

These are situations that are not life threatening but require prompt medical attention or Urgent Care. Examples of Urgent Care situations include but are not limited to: sprains, high fever, minor cuts, minor burns, requiring stitches, significant vomiting or diarrhea, severe stomach pain, swollen glands, rashes, poisoning, strains, cramps, bumps, bruises and back pain.

Members are encouraged to contact their PCPs for an appointment, if available, before seeking care from another Participating Provider. If not, and 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.

Members may contact Lovelace Health Plan Customer Care Department for information regarding the closest In-Network facility that can provide Urgent Care.

### **Emergency Services**

**Emergency care coverage under your Lovelace Health Plan's HMO 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: ambulance, medical, surgical, hospital, and 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 part, or disfigurement to a person.

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

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 received in an Emergency Room, Urgent Care Clinic or Provider office does not require Prior Authorization. However, if you are admitted to a Hospital, Lovelace Health Plan must be contacted to Prior Authorize your hospital stay, after your emergency medical condition is stabilized. Prior Authorization is required for all Inpatient Admissions. 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 Provider under established Plan guidelines.

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

### **What to do in an Emergency**

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

### **Emergency Services at a Non-Participating Provider/Facility**

Emergency care can be obtained from Non-Participating Providers or Facilities. Emergency Services (as defined above) obtained from Non-Participating Providers will be reviewed by Lovelace Health Plan and paid at the In-Network level of benefits. Services determined to be non-emergency or follow-up care require Prior Authorization; otherwise, Lovelace Health Plan will not pay for these services. Please refer to the Claims Payment section of this EOC to find out how services will be paid and/or reimbursed.

**Please Note: If you are admitted to a Non-Participating Facility, you must ensure that Lovelace Health Plan is contacted for Prior Authorization. Prior Authorization is required for all Inpatient Admissions for maximum benefits to be available.**

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.

Benefits 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 designated level I, level II or other appropriately designated trauma center), including physician's services.
- Ambulance service when Medically Necessary

NOT covered as In-Network Emergency Care include, but are not limited to:

- Elective care or non-emergency care, including Follow-up Care
- Non-emergency or non-Urgent Care provided outside of the Service Area
- Supplies, medications, and Durable Medical Equipment provided outside of the Service Area, except in an emergency or for an urgent illness. This is true unless the need for care could not have been foreseen before leaving the Service Area
- Care received after it is medically feasible to return to the Service Area

### **Ambulance Service**

When an ambulance is necessary, call 911 or a local ambulance service. This service is covered if it is Medically Necessary because of an Emergency. The Plan Medical Director determines this by reviewing ambulance and medical records. Non-Emergent ambulance transport requires Prior Authorization from the Plan. If ambulance services were not Medically Necessary and were not prior authorized by the Plan, you are responsible for payment.

**Emergency Dental Care**

Your Plan covers emergency dental care which is needed because of accidental injury from an outside force to a sound, natural tooth. To be considered sound, the tooth must not have significant decay or prior trauma. Emergency treatment of jawbones or surrounding tissues is also covered. You may contact the Customer Care Center at 505.727.5700 or 800.808.7363 to obtain the names of Participating Providers authorized to provide such care.

## **COVERED BENEFITS AND SERVICES**

Your Plan covers the following Medically Necessary health care services. You and your covered Dependents are entitled to receive services and benefits listed in this section. For some services to be Covered, Lovelace Health Plan must authorize them. Please refer to the Prior Authorization section in this EOC Handbook or contact the Customer Care Center. Lovelace Health Plan is not liable and has no obligation to pay for any service received without prior approval, for those services that require a Prior Authorization.

You are responsible for Co-Payment/Co-Insurance and Deductible (if applicable) amounts and certain other charges. Please refer to your Summary of Benefits or Rider, if applicable or you may contact the Customer Care Center for more information.

### **Behavioral/Mental Health Services**

The behavioral/mental health benefit covers eligible Medically Necessary inpatient and outpatient services for behavioral health concerns. Inpatient hospitalization and outpatient mental health services must be furnished by Providers qualified to treat mental illness. Some services require Prior Authorization by Lovelace Health Plan.

Psychiatric inpatient hospitalization and psychiatric partial hospitalization furnished by Participating Providers are covered for acute stabilization of a mental illness. Behavioral/Mental Health Services are covered on an outpatient basis for treatment of a number of Conditions, including but not limited to:

- Anxiety or depression interfering with daily functioning
- Emotional adjustment or concerns related to chronic Conditions such as psychosis or depression
- Emotional reactions associated with marital problems or divorce
- Child/adolescent problems of conduct or poor impulse control
- Acute exacerbation of chronic mental illness (crisis intervention and relapse prevention)

Coverage is also provided for outpatient testing and assessment, as authorized by Lovelace Health Plan. Please refer to your Summary of Benefits for level of Covered Services.

### **Diabetes Supplies and Treatment**

When used to treat insulin dependent, non-insulin dependent diabetes or high blood glucose levels induced by pregnancy, the following medically necessary services and supplies are covered:

- Blood glucose monitors, including those for the legally blind, and test strips
- Glucagon emergency kits
- Insulin
- Prescriptive oral agents
- Injection aids, including those adaptable to meet the needs of the legally blind
- Lancet and lancet devices
- Podiatric appliances for prevention of feet complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment
- Post diagnosis follow-up
- Self-management training, including medical nutritional therapy related to diabetes management; medically necessary visits upon diagnosis of diabetes; visits following a physician diagnosis that represents a significant change in patient; and visits for re-education.
- Syringes
- Visual reading Urine and Ketone strips

Some services require or Prior Authorization from the Plan. Contact the Customer Care Center regarding Prior Authorization Requirements.

Approved medications to treat diabetes are covered are required by state law, even if your employer has not chosen prescription drug benefit coverage.

When new or improved equipment, appliances, prescription drugs for the treatment of diabetes, insulin or supplies for the treatment of diabetes are approved by the food and drug administration (FDA), Lovelace Health Plan will evaluate if changes or additions to formulary/coverage is necessary. Contact the Customer Care Center or visit our website for up-to-date information.

### **Diagnostic Services**

Laboratory, X-ray and other diagnostic tests are covered when medically necessary, including, but not limited to:

- Blood tests
- Urinalysis
- Pathology tests
- X-rays, ultrasounds and other imaging studies
- Electrocardiograms (EKGs), Electroencephalograms (EEGs) and other electronic diagnostic procedures
- CT scans, PET scans and MRIs

### **Family Planning Services**

This covered service is provided on a voluntary basis and includes:

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

### **Hearing Aids for Dependent Children**

For all dependent children up to the age of twenty-one (21), coverage is provided for hearing aids and certain related services. Coverage includes fitting and dispensing services, including providing ear molds as necessary to maintain optimal fit. Services must be provided by a Participating audiologist, hearing aid dispenser or physician.

### **Illness and Injury**

Primary care and specialist services to diagnose and treat illness and injuries are covered when medically necessary and provided to you by Participating physicians and other Participating Practitioners, acting within the scope of their license, in a medical office setting.

### **Implanted Medical Devices**

Implanted medical devices are covered when ordered by a Participating Physician and receive Prior Authorization by us. Examples include but are not limited to pacemakers, artificial hip-joints and cardiac stents.

Coverage consists of permanent or temporary internal aids and supports for defective body parts. Repairs or maintenance of a covered appliance are also covered.

### **Inpatient Acute Care Hospital Services**

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

- Semi-private room and board

- Care and services in an intensive care unit
- Physician and surgeon services
- Medications, Biological, fluids and chemotherapy
- Meals
- Special diets and nutritional supplements when Medically Necessary
- Dressings and casts
- 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
- Inhalation therapy (respiratory therapy)
- Radiation therapy
- Other such services customarily provided in an acute care hospital

### **Inpatient Rehabilitation Hospital Services**

Inpatient services at an acute rehabilitation facility are covered. For coverage, these services must be Medically Necessary, receive Prior Authorization by us, and be furnished by a licensed and qualified Provider.

- Semi-private room and board
- Skilled and general nursing services
- Physician visits
- Limited rehabilitative therapy
- X-rays
- Administration of covered drugs, medications, Biological and fluids

### **Inpatient Long Term Acute Care Hospital Services**

Long Term Acute Care (LTAC) hospitalization requires Prior Authorization by Lovelace Health Plan. LTAC hospitalization provides care for members who require longer term hospital level inpatient care due to complex medical conditions and who cannot be treated effectively at an alternative lower level of care, such as those provided at skilled nursing or inpatient rehabilitation facilities. LTAC includes, but is not limited to pulmonary care; advanced wound care; and critical care services. Covered services include, but are not limited to:

- Laboratory tests
- Stat testing
- Respiratory therapy
- 3 or more IV antibiotics, other IV medications, TPN, and IV fluids
- Pain management
- Limited rehabilitation, including physical, occupational, cognitive, and speech therapy
- Frequent vital signs, neurologic signs, or vascular checks
- Cardiac monitoring
- Medication monitoring
- Nutrition management
- Fluid management, intake and output, and daily weights
- Patient, family, and caregiver education

### **Maternity Care**

Medical, surgical and hospital care during the term of pregnancy (prenatal, intrapartum and perinatal care), 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 Participating Physician Provider in consultation with the mother.

If the hospitalization period is shortened to less than forty-eight (48) hours for vaginal delivery or less than ninety-six (96) hours for Cesarean, benefits for at least three (3) home care visits will be provided, unless the attending Participating Physician or home care Participating Provider and you agree that one (1) or two (2) visits are sufficient. Home care includes parent education, assistance and training in breast and bottle-feeding, and the administering of any appropriate clinical tests.

Transportation, including air transport to the nearest available licensed Health Care Facility, is available for medically high-risk pregnant women with an impending delivery of a potentially viable infant. When necessary to protect the life of the infant, transportation, including air transport, to the nearest available tertiary care Health Care Facility, is covered.

### **Newborn and Adopted\* Children Coverage**

Newly born and adopted children of a Member will be covered from the moment of birth/adoption if the newborn/adopted child is enrolled with Lovelace Health Plan within 31 days of the birth or placement for adoption. **Newborns 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. Where necessary to protect the life of the infant, transportation (including air transport) to the nearest available tertiary Health Care Facility is covered.

*\*Includes children in "Placement for Adoption" status*

### **Nutritional Evaluation**

The Plan covers dietary evaluation and counseling provided by a Participating physician or registered dietician. This is covered as medical management of a documented disease, including obesity. Refer to the Exclusions section for further details specific to dietary supplements and nutritional formulae.

## **Physician Office Visits**

### **Preventive Care Services**

Primary care and specialist services to provide preventive care and periodic health exams are covered, including, but not limited to:

- Adult and child immunizations
- Annual men's exam
- Annual women's exam, including preventive mammogram
- Annual physicals (for Members 20 years of age and older)
- Colon cancer screenings listed below for all persons 35 years of age or older:
  - Fecal occult blood test (FOBT)
  - Flexible sigmoidoscopy
  - Fecal occult blood test plus sigmoidoscopy
  - Double contrast barium enema
  - Colonoscopy
- Educational materials or consultation from providers to promote a healthy lifestyle
- Glaucoma (periodic) eye test for all persons thirty-five (35) years of age or older
- Hearing screening (for Members age 17 and under)
- Laboratory (periodic) tests

- Radiological (periodic) tests
- Tests (periodic) to determine blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level or, alternatively, a fractionated cholesterol
- Vision screening performed by your Primary Care Physician (for Members age 17 and under)
- Well-baby and well-child care, including immunizations

The U. S. Preventive Services Task Force (USPSTF) conducts research reviews to create recommendations for preventive services that should be provided in a physician's office. The USPSTF requires Lovelace Health Plan to provide "A" and "B" graded recommended services at no cost to our members. For a list of these "A" and "B" recommended services, please refer to the USPSTF website at <http://www.ahrq.gov/clinic/uspstf/uspsabrecs.htm>. Though these Preventive Care services are covered at no charge, an office visit copay may apply.

### **Outpatient Hospital or Ambulatory Surgical Procedures**

Outpatient hospital or ambulatory surgical procedures are covered when medically necessary and are prescribed by a covered person's primary care or attending health care professional. Such services may be provided at a hospital, a physician's office, any other appropriate licensed facility if the health care professional delivering the services is licensed to practice, is certified, and is practicing under authority of the health care insurer, medical group, independent practice association or other authority authorized by applicable New Mexico law. Some of these services must be Prior Authorized by Lovelace Health Plan:

- Operating, recovery and other treatment rooms
- Physician and surgeon services
- Diagnostic laboratory tests, x-rays and pathology services
- Pre-surgical testing
- Administration of blood, blood plasma and other biological
- Blood and blood plasma, if not donated or replaced
- Dressings, casts and sterile tray services
- Medical supplies
- Anesthetics and anesthesia services

### **Short-Term Rehabilitation Therapy**

Short-term rehabilitation therapy includes outpatient services where the Member's Participating Practitioner determines that such services can be expected to result in significant improvement of a Member's physical condition within a period of 2 months. Such services may be extended beyond the two month period upon recommendation by the Participating Practitioner in consultation with Lovelace Health Plan. Examples include: physical, speech, occupational, cardiac and pulmonary therapy. Such coverage is available for rehabilitation due to injuries, surgeries or acute medical Conditions. Related occupational therapy is provided for purposes of training Members to perform the activities of daily living.

### **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/Co-Insurance amount.

If you prefer a group setting rather than phone counseling, we can refer you to cessation counseling. The coverage for prescription medications also applies if you choose group classes instead of the *S.T.O.P.* Program. Please contact the *S.T.O.P.* program for specific benefit coverage information. Call 505.727.5344 or toll-free 877.480.9368 to speak with a *S.T.O.P.* counselor.

### **Substance Abuse Services**

Medically necessary services are covered for inpatient and outpatient treatment of alcoholism and/or drug abuse. Inpatient treatment in a Participating Hospital or Substance Abuse treatment center requires Prior Authorization. Partial hospitalization, which also requires Prior Authorization, can be substituted for Inpatient Substance Abuse services.

Partial hospitalization is a non-residential day program, attended by the Member for fewer than 24 hours a day, based in a Hospital or treatment center that includes various daily and weekly therapies. Partial hospitalization services require Prior Authorization from Lovelace Health Plan.

Outpatient, non-Hospital based Intensive and standard Outpatient evaluative and therapeutic services for Admission and/or Substance Abuse do not require Prior Authorization.

#### **Inpatient Services**

- Alcohol and drug abuse detoxification
- Partial hospitalization
- Rehabilitation

#### **Outpatient Services**

- Outpatient Detoxification
- Individual, Family or Marital Therapy
- Intensive Outpatient Program (IOP)
- Group Therapy

### **Women's Health Care**

Women's Health Care includes the following services provided by Participating Providers:

- Prenatal care, including Medically Necessary nutritional supplements prescribed by a Provider
- Mammograms for screening and diagnostic purposes including, but not limited to, low-dose mammography screenings performed at designated Participating imaging facilities. Mammograms for screening and diagnostic purposes, including, but not limited to, low-dose mammography screenings performed at designated approved imaging facilities. At a minimum, coverage shall include one baseline mammogram for person's age thirty-five (35) through thirty-nine (39). One mammogram biennially to persons age forty (40) through forty-nine (49). One mammogram annually for person's age fifty (50) and over.
- Prosthetic devices and reconstructive 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 Provider 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, and coverage of the human papillomavirus vaccine for females nine (9) to fourteen (14) years of age.
- Services related to the diagnosis, treatment, and appropriate management of osteoporosis when determined to be Medically Necessary
- Direct access to obstetric and gynecological care by qualified women's health care Providers

- 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
- Benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema.
- Direct access to obstetric and gynecological care to female Dependents age thirteen (13) or older.

## **COVERED SERVICES WITH LIMITATIONS**

The Plan covers the following services, with some limitations, from Participating Providers. The limitations may be in the number of visits allowed under this Plan or the type of service provided and who provides it. For dollar and/or visit and/or Provider limitation details, review your Summary of Benefits and Rider, if applicable.

### **Acupuncture**

Covered Acupuncture must be provided by licensed Participating Providers and be appropriate for the treatment of your condition. **The number of Visits are limited under this Plan - please refer to your Summary of Benefits.**

### **Ambulance Service**

Ambulance services are covered when Medically Necessary. The Plan determines this by reviewing ambulance and medical records. Non-emergency ambulance transportation requires Prior Authorization by Lovelace Health Plan. If ambulance services are not Medically Necessary, you may be responsible for payment.

### **Autism Spectrum Disorder**

Coverage for the diagnosis and treatment of autism spectrum disorder is covered for members nineteen years of age or younger, or members twenty two years of age or younger and enrolled in high school. Coverage includes well-baby and well-child screening for diagnosing the presence of autism spectrum disorder; treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy and applied behavioral analysis. Coverage is excluded for services received under the federal Individuals with Disabilities Education Improvement Act of 2004 and specialized education and related services that are the responsibility of state and local school boards. There is a Benefit Maximum of \$36,000 per Calendar Year for Applied Behavioral Analysis when part of a prior-authorized treatment plan.

### **Cancer Clinical Trials**

Coverage shall be provided for Medically Necessary covered Routine Patient Care Costs at a New Mexico facility, incurred as a result of the Member's participation in a cancer clinical trial if:

- (1) The clinical trial is undertaken for the purposes of the prevention, early detection or treatment of cancer for which no standard cancer treatment exists or more effective standard cancer treatment exists;
- (2) The clinical trial is not designed exclusively to test toxicity or disease pathophysiology, and it has a therapeutic intent;
- (3) The clinical trial is being provided in this state as part of a scientific study of a new therapy or intervention that is being conducted at an institution in this state and is for the treatment, palliation or prevention of cancer in humans with: specific goals; a rationale and back ground for the study; criteria for patient selection; specific direction for administering the therapy or intervention and for monitoring patients; a definition of quantitative measures for determining treatment response; methods for documenting and treating adverse reactions; and a reasonable expectation that the treatment will be at least as efficacious as standard cancer treatment
- (4) The clinical trial is being provided as part of a cancer clinical trial being conducted in accordance with a clinical trial approved by at least one of the following: (a) One of the federal National Institutes of Health; (b) A federal National Institute of Health Cooperative Group or center; (c) The United States Food and Drug Administration in the form of an investigational new drug application; (d) The United States Department of Defense; (e) The United States Department of Veteran Affairs; or (f) A qualified research entity that meets the criteria established by the federal National Institutes of Health for grant eligibility;
- (5) The clinical trial or study has been reviewed and approved by an Institutional Review Board that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the federal National Institutes of Health;
- (6) The personnel providing the clinical trial or conducting the study (a) Are providing the clinical trial or conducting the study within their scope of practice, experience and training and are capable of providing the clinical trial because of their experience, training and volume of patients treated to maintain their expertise; and (b) Agree to accept reimbursement as payment in full from Lovelace Health Plan and that is not more than the level of reimbursement

applicable to other similar services provided by the Participating Providers within Lovelace Health Plan's network; (c) agree to provide written notification to the health plan when a patient enters or leaves a clinical trial

(7) There is no non-investigational treatment equivalent to the clinical trial; and the available clinical or preclinical data provide a reasonable expectation that the clinical trial will be at least as efficacious as any non-investigational alternative; and there is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial will be at least as effective as any other medical treatment.

(8) Pursuant to the patient informed consent document, no third party is liable for damages associated with the treatment provided during a phase of a cancer clinical trial.

(9) If a member is denied coverage of a cost and contends that the denial is in violation of NM law, the member may appeal the decision to deny the coverage of a cost to the superintendent and that appeal shall be expedited to ensure resolution of the appeal within no more than thirty (30) days after the date of the appeal to the Superintendent of Insurance.

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

• "Routine Patient Care Cost" – means (1) A medical service or treatment that is a benefit under the Plan that would be covered if the patient were receiving standard cancer treatment; or (2) A drug provided to a patient during a cancer clinical trial if the drug has been approved by the United States Food and Drug Administration, whether or not that organization has approved the drug for use in treating the patient's particular Condition, but only to the extent that the drug is not paid for by the manufacturer, distributor or Provider of the drug. Routine Patient Care Cost does not include (1) The cost of an investigational drug, device or procedure; (2) The cost of a non-health care service that the patient is required to receive as a result of participation in the cancer clinical trial; (3) Costs associated with managing the research that is associated with the cancer clinical trial; (4) Costs that would not be covered by the patient's if non-investigational treatments were provided; or (5) Costs paid or not charged for by the cancer clinical trial Providers.

### **Chiropractic Care**

Covered Chiropractic Care must be provided by licensed Participating Providers and be appropriate for the treatment of your condition. **The number of Visits are limited under this Plan - please refer to your Summary of Benefits.**

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

Certain complications of pregnancy are covered if Prior Authorization is obtained from Lovelace Health Plan. Complications of pregnancy that are covered under this Plan when the pregnancy is not terminated include Conditions that are distinct from the pregnancy, but are affected by pregnancy or caused by pregnancy. These Conditions include, but are not limited to, acute nephritis, nephrosis, cardiac decompensation, gestational diabetes, pregnancy-induced hypertension, missed abortion, life threatening or massive bleeding and similar medical and surgical Conditions of comparable severity; and ectopic pregnancy.

This Plan will provide coverage for an alpha-fetoprotein IV screening test for pregnant women, generally between sixteen (16) and twenty (20) weeks of pregnancy, to screen for certain genetic abnormalities in the fetus.

### **Consumable Medical Supplies**

Consumable medical supplies are only covered during hospitalization, 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
- Are ordered or prescribed by a license, qualified Provider

- Examples include, but are not limited to, bandages and dressing supplies

## **Craniomandibular Joint (CMJ) and Temporomandibular Joint (TMJ) Dysfunction Conditions**

The Plan covers services for CMJ and TMJ when Medically Necessary and Prior Authorized by Lovelace Health Plan. Services include Medically Necessary surgical and non-surgical treatment similar to treatment authorized and covered for other joints in the body. The Plan does not cover orthodontic treatment and appliances, crowns, bridges and dentures used for treatment of these disorders unless the member's disorder is caused by trauma.

## **Dental Anesthesia**

This Plan provides coverage for hospitalization and general anesthesia for dental services that are provided in a hospital or ambulatory surgical center. Services must meet one of the following to be covered by the Plan:

- Member exhibits physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce superior results;
- Members for whom local anesthesia is ineffective because of acute infection, anatomic variation or allergy;
- Covered dependent children or adolescents who are extremely uncooperative, fearful, anxious or uncommunicative with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity (children under the age of five years are not required to meet any of these criteria);
- Members with extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised; or
- Other procedures for which hospitalization or general anesthesia in a hospital or ambulatory surgical center is medically necessary.

Services are subject to the applicable Co-Payments, Co-Insurance and Deductible (if applicable) amounts as indicated in your Summary of Benefits. The Plan does not cover charges for routine dental care.

## **Dental Services**

This Plan covers the following services when Medically Necessary and Prior Authorized by us:

- Accidental injury from an outside force to a sound, natural tooth. To be sound, the tooth must not have significant decay or prior trauma. Treatment of jawbones or surrounding tissues related to an accidental injury is also covered.
- Treatment of tumors and cysts that require pathological examination of the jaws, cheeks, lips, tongue, or the roof and floor of the mouth.
- Medically Necessary reconstructive surgery that is expected to correct documented functional disorders and where improvement in physiologic functioning can be expected. These disorders result from accidental injury or from congenital and developmental defects or disease.

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

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

## **Durable Medical Equipment (DME)**

DME is covered upon Prior Authorization by Lovelace Health Plan. For coverage, DME must be Medically Necessary for a person's case or health status.

Coverage includes the rental or purchase of DME, at our option. Examples of DME include, but are not limited to:

- Crutches
- Hospital beds
- Oxygen equipment
- Wheelchairs
- Walkers
- Diabetic Insulin Pumps

Durable Medical Equipment is defined as an item that has all the following characteristics:

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

There are some exclusions and limitations to coverage. DME, including upgrades or accessories that do not serve a therapeutic purpose or is beneficial primarily in allowing a member to participate in recreational or leisure activities is not covered

Lovelace will cover the rental or purchase, at our option, of medically necessary durable medical equipment, including repair and adjustment of durable medical equipment. We will not cover repairs which exceed the purchase price.

Coverage is for medically appropriate equipment and does not include special features, upgrades or accessories unless Medically Necessary. Repair or replacement of DME is covered if it is Medically Necessary, as determined by Lovelace Health Plan, or due to a change in the member's physical or medical condition.

Coverage for repairs of Durable Medical Equipment (DME), prosthetic or orthotic devices, which were previously owned by the Member; not supplied to them through the Plan, except as defined under Diabetes Supplies and Treatment, shall be at the option of Lovelace Health Plan.

Lovelace Health Plan follows guidelines established by Medicare for the reasonable, useful lifetime of durable medical equipment. Such equipment is expected to last at least 5 years.

Replacement due to loss, theft, misuse, abuse, or destruction is not covered. Lovelace also will not cover replacement in cases where the patient improperly sells or gives away the equipment.

Lovelace Health Plan does not cover replacement of DME solely for warranty expiration, or due to new or improved equipment becoming available. Lovelace Health Plan does not cover duplicate or extra DME for member comfort, convenience or travel.

## **External Prosthetic Appliance (EPA)**

EPA is covered only upon Prior Authorization by Lovelace Health Plan. For coverage, EPA must be Medically Necessary for a person's case or health status and have received Prior Authorization from us.

External Prosthetic Appliances have the following characteristics:

- Are artificial substitutes worn on, or attached to the outside of the body
- Are used to replace a missing part (such as the leg, arm, or hand)
- Are needed to alleviate or correct illness, injury, or congenital defect

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

There are some exclusions and limitations to coverage. The Plan covers EPA for K1-3 ambulators. EPA for Level 0 or Level 4 ambulators are not covered. This Plan covers replacement of EPA if this is needed due to normal body growth or changes due to illness or injury. This Plan follows Medicare guidelines to determine lifetime of EPA. The Plan covers pre-fabricated EPA unless there is clinical documentation supporting Medically Necessary custom EPA. EPA, including upgrades or accessories that do not serve a therapeutic purpose or is beneficial primarily in allowing a member to participate in recreational or leisure activities is not covered. Repair or replacement of EPA is covered if it is Medically Necessary, as determined by Lovelace Health Plan. However, repair or replacement due to loss, theft or destruction is not covered. Your Plan does not cover duplicate or extra EPA for Member convenience or comfort. This Plan does not cover biomedical EPA. This Plan does not cover duplicate or extra DME for Member convenience or comfort.

### **Family, Infant and Toddler (FIT) Program**

This Plan provides coverage (up to \$3500 annually, per eligible child) to those covered Dependent children from birth through three years of age who qualify for services through the FIT Program. Qualified providers are those certified and licensed personnel as defined in New Mexico regulations, who are working in early intervention programs approved by the New Mexico department of health. The program provides intervention services for children 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** as defined in 7.30.8. of the New Mexico Administrative Code.. Coverage and services are provided as defined in the requirements for the Family, Infant and Toddler Program Early Intervention Services under New Mexico law. More information can be obtained from the New Mexico State Department of Health.

### **Growth Hormone Therapy**

This Plan does not cover growth hormone treatment for children with idiopathic short stature or for adults without a covered medical diagnosis. An endocrinologist must document a covered medical diagnosis before hormone therapy is covered.

### **Hearing Care**

Hearing exams are covered when they are used to diagnose and treat ear injuries or diseases of the ear. For Members age seventeen (17) or younger, routine hearing screenings by their Primary Care Provider are covered.

### **Home Health Services**

Home health services are covered for a Member under certain conditions. The Member must require Skilled Care and be 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 licensed and qualified Provider. There is a limited number of home health visits during a Calendar Year; at least one hundred (100) four (4) hour home visits per insured. Please review your Summary of Benefits for details.

Home health services include:

- Visits by professional nurses, including, but not limited to registered nurses and licensed professional nurses, and other participating health professionals (including physical, occupational and respiratory therapists, speech pathologists, home health aides, social workers and dieticians)
- Consumable medical supplies and DME 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

Physical, occupational, respiratory and speech therapy provided in the home is covered. These are limited to services provided on the written order of a Provider. The services must also be Prior Authorized by Lovelace Health Plan.

### **Hospice Care Services**

This Plan covers hospice care services. To be covered, these services must be provided due to terminal illness. These services are limited as stated in your Summary of Benefits. The services must be given under a hospice care program and provided by a licensed and qualified Provider. Hospice care services include inpatient care and outpatient services. Also included are the professional services of a Physician. Other Covered Services include those of a psychologist, social worker or family counselor. Home health services are also covered.

Hospice care services do not include the following:

- Services provided by a member of your family or your Dependent's family, or someone who usually lives in your or your Dependent's home
- Services or supplies not listed in the hospice care program
- Services for curative or life prolonging procedures
- Services for which any other benefits are payable under the Plan
- Services or supplies that are primarily to aid in daily living
- Bereavement counseling
- Services for respite care
- Nutritional supplements, non-Prescription Drugs or substances, medical supplies, vitamins or minerals

### **Internal Prosthetics/Medical Appliances**

Internal prosthetics and/or medical appliances are covered when ordered by a Physician and receive Prior Authorization by us. Examples include but are not limited to pacemakers, artificial hip-joints and cardiac stents. Coverage consists of permanent or temporary internal aids and supports for defective body parts. Repairs or maintenance of a covered appliance are also covered.

### **Morbid Obesity Treatment**

Surgical treatment of morbid obesity is covered only if medically necessary and Prior Authorization has been obtained from Lovelace Health Plan. There is a lifetime limit of one surgical procedure for the treatment of morbid obesity.

### **Organ Transplant Services**

This Plan covers human organ and tissue transplant services. These services require Prior Authorization by Lovelace Health Plan and are only covered at certain Lovelace Health Plan-approved facilities within the United States.

The recipient of an organ transplant must be a Member at the time of services. Benefits are not available when the Member is a donor. Benefits are not available if the recipient is not a Member. The term recipient is defined to include a Member receiving authorized transplant-related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event, or (d) post-transplant care. Coverage is subject to the conditions and limitations outlined in the Summary of Benefits or Rider, if applicable and in this EOC Handbook.

### **Definition of Transplant Services**

Transplant services include medical, surgical and hospital services for the recipient. This Plan also covers organ procurement needed for human-to-human organ or tissue transplant. The types of transplants covered include, but are not limited to, kidney, kidney/pancreas, cornea, bone marrow/stem cell, heart, heart/lung, liver and pancreas.

## **Prior Authorization**

In order for benefits under this Plan to be available, transplant services must have Prior Authorization from Lovelace Health Plan. The Prior Authorization is based on an evaluation conducted by a Lovelace Health Plan-approved transplant facility and on the relevant evidence-based medical guidelines.

A member may seek authorization from the health plan for dual transplant listing. The second listing must be within a separate or different Organ Procurement Organization. While dual listing is authorized, payment will be made to only one facility for the actual transplant event.

## **Organ Procurement Costs**

This Plan covers costs directly related to procuring the organ from a cadaver or from a live donor. Surgery needed for organ removal is covered. Organ transit and the transportation, hospitalization and surgery of a live donor are also covered. Coverage for compatibility testing done before procurement is limited. Compatibility testing undertaken prior to procurement is covered only if determined to be medically necessary by Lovelace Health Plan.

## **Transplant Travel**

Travel expenses incurred by a Member in connection with a pre-approved organ/tissue transplant are covered subject to the following conditions and limitations. Benefits for transportation, lodging, and food are available to Members only if they are the recipient of a pre-approved organ/tissue transplant from a Lovelace Health Plan approved Provider. Prior Authorization is required and there is a Lifetime Maximum benefit of \$10,000.00.

Covered Travel expenses for the Member receiving the transplant will include charges for:

- Transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility);
- Lodging while at, or traveling to and from the transplant site; and
- Food while at, or traveling to and from the transplant site.

In addition, travel expenses for one companion who accompanies the Member will be covered as described above. Minors are allowed travel benefits for themselves, one or both parents, or a parent and a designated companion. The term companion includes a spouse, a Member of the family, a legal guardian, or any person not related to the Member, but actively involved as the Member's caregiver.

The following are specific travel expenses travel expenses excluded from coverage:

- Travel costs incurred due to travel within 60 miles of the Member's home;
- Laundry bills;
- Telephone bills;
- Alcohol or tobacco products; and
- Charges for transportation that exceed coach rates.

## **Immunosuppressive Drugs for Organ Transplants**

Inpatient immunosuppressive drugs for organ transplants are covered.

## **Outpatient Prescription Drugs**

The Plan provides coverage for drugs, supplies, supplements and administration of a drug (if such services would not otherwise be excluded from coverage) when prescribed by a licensed and qualified Provider and obtained at a Pharmacy or through our Mail Order program. If your Employer Group has chosen this optional benefit, you will find additional information about it in the Summary of Benefits or Prescription Drug Rider. Lovelace Health Plan uses a list of Prescription Drugs which are covered by this Plan. This is called a Preferred Drug List. The Preferred Drug List includes drugs for a wide variety of disease states and Conditions. This medication list is reviewed and updated

periodically in order to assure that the most current and clinically appropriate drug therapy is being used. Sometimes it is Medically Necessary for a Member to use a drug not on this list. When this occurs, the prescribing physician may request an exception through the Lovelace Health Plan's Pharmacy Exception Center. Information regarding medications on the Preferred Drug List or your Outpatient Prescription benefit and exclusions may be obtained by calling the Customer Care Center. Additional information regarding Prescription Drug Limitations and Exclusions can be found in the Exclusions section of this EOC. Please refer to your Summary of Benefits or Prescription Drug Rider for applicable cost-sharing information.

In cases where a Member has received out-of-area Emergency Care and it was necessary to have prescriptions filled, this Plan requires that the claim for reimbursement be submitted no later than 1 year (365 days) following the emergency services. The claim must contain an itemized statement of expenses.

There are certain Outpatient Prescription Drugs that are required to be covered by New Mexico law, related to the treatment of diabetes and smoking cessation. Please refer to the sections of this EOC and your Summary of Benefits regarding these covered Outpatient Prescription Drugs.

### **Podiatry**

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

### **Routine Physical Exams**

Routine physical exams are covered one (1) time per Calendar Year.

### **Skilled Nursing**

Inpatient services at a skilled nursing are covered. These services must be Medically Necessary, receive Prior Authorization by us, and be furnished by a licensed and qualified Provider. Covered Services are limited as stated in the Summary of Benefits and include:

- Semi-private room and board
- Skilled and general nursing services
- Physician visits
- Limited Rehabilitative therapy
- X-rays
- Administration of covered drugs, medications, Biological and fluids

### **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. You must obtain Prior Authorization to have an available benefit for these foods.

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 a Lovelace Health Plan Participating Vendor/Provider

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

**Vision Care**

Eye exams are covered only to diagnose and treat eye injuries or diseases. For Members age seventeen (17) and under, vision screenings are covered when provided by a Primary Care Provider. In cases of Medically Necessary treatment after cataract surgery, the first pair of contact lenses is covered by this Plan. Contact lenses for the Medically Necessary treatment of keratoconus are covered.

## EXCLUSIONS

Any services that are not described in the Covered Benefits & Services section are not covered by this Plan. This includes any optional benefits not chosen by your Plan. The following are 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 receiving Prior Authorization by Lovelace Health Plan
- Alternative treatments including, but not limited to, aromatherapy, massage therapy, hypnotherapy and biofeedback
- 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, 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 or Rider(s), if applicable.
- Care for Conditions or 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 because of his or her military service.
- 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 treating physician and approved by Lovelace
- Cosmetics and health and beauty aids
- Cosmetic therapy, drugs/medications or procedures for the purpose of changing appearance. Examples include, but are not limited to:
  - Surgical excision or reformation of sagging skin on any part of the body including, but not limited to, eyelids, face, neck, abdomen, arms, lips, or buttocks
  - Services for the enlargement, reduction, implantation or change in appearance of a part of the body. Examples include the: breast, face, lips, jaw, chin, nose, ears or genitals
  - Hair transplantation
  - Chemical or laser face peels or abrasions of the skin
  - Removal of hair by electrolysis or other methods including lasers
  - Any other surgical or non-surgical procedures which are primarily for the purpose of altering appearance and not performed for the purpose of correcting functional disorders resulting from accidental injury or from congenital defects or disease
- 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)
- Equipment that basically serves the comfort or convenience of the patient or the person caring for the patient
- Expenses for reproductive or infertility services. Excluded services include, but are not limited to::
  - In vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) and variations of these procedures
  - Surrogacy services, including the medical care of the surrogate mother, and the medical care of the surrogate mother's newborn child, unless and until that child becomes an eligible Dependent of the Subscriber as provided in the "Who May Enroll" section of this EOC Handbook

- Reversal of sterilization
- Any costs associated with the collection, preparation or storage of sperm for artificial insemination, including donor fees, donor egg or sperm retrieval
- Infertility injectable and suppository medications
- Foot care including, but not limited to, cutting or removal of corns/calluses, nail trimming, cutting or debridement, unless Medically Necessary, (i.e. for the treatment of diabetes)
- Hearing aids, ear molds, or fitting of hearing aids or ear molds for adults. Coverage is available for dependent children. Refer to section entitled "Hearing Aids for Dependent Children"
- Homebirths, including but not limited to deliveries and services provided by a lay-midwife
- Immunizations, inoculations, exams and other related services for reasons other than health, such as those required for licensing, employment, marriage, insurance or travel purposes
- Infant or baby food/formula or breast milk or other regular grocery products that can be processed for oral or tube feedings
- Injuries sustained in the course of committing a criminal act
- 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, unproven, ineffective or investigational treatment. This is determined by the Medical Director in accord with peer-reviewed published 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 phase I, II or III clinical trials, except when the chemotherapy is prescribed under medical research protocol and submitted to regional and national databases
  - Therapy administered under experimental protocols
 Exceptions: See Cancer Clinical Trials in this EOC Handbook.
- Membership costs or fees associated with health clubs and weight loss clinics, including personal trainers and the use of club swimming pools for therapy
- Modifications or installations to building and related structures and vehicles
- 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, except for those services that have Prior Authorization Lovelace Health Plan and are provided in a skilled nursing facility approved by Lovelace Health Plan.
- Orthopedic shoes, foot orthotics, shoe lifts and wedges unless determined to be Medically Necessary for the treatment of diabetes
- Outpatient Prescription and non-Prescription Drugs and medications, except as required by law. Exclusions include:
  - Any drugs or medications available over the counter (including vitamins, dietary supplements, and fluoride products) that do not require a prescription by Federal or State Law, other than insulin, and any drug or medication that is equivalent (in strength, regardless of form) to an over the counter drug (Prescription prenatal vitamins and supplements prescribed by a physician are covered.)
  - Any injectable drug/medication, except as otherwise covered and Prior Authorized by the Medical Director. Applicable Co-Payments, Co-Insurance and Deductibles apply.

- Any drugs that are experimental or investigational, within the meaning set forth in the Exclusions Section of this document
- Non-FDA (Food and Drug Administration) approved drugs or medications
- FDA approved Prescription Drugs used for purposes other than those approved by the FDA, unless the drugs are recognized for the treatment of a particular indication in one of the standard reference compendia (The United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or The American Hospital Preferred Drug List Service Drug Information) or in medical literature, or, as required for cancer clinical trials as defined under New Mexico law. Medical literature means scientific studies published in a peer-reviewed national professional medical journal.
- All newly FDA approved drugs, prior to review by the Lovelace Pharmacy and Therapeutics Committee
- Any Prescription Drug or medications used for treatment of sexual dysfunction including, but not limited to, erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido (such as Viagra®, Cialis® or Levitra®)
- Prescription Drugs used for cosmetic purposes such as drugs used to reduce wrinkles, promote hair growth, control perspiration, fade cream products, Retin-A for Members over forty-six (46) years of age, and other prescription products to reduce wrinkles
- Lifestyle drugs/medications, or medications which treat non-life threatening and non-painful conditions such as baldness, impotence, wrinkles, or acne.
- Diet pills or appetite suppressants unless specifically included in your Plan
- Medications or injections and/or Biological required for travel purposes.
- Medication used to enhance athletic performance
- Penile implants, unless Medically Necessary
- 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
- Repairs for Durable Medical Equipment (DME), prosthetic or orthotic devices, which were previously owned by the Member; not supplied to them through the Plan, except as defined under Diabetes Supplies and Treatment
- 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.
- Routine physical exams, checkups, medications, and inoculations and/or Biological 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 that are not described in the Benefits and Services and Limitations sections of this EOC Handbook. These excluded services include, but are not limited to, the following:
  - Any court-ordered treatment or therapy, or any treatment or therapy ordered as a Condition of parole, probation or custody or visitation evaluations unless Medically Necessary and covered under the Services and Benefits section of this EOC Handbook.
  - Treatment of organic mental disorders associated with permanent dysfunction of the brain
  - Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorder, developmental language disorder or developmental articulation disorder
  - Treatment, therapies, counseling, programs or activities of an educational nature
  - Treatment, therapies, counseling, programs and activities for borderline intellectual functioning
  - Treatment, therapies, counseling, programs and activities for occupational problems or vocational or religious counseling
  - Treatment, therapies, counseling, programs and activities related consciousness raising
  - Intelligence Quotient (I.Q.) testing
  - Residential treatment center (RTC) and treatment foster care (TFC) services
  - Therapeutic schools and programs, including, but not limited to wilderness and other experimental programs

- Psychological testing on children requested by or for a school system, unless Medically Necessary
- 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 (Human Chorionic Gonadotrophin) injections to increase ovulation
  - 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
- Services for non-emergency or non-urgent care received outside the United States
- Travel, lodging and other related expenses, except as defined in this EOC Handbook
- Treatment for sexual dysfunction, including but not limited to medications, counseling and clinics
- Treatment of an immediate family member or engagement in self treatment absent an emergency or a short term situation involving a minor problem in which a qualified physician is not available.
- Treatment or services provided in connection with or to comply with involuntary commitments, police detention, court orders or other similar arrangements
- Treatment, including immunizations, evaluations (including functional capacity evaluations) for purposes of finding or returning to work, operating a vehicle or other equipment)
- Treatment which results from an injury or illness that arises out of, or as the result of employment for wage or profit, regardless of whether such treatment is covered by any Workers' Compensation or other similar coverage or if covered, whether such treatment is found compensable thereunder.
- Vocational rehabilitative services
- Weight loss, physical conditioning programs or exercise programs and equipment, including software designed to promote good health and activity
- 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 excluded, contact the Customer Care Center before the treatment or service is provided. Any services and benefits not described in this EOC Handbook and the Summary of Benefits are not covered under this Plan.**

## MEMBER APPEAL AND GRIEVANCE PROCEDURE

*DEFINITIONS: (As prescribed by the New Mexico Department of Insurance Grievance Rule 13.10.17.7)*

- A. Administrative Grievance means an oral or written complaint submitted by or on behalf of a covered person regarding any aspect of a health benefits plan other than a request for health care services, including but not limited to:
  - (1) Administrative practices of the health care insurer that affects the availability, delivery, or quality of health care services;
  - (2) Claims payment, handling or reimbursement for health care services; and
  - (3) Terminations of coverage;
- B. Adverse Determination means a decision made either pre-service or post-service, by a health care insurer that a health care service requested by a provider or covered person has been reviewed and, based upon the information available, does not meet the health care insurer's requirements for coverage or medical necessity, and the requested health care service is therefore denied, reduced or terminated;
- C. Adverse Determination Grievance means an oral or written complaint submitted by or on behalf of a covered person regarding an adverse determination;
- D. Certification means a decision by a health care insurer that a health care service requested by a provider or covered person has been reviewed and, based upon the information available, meets the health care insurer's requirements for coverage and medical necessity, and the requested health care service is therefore approved;
- E. Covered Person means a policyholder, subscriber, enrollee, or other individual entitled to receive health care benefits provided by a health benefits plan, and includes Medicaid recipients enrolled in a health care insurer's Medicaid plan and individuals whose health insurance coverage is provided by an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act;
- F. Grievant means a covered person, a covered person's authorized representative, or a provider acting on behalf of a covered person with the covered person's consent;
- G. Health Benefits plan means a policy, contract, certificate or agreement offered or issued by a health care insurer or plan administrator to provide, deliver, arrange for, pay for, or reimburse the costs of health care services; this includes a health benefits plan as defined under NMSA 1978 Section 59A-22A-3(D) as "the health insurance policy or subscriber agreement between the covered person or the policyholder and the health care insurer which defines the covered services and benefit levels available";
- H. Health Care Insurer means a person that has a valid certificate of authority in good standing issued pursuant to the Insurance Code to act as an insurer, health maintenance organization, nonprofit health care plan, fraternal benefit society, vision plan, or pre-paid dental plan;
- I. Health Care Professional means a physician or other health care practitioner, including a pharmacist, who is licensed, certified or otherwise authorized by the state to provide health care services consistent with state law;
- J. Health Care Services means services, supplies, and procedures for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury, or disease, and includes, to the extent offered by the health benefits plan, physical and mental health services, including community-based mental health services, and services for developmental disability or developmental delay;
- K. Hearing Officer, independent co-hearing officer or ICO means a health care or other professional licensed to practice medicine or another profession who is willing to assist the superintendent as a hearing officer in understanding and analyzing medical necessity and coverage issues that arise in external review hearings;
- L. Medical Necessity or Medically Necessary means health care services determined by a provider, in consultation with the health care insurer, to be appropriate or necessary, according to any applicable generally accepted principles and practices of good medical care or practice guidelines developed by the federal government, national or professional medical societies, boards and associations, or any applicable clinical protocols or practice guidelines developed by the health care insurer consistent with such federal, national, and professional practice guidelines, for the diagnosis or direct care and treatment of a physical, behavioral, or mental health condition, illness, injury, or disease;
- M. Provider means a duly licensed hospital or other licensed facility, physician, or other health care professional authorized to furnish health care services within the scope of their license;
- N. Summary of Benefits means the written materials required by NMSA 1978 Section 59A-57-4 to be given to the covered person by the health care insurer or group contract holder;

- O. Termination of coverage means the cancellation or non-renewal of coverage provided by a health care insurer to a covered person but does not include a voluntary termination by a covered person or termination of a health benefits plan that does not contain a renewal provision;
- P. Traditional Fee-for-Service indemnity benefit means a fee-for-service indemnity benefit, not associated with any financial incentives that encourage covered persons to utilize preferred providers, to follow pre-authorization rules, to utilize prescription drug formularies or other cost-saving procedures to obtain prescription drugs, or to otherwise comply with a plan's incentive program to lower cost and improve quality, regardless of whether the benefit is based on an indemnity form of reimbursement for services;
- Q. Uniform Standards means all generally accepted practice guidelines, evidence-based practice guidelines or practice guidelines developed by the federal government or national and professional medical societies, boards and associations, and any applicable clinical review criteria, policies, practice guidelines, or protocols developed by the health care insurer consistent with the federal, national, and professional practice guidelines that are used by a health care insurer in determining whether to certify or deny a requested health care service.

#### PROCESS:

Lovelace Health Plan's Appeal and Grievance process is overseen by our Appeals and Grievance Department. Its purpose is to resolve issues from Members who disagree with Lovelace Health Plan's decision to deny, reduce or terminate or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on:

- A determination of an individual's eligibility to participate in a plan or health insurance coverage
- A determination that a benefit is not a covered benefit;
- The imposition of a pre-existing condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or
- A determination that a benefit is experimental, investigational, or not medically necessary or appropriate.
- Lack of Medical Necessity; or
- Rescinding coverage

Such a decision is called an Adverse Determination.

You may also disagree with Lovelace Health Plan's administrative practices, called an administrative grievance. That is, those decisions that appears 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 have established a process for working to research and resolve your Concern or Complaint.

#### *Start with the Customer Care Center*

We are here to listen and help. If you have a Concern regarding a person, a service, the quality of care, or contractual benefits, you can contact the Customer Care Center in Albuquerque at 505.727.5700 or toll-free outside of Albuquerque at 800.808.7363 (TTY Services provided by Relay New Mexico 800.659.8331). One of our Customer Care Center representatives can assist you and address your Concern.

A 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 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 the above noted address or by fax to:  
505.727.9664

All requests received will be thoroughly reviewed to determine the best course of action. If your concern involves clearly separate administrative and Adverse Determination grievances, we will process the complaints separately. Lovelace Health Plan shall assist you to complete all the forms required to pursue internal review and shall advise the you that the managed health care bureau of the New Mexico Insurance Division is available for assistance.

### *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 Prior Authorization for a service, Lovelace Health Plan will 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 and you or your provider gives us sufficient information to determine whether, or to what degree, benefits are covered or payable under your plan ) 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) show reasonable cause beyond our control for the delay; 2) can show that the delay will not result in increased medical risk to you; 3) provide 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 we make 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 coverage for services that are 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 coverage 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) show reasonable cause beyond our control for the delay; 2) can show that the delay will not result in increased medical risk to you; and 3) provide 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. If Lovelace fails

to comply with the deadline for completion of an internal review, the requested health care service shall be deemed approved unless you, after being fully informed of your rights, has agreed in writing to extend the deadline.

Some appeals of pre-service denials are processed on an expedited basis. A health care insurer shall make its initial certification or adverse determination decision in accordance with the medical exigencies of the case. The health care insurer shall make decisions within twenty-four (24) hours of the written or verbal receipt of the request for an expedited decision whenever:

- (1) The life or health of a covered person would be jeopardized;
- (2) The covered person's ability to regain maximum function would be jeopardized;
- (3) The provider reasonably requests an expedited decision; or
- (4) The medical exigencies of the case require an expedited decision

We do not conduct expedited appeals for services already provided ("post service") to a Member. If a Member requests an expedited decision, a Lovelace Health Plan Medical Director will review the request. If the Medical Director determines that the 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 will notify you and then process your appeal within the standard five (5) working days. Members in emergent care situations may be allowed to proceed with expedited external review, at the same time as the internal appeals process.

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

- The medical director, or an appropriate person designated by the medical director, shall complete his or her review of the adverse determination within the timeframes required by the medical factors of the case.
  - (1) Coverage. If the initial adverse determination was based on a lack of coverage, the medical director, or an appropriate person designated by the medical director, shall review the health benefits plan and determine whether there is any provision in the plan under which the requested health care service could be certified.
  - (2) Medical necessity. If the initial adverse determination was based on a lack of medical necessity, the medical director shall render an opinion as to medical necessity, either after consultation with specialists who are experts in the area that is the subject of review, or after application of uniform standards used by the health care insurer.
- The Plan shall provide you, with any new or additional evidence considered, relied upon, or generated by the plan in connection with your appeal. Such evidence shall be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date. The evidence shall be provided to you free of charge.
- If we issue an adverse benefit determination on review, based on new or additional rationale, we shall provide you with the rationale, free of charge. The rationale shall be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

#### *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 coverage of 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" on 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.

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, coverage for health care services will be continued subject to applicable co-payments and deductibles 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 described above 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 Member and us. 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 will not participate in the decision. Panel members cannot have been previously involved in the adverse determination.

#### *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. The notice will also advise you if we will have legal representation at the hearing and that you may wish to obtain legal representation of your own. 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 health care 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.

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

#### *Timeframes for Internal Panel Review Committee*

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; your health benefits plan, specifically the Summary of Benefits or Rider, if applicable. and/or Evidence of Coverage (EOC) Handbook ; 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.

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

In an EXPEDITED review, all information cited above shall be transmitted between Lovelace and you by the most expeditious method available. If an EXPEDITED review is conducted during a member's hospital stay or course of treatment, health care services shall be continued without cost (except for applicable co-payments and deductibles) to you until Lovelace makes a final decision and notifies you. Lovelace shall not conduct an expedited review of an adverse determination made after health care services have been provided to a covered person.

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: twenty (20) working 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 or by electronic means within one (1) working day of the telephone notice.

The Plan shall provide you, with any new or additional evidence considered, relied upon, or generated by the plan in connection with your appeal. Such evidence shall be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date. The evidence shall be provided to you free of charge.

If we issue an adverse benefit determination on review, based on new or additional rationale, we shall provide you with the rationale, free of charge. The rationale shall be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

#### *Notice of Decision of Internal Panel Review Committee*

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 Member'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 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 Mexico 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.

#### External Review of Adverse Determinations 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 require you to exhaust any grievance procedures adopted by the health care insurer or the entity that purchases health care benefits pursuant to the New Mexico Health Care Purchasing Act, as appropriate, before accepting a grievance for external review. 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](mailto: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 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.

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 will 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.

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 will 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 will 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, treatment. 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. The provider's certification and recommendation must be filed by the member, along with the copy of the internal review decision, medical release and other relevant supporting documents.

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. Upon receipt of the copy of the request for external review, Lovelace Health Plan shall, within five (5) working days for standard review or the time limit set by the superintendent for expedited review, provide to the superintendent and you by any available expeditious method:

- (1) The summary of benefits;
- (2) The complete health benefits plan, which may be in the form of a member handbook/evidence of coverage;
- (3) All pertinent medical records, internal review decisions and rationales, consulting physician reports, and documents and information submitted by the grievant and health care insurer;
- (4) Uniform standards relevant to the grievant's medical condition that were used by the internal panel in reviewing the adverse determination; and
- (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

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.

### *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 will 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 one of them shall practice in a specialty that would typically manage the case that is the subject of appeal. Prior to accepting designation as an ICO, each potential ICO shall provide to the superintendent a list identifying all health care insurers and providers with whom the potential ICO maintains any health care related or other professional business arrangements and briefly describe the nature of each arrangement. Each potential ICO shall disclose to the superintendent any other potential conflict of interest that may arise in hearing a particular case, including any personal or professional relationship to the covered person or to the health care insurer or providers involved in a particular external review. Testimony at the hearing shall be taken under oath. The Superintendent or hearing officers may call and examine Lovelace Health Plan representatives, you and other witnesses. The hearing may be conducted by telephone conference call, video conferencing or other appropriate technology at the insurance division's expense.

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 Department 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 recorded at the Division of Insurance's expense. Both you and we have the right to: 1) attend the hearing, (we will 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. Neither the member nor Lovelace may file a subsequent request for external review of the same adverse determination that was the subject of the superintendent's order. The Order shall be binding on Lovelace Health Plan and you and will state that Lovelace Health Plan and you have a right to judicial review in district court. State and Federal law may provide other options.

#### *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.

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 Member and us.

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 twenty (20) working days after receiving your response letter, or the Initial Review decision will be final.

#### *Reconsideration Committee*

Upon receipt of your request for a Reconsideration Committee hearing, Lovelace Health Plan will schedule and hold a hearing 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.

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.

#### *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 Member 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 by the New Mexico Superintendent of Insurance

##### *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](mailto: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>.

The superintendent may require the covered person to exhaust any grievance procedures adopted by an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act or a health care insurer, as appropriate, before accepting an administrative grievance for external review. 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 will 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, including the summary of benefits; the complete health benefits plan, which may be in the form of a member handbook/evidence of coverage; all pertinent medical records, internal review decisions and rationales, consulting physician reports, and documents and information submitted by the grievant and health care insurer; uniform standards relevant to the grievant's medical condition that were used by the internal panel in reviewing the adverse determination; and 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.

### External Review of Administrative Grievance

The Superintendent will review the documents submitted by Lovelace Health Plan and by 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. The hearing may be conducted by telephone conference call, video conferencing, or other appropriate technology at the insurance division's expense. The superintendent or hearing officers may call and examine the grievant, the health care insurer, and other witnesses. The superintendent may designate a hearing officer who shall be an attorney licensed to practice in New Mexico. The hearing may be conducted by telephone conference call, video conferencing, or other appropriate technology at the insurance division's expense. The superintendent may designate two (2) independent co-hearing officers who shall be licensed health care professionals. If the superintendent designates two (2) independent co-hearing officers, at least one of them shall practice in a specialty that would typically manage the case that is the subject of the grievance. Prior to accepting designation as an ICO, each potential ICO shall provide to the superintendent a list identifying all health care insurers and providers with whom the potential ICO maintains any health care related or other professional business arrangements and briefly describe the nature of each arrangement. Each potential ICO shall disclose to the superintendent any other potential conflict of interest that may arise in hearing a particular case, including any personal or professional relationship to the covered person or to the health care insurer or providers involved in a particular external review.

Co-hearing officers. The superintendent may designate two (2) independent co-hearing officers who shall be licensed health care professionals. If the superintendent designates two (2) independent co-hearing officers, at least one of them shall practice in a specialty that would typically manage the case that is the subject of the grievance.

Powers. The superintendent or attorney hearing officer shall regulate the proceedings 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:

- require the production of additional records, documents, and writings relevant to the subject of the grievance;
- exclude any irrelevant, immaterial, or unduly repetitious evidence; and
- if the grievant or health care insurer fails to appear, proceed with the hearing or adjourn the proceedings to a future date, giving notice of the adjournment to the absent party.

Staff participation. 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.

Testimony. Testimony at the hearing shall be taken under oath. The superintendent or hearing officers may call and examine the grievant, the health care insurer, and other witnesses.

Hearing recorded. The hearing shall be stenographically recorded at the insurance division's expense.

Rights of parties. Both the grievant and the health care insurer have the right to:

- attend the hearing; the health care insurer shall designate a person to attend on its behalf and the grievant may designate a person to attend on her behalf if the grievant chooses not to attend personally;
- be assisted or represented by an attorney or other person; and
- call, examine and cross-examine witnesses.

Stipulation. The grievant and the health care insurer shall each stipulate on the record that the hearing officers shall be released from civil liability for all communications, findings, opinions, and conclusions made in the course and scope of the external review.

## **COVERAGE UNDER OTHER INSURANCE**

### **Injuries Caused by Third Parties and Subrogation**

This section applies when another party is, or may be considered, liable for a Member's injury, sickness or other condition (including insurance carriers who are so financially liable) and Lovelace Health Plan has advanced benefits.

In consideration for the advancement of benefits, Lovelace Health Plan is subrogated to all of the rights of the Member against any party liable for the Member's injury or illness, or is or may be liable for the payment for the medical treatment of such injury or occupational illness (including any insurance carrier), to the extent of the value of the medical benefits advanced to the Member under the Plan. Lovelace Health Plan may assert this right independently of the Member. This right includes, but is not limited to, the Member's rights under uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, or other insurance, as well as the Member's rights under the Plan to bring an action to clarify his or her rights under the Plan. Lovelace Health Plan is not obligated in any way to pursue this right independently or on behalf of the Member, but may choose to pursue its rights to reimbursement under the Plan, at its sole discretion.

The Member is obligated to cooperate with Lovelace Health Plan and its agents in order to protect Lovelace Health Plan's subrogation rights. Cooperation means providing Lovelace Health Plan or its agents with any relevant information requested by them, signing and delivering such documents as Lovelace Health Plan or its agents reasonably request to secure the Lovelace Health Plan's subrogation claim, and obtaining the consent of Lovelace Health Plan or its agents before releasing any party from liability for payment of medical expenses. If a Member fails to obtain Lovelace Health Plan's prior written consent to any settlement releasing any party from liability for payment of medical expenses, the Member will be required to repay Lovelace Health Plan for the value of any benefits advanced by Lovelace Health Plan under the Plan.

The Member is obligated to cooperate with Lovelace Health Plan and its agents in order to protect Lovelace Health Plan's subrogation rights. Cooperation means providing Lovelace Health Plan or its agents with any relevant information requested by them, signing and delivering such documents as Lovelace Health Plan or its agents reasonably request to secure the Lovelace Health Plan's subrogation claim, and obtaining the consent of Lovelace Health Plan or its agents before releasing any party from liability for payment of medical expenses. If the Member enters into litigation or settlement negotiations regarding the obligations of other parties, the Member must not prejudice, in any way, the subrogation rights of Lovelace Health Plan under this section. If a Member fails to obtain Lovelace Health Plan's prior written consent to any settlement releasing any party from liability for payment of medical expenses, or otherwise fails to cooperate with this provision, including executing any documents required herein, the Member will be required to repay Lovelace Health Plan for the value of any benefits advanced by Lovelace Health Plan under the Plan.

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:

Discovery Health Partners  
1701 Golf Road, Suite 1-1100  
Rolling Meadows, IL 60008-9928

### **Coordination of Benefits (COB)**

Coordination of Benefits (COB) refers to Members who have coverage under more than one healthcare benefit 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 Charge. (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).

Benefits payable under the Plan will be secondary to benefits provided or required by any group or individual automobile, homeowner's or premises insurance, including medical payments, personal injury protection, or no-fault coverage, regardless of any provision to the contrary in any other policy of insurance.

Lovelace Health Plan must know what other health insurance coverage you have in order to coordinate benefits with your other carrier(s). This could reduce the out-of-pocket or "not covered" amounts that you are liable for. Therefore, it is in your best interest to provide us with the most up-to-date information about other coverage carried by you and your dependents. When you end or begin your other health insurance coverage, you should notify the Customer Care Center immediately. If you have any questions, please contact the Customer Care Center at 505.727.5700 or toll-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 Provider for your covered medical care. If you have already paid a Provider for emergency care or care performed outside the Service Area, Lovelace Health Plan still must pay the Provider. You must seek reimbursement from the Provider.

## WHO MAY ENROLL

### Enrollment Provisions – Who Can Enroll as a Member

To be eligible for Covered Benefits, Services and Supplies you must be enrolled as a Member. To be eligible to enroll as a Member you must meet either the Subscriber or Dependent eligibility criteria listed below. You must also meet and continue to meet the New Mexico Health Insurance Alliance specific enrollment and eligibility rules.

#### A. To be eligible to enroll as a Subscriber, you must:

1. Be an employee of the Employer Group or a participant in a covered group (including part-time employees who work at least twenty (20) hours per week over a six month period as defined by State Law); and
2. Reside or work in the Service Area, as determined by Lovelace Health Plan; and
3. Meet and continue to meet these criteria; and
4. Never have been terminated as a Member of Lovelace Health Plan or Lovelace Health Plan for any of the reasons explained in the Termination for Cause section of this EOC Handbook.

#### B. To be eligible and enroll as a Dependent, you must:

1. Be the legal spouse of the Subscriber; or
2. Be the natural child, step-child, or adopted child of the Subscriber or the Subscriber's spouse, or the child for whom the Subscriber or Subscriber's spouse is the legal guardian, legally placed with the Subscriber or Subscriber's spouse for adoption, or supported pursuant to a court order imposed on the Subscriber as the non-custodial parent (including a qualified medical child support order), provided that the child:
  - a. Has not yet reached age twenty-six (26) as required by State Law or is within the Employer Group's age limitations, if older; or
  - b. The child is twenty-six (26) or older and continuously incapable of self-sustaining support because of a mental or a physical disability which existed prior to attaining twenty-six (26) years of age. You must submit proof of the child's Condition and dependence to us within thirty-one (31) days after the date the child ceases to qualify as a Dependent under subsection (i) and (ii) above. We may, from time to time during the next two (2) years, require proof of the continuation of the child's condition and dependence. Thereafter, we may require such proof only once a year.

We may not exclude children, who, having met applicable requirements above, were born out of wedlock or are not claimed as dependents on their parents' federal tax return.

### Enrollment of Dependents Due to Qualified Medical Child Support Order

Lovelace Health Plan will provide coverage to Dependent children of employees required to provide medical insurance for such Dependents due to a Qualified Medical Child Support Order in accordance with New Mexico Public Regulation Commission Insurance Division regulations and under federal law. Court ordered dependents are covered at the in-network benefit coverage even if they reside outside of the Service Area and are not bound by enrollment season restrictions. The effective date of coverage is the first of the month following receipt of the Order or the effective date of the Order, not to exceed sixty (60) days retroactive coverage. A child will be covered until satisfactory written evidence is provided; indicating that: 1) the order has been vacated or terminated; or 2) the child is or will be enrolled in comparable health coverage through another insurer that will take effect not later than the effective date of disenrollment.

**PLEASE NOTE:**

- A Subscriber's grandchild is not eligible for coverage unless the grandchild meets the eligibility criteria for a Dependent.
  - A child born of a surrogate parent, if that parent is not a Member, is not eligible for coverage
  - A Dependent who resides outside of the Service Area will be entitled to out-of-area emergency and Urgent Care benefits only while out of the Service Area, and must return to the Service Area to receive other covered services.
- C. **If the employer has chosen a Plan to allow enrollment of a domestic partner, the domestic partner must:**
1. Share a permanent residence with the Subscriber;
  2. Have resided with the Subscriber for not less than 1 year (365 days);
  3. Be at least eighteen years of age;
  4. Be financially interdependent with the Subscriber and have proven such interdependence by providing documentation of at least two of the following arrangements:
    - a. Common ownership of real property or a common leasehold interest in such property;
    - b. Common ownership of a motor vehicle;
    - c. A joint bank account or a joint credit account;
    - d. Designation as a beneficiary for life insurance or retirement benefits or under the Subscriber's last will and testament;
    - e. Assignments of a durable power of attorney or health care power of attorney; or
    - f. Such other proof as is considered by Lovelace Health Plan to be sufficient to establish financial interdependency under the circumstances of a particular case.
  5. Not be a blood relative any closer than would prohibit legal marriage;
  6. Have signed jointly with the Subscriber a notarized affidavit in form and content as may be requested by satisfactory to Lovelace Health Plan; and
  7. Have registered with the Subscriber as domestic partners if you reside in a state that provides for such registration.

**PLEASE NOTE:**

- You are not eligible to enroll as a domestic partner if either you or the Subscriber has signed a domestic partner affidavit or declaration with any other person within twelve (12) months prior to designating each other as domestic partners under this Plan; are currently legally married to another person; or have any other domestic partner, spouse or spouse equivalent of the same or opposite sex.
- An eligible domestic partner's children who meet the Dependent eligibility requirements are also eligible to enroll.
- The "Continuation of Group Coverage under COBRA" section of this EOC Handbook does not apply to the Subscriber's domestic partner and his/her Dependents.

## Enrollment and Effective Dates of Coverage

### Enrollment during an Open Enrollment Period

1. If you meet the Subscriber or Dependent eligibility criteria, you may enroll as a Member during an Open Enrollment Period by submitting a completed Enrollment Application, together with any applicable fees, to the Employer Group.

If enrolled during an Open Enrollment Period, your effective date of coverage is the first day of the Contract Year.

### Enrollment after an Open Enrollment Period

1. If, after the Open Enrollment Period, you become eligible for coverage as a Subscriber or a Dependent, you may enroll as a Member within thirty-one (31) days of the day on which you met the eligibility criteria. To enroll, you must submit an Enrollment Application, together with any additional Premium fees due, to the Employer Group. After enrolling, your effective date of coverage will be the day on which you meet the eligibility criteria.

If you do not enroll within the thirty-one (31) days, your next opportunity to enroll will be during the next Open Enrollment Period.

2. If you are a Subscriber who is enrolled as a Member and want to enroll a newly born child, you **must enroll the child within thirty-one (31) days after the child's birth**. To enroll a newborn child, you must submit an Enrollment Application, together with any additional Premium fees due, to the Employer Group. After enrolling, the effective date of coverage for your newborn child will be the moment of birth. **Please Note:** Failure to enroll a newly born child within the thirty-one (31) days will result in denial of benefits for applicable charges incurred for the birth of that child.

If you do not enroll a newborn child or pay the applicable Premiums within the thirty-one (31) days after the child's birth, your child will not be covered and your next opportunity to enroll the child will be during the next Open Enrollment Period.

3. If you are a Subscriber who is enrolled as a Member, you may enroll an adopted child or child for whom you have been granted legal guardianship within thirty-one (31) days of the date the child is legally placed with you for adoption or within thirty-one (31) days of the date you are granted legal guardianship. To enroll an adopted child or child for whom you are the legal guardian, you must submit an Enrollment Application, together with any additional fees due, to the Employer Group and submit a copy of the court or agency order granting placement for purposes of adoption to Lovelace Health Plan. After enrolling, the effective date of coverage for your child will be the date of legal placement of the child for adoption or the date of court ordered legal guardianship. Coverage shall include the necessary care and treatment of medical conditions existing prior to the date of placement.

If you do not enroll an adopted child or a child for whom you are legal guardian within thirty-one (31) days of events noted above, your next opportunity to enroll the child will be during the next Open Enrollment Period.

### Enrollment of Dependents Due to Qualified Medical Child Support Order

Lovelace Health Plan will provide coverage to Dependent children of employees required to provide medical insurance for such Dependents due to a Qualified Medical Child Support Order in accordance with New Mexico Public Regulation Commission Insurance Division regulations and under federal law. Court ordered dependents are covered at the in-network benefit coverage even if they reside outside of the Service Area and are not bound by enrollment season restrictions, and will be covered until court documents are provided, indicating the order has been vacated or terminated. The effective date of coverage is the first of the month following receipt of the Order or the effective date of the Order, not to exceed sixty (60) days retroactive coverage.

The employee, if not already enrolled, may enroll at this time. This is NOT a requirement. The employee may choose to enroll only the Dependent(s) that appear on the Order. It is important to note that only the employee and Dependent(s) that appear on the Order are eligible for enrollment at this time.

### **Special Enrollment after Open Enrollment Period**

There are special circumstances under which an individual who was eligible to enroll for coverage as a Subscriber, but did not do so, may be eligible to enroll himself and any eligible Dependents outside of the Open Enrollment Period.

1. After the Open Enrollment Period, you may submit an Enrollment Application and any applicable fees, to the Employer Group, for yourself and any eligible Dependent(s) within thirty-one (31) days of the date of the following events:
  - a. Marriage – You may enroll your new spouse and eligible stepchildren;
  - b. Birth of a dependent newborn child – You may enroll your newborn and spouse (if not already enrolled) at this time. Other eligible dependents not previously enrolled may be enrolled during your Employer Group's next Open Enrollment Period; or
  - c. Adoption of a dependent child or legal placement of a dependent child for adoption – You may enroll your adopted or legally placed child and your spouse (if not already enrolled). Other eligible Dependents may be enrolled during your Employer Group's next Open Enrollment period. Coverage shall include the necessary care and treatment of medical conditions existing prior to the date of placement.If enrolled, the effective date of coverage will be the day of the event creating eligibility.
2. If you do not enroll within the thirty-one (31) days of one of these events, the next opportunity for you and any eligible Dependents to enroll will be during the next Open Enrollment Period.

### **Enrollment Due to Loss of Prior Creditable Coverage**

If you and/or your Dependent(s) did not enroll as a Member during the Open Enrollment Period because you and/or your Dependent(s) had other creditable health care coverage, you will be eligible to enroll for coverage under this Plan if you later lose that coverage, provided you meet all other eligibility requirements.

You will receive credit for your previous coverage that occurred without a break in coverage of 95 days.

You must submit to the Employer Group an Enrollment Application, and any applicable fees due within thirty-one (31) days of the day that you or your Dependent(s):

1. Are no longer eligible for the other coverage for any reason (including legal separation, divorce or death of the Subscriber);
2. Lost the other coverage because an employer or Plan sponsor failed to pay required Premium or fees; or
3. Completed continuation of other coverage as provided under federal or state law.

If enrolled, the effective date of coverage will be the day after the qualifying event.

If these conditions are not met, or if you do not submit an Enrollment Application within thirty-one (31) days of one of these events, the next opportunity for you and any eligible Dependent(s) to enroll will be during the next Open Enrollment Period.

### **Special Enrollment Period and Qualifying Events for Health Care Coverage under CHIPRA**

The Children's Health Insurance Program (CHIP) (formerly the State Children's Health Insurance Program or SCHIP) provides health insurance to children and some adults in families that earn too much money to qualify for Medicaid, but still cannot afford to pay for private insurance. On February 4, 2009, a bill to reauthorize and expand CHIP was signed into law.

As a result, effective April 1, 2009, a new midyear special enrollment period related to two new qualifying events may be available for eligible employees and dependents to enroll in employer group health plans. This means that in addition to enrolling upon hire, at open enrollment, or as the result of existing qualifying events, employees and their dependents may now have additional opportunities to enroll in a health care plan.

Following are the two new qualifying events:

- Employees or dependents lose Medicaid or CHIP coverage due to loss of eligibility
- Employees or dependents become eligible for a Medicaid or CHIP premium assistance program (not all states may offer a premium assistance program)

Employees must request coverage within 60 days of the new qualifying event(s).

### **Special Enrollment Period and Qualifying Events for Persons who have reached a Lifetime Maximum of an applicable Lovelace Health Plan HMO plan and are eligible to Re-enroll**

Under the Patient Protection and Affordable Care Act, the lifetime limit on the dollar value of benefits under Lovelace Health Plan products no longer applies, effective September 23, 2010. Individuals whose coverage ended by reason of reaching a lifetime limit under a plan are eligible to enroll in the plan. Individuals have 30 days from the date of notice to request enrollment. For more information contact the Lovelace Health Plan Customer Care Center at 505.727.5683, toll-free at 800.808.7363 or TTY 800.659.8331.

### **Full and Accurate Completion of Enrollment Application**

Each Subscriber must fully and accurately complete the Enrollment Application. False or fraudulent statements or representations provided in any Enrollment Application may, in Lovelace Health Plan's sole discretion, cause the coverage of the Subscriber and/or his Dependents to be null and void from its inception.

### **Hospitalization on the Effective Date of Coverage**

If you or a Dependent are confined in a hospital on the effective date of your coverage, you must notify us of the hospitalization within two (2) days, or as soon as reasonably possible thereafter, to help ensure that appropriate benefits are available.

### **Change of Status**

Changes in Dependent status, marital status, place of work, or residence (in and out of Service Area), or leaving an Employer Group may affect your Plan coverage. Lovelace Health Plan must know about these changes as soon as they occur. Please contact your Employer Group's personnel office. Ask that the Employer Group notify Lovelace Health Plan right away. If you change your address, be sure to notify us to assure that you receive Plan notices and mailings.

### **Continuing Enrollment**

Members enrolled in the Plan on the effective date of a new Contract Year may be automatically re-enrolled. If you do not want to re-enroll, you will need to inform the Employer Group of your intent to cancel Membership. Contact your Employer Group personnel office for details.

## TERMINATION OF COVERAGE

### Termination for Cause

Upon written notice to the Employer Group and you, we may terminate your coverage or your Covered Family Unit's coverage for cause if any of the following events occur:

1. You intentionally omit, misrepresent, or provide materially false or fraudulent information in the Enrollment Application, in which case, we may render coverage of a Covered Family Unit to be null and void from the effective date of coverage;
2. You permit a non-Member to use your Lovelace Health Plan ID card or to falsely obtain Services and Supplies;
3. You obtain or attempt to obtain Services and Supplies by means of false or fraudulent information, acts or omissions;
4. Your behavior, in our sole opinion, is disruptive, unruly, abusive or uncooperative to such an extent that we are seriously impaired in our ability to provide coverage to you or to any other Member; or
5. You threaten the life or well being of any Lovelace Healthy Plan employee, Participating Provider or another Member

In no event, however, will we terminate your coverage due to health status, need for health care services, race, gender, age, sexual orientation or utilization of Services and Supplies. If you feel that your coverage has been unjustly terminated, you can file an Appeal with Lovelace Health Plan or 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

We shall not terminate your coverage for a member receiving treatment for a life threatening condition or for failure to follow a prescribed course of treatment.

### Termination By Reason of Ineligibility

When you fail to meet the eligibility criteria in "Enrollment and Effective Date of Coverage" as either a Subscriber or Dependent, your coverage under this Plan will end. Coverage of all Members within a Covered Family Unit shall cease when the Subscriber fails to meet the eligibility criteria. The Employer Group shall notify us of all Members who fail to meet the eligibility criteria.

Generally, if you fail to meet the eligibility criteria your coverage will end at midnight of the last day of the month in which the eligibility event occurred, including, but not limited to, a subscriber's termination of employment or a covered dependent's twenty-sixth birthday. Please contact your employer to confirm the company's policy regarding the exact date and time coverage ends when loss of eligibility occurs. When the loss of eligibility occurs, we will have no further obligation to cover Services and Supplies

## **Termination By Termination of the Policy**

This Policy may be terminated for certain reasons including the failure of the Employer Group to pay Premiums owed to us, fraud or intentional misrepresentation of a material fact, violation of contribution or participation requirements and upon appropriate Notice given by either Lovelace Health Plan or the Employer Group.

## **Additional Reasons for Termination Under New Mexico Law**

Lovelace Health Plan ceases to offer coverage in the market in accordance with New Mexico law.

If there is no longer any member in connection with the Plan who lives, resides or works in the Plan's service area and/or where Lovelace Health Plan is authorized to do business and in the case of Small Employer Groups, as defined by New Mexico Law, limit the employers that may apply for the coverage to those with eligible individuals who live, work or reside in the service area for the network plan.

If membership through one or more bona fide association ceases, but without regard to any health status related factor related to a covered individual.

## **Termination Effective Date**

Coverage under this Policy may terminate at different times, depending upon the reasons for termination, including, but not limited to: termination for cause; loss of eligibility due to termination of employment; and loss of eligibility due to change in dependent status. Please be sure to ask your employer group's benefits' administrator for specific information about termination effective dates.

## **Notice of Termination to Members**

If this Policy is terminated for cause, Lovelace Health Plan will send a Notice of Cancellation to Subscriber no less than thirty (30) days prior to the effective date of termination. The notice will be dated; state the reasons for termination; state the reasons for which you cannot be terminated, including, but not limited to health status, age or gender; state the effective date of termination; state your right to file an Appeal with Lovelace Health Plan or t with the Superintendent of Insurance if you feel you have been wrongly dis-enrolled; provide information about your ability to enroll in a conversion plan; and any other matters required by law, including premium refund, if applicable and information related to reinstatement of a Policy.

## **Responsibility for Payment**

The Employer Group shall be responsible for the payment of all Premiums and fees due through the date on which coverage ceases. You shall be financially responsible for all services rendered after that date.

## **Certification of Creditable Coverage upon Termination**

We will issue you a Certification of Group Health Plan Creditable Coverage as required by law and based on information provided to us by the Employer Group at the following times:

1. When your coverage is terminated for cause or by reason of ineligibility or you otherwise become covered under "Continuation of Coverage";
2. When your continuation coverage, if you elected to receive it, is exhausted; and
3. When you make a request within twenty-four (24) months after the date coverage expires under either of the above two situations.

## **Continuation of Group Coverage under COBRA**

Under the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, a qualified employer must give its employees and dependents the right to continue their group health care benefits. A person who would otherwise lose coverage as a result of a qualifying event is generally entitled to continue the same

benefit coverage that was in effect the day before the date of the qualifying event. Coverage may be continued under COBRA only if the required Premiums are paid when due and will be subject to future Plan changes.

**IMPORTANT NOTICE** – COBRA BENEFITS WILL ONLY BE ADMINISTERED ACCORDING TO THE TERMS OF THE CONTRACT SIGNED WITH THE QUALIFIED EMPLOYER AND LOVELACE HEALTH PLAN. LOVELACE HEALTH PLAN IS NOT THE DETERMINING AUTHORITY OF COBRA ELIGIBILITY AND WILL NOT BE OBLIGATED TO ADMINISTER, OR FURNISH, ANY COBRA BENEFITS AFTER THE CONTRACT HAS TERMINATED.

**A COBRA qualifying event** is any of the following:

- Termination of the Subscriber's employment (other than for gross misconduct) or reduction of hours worked so as to render the Subscriber ineligible for coverage;
- Death of the Subscriber;
- Divorce or legal separation of the Subscriber from his or her spouse;
- Loss of coverage due to the Subscriber becoming entitled to Medicare;
- A Dependent child ceasing to qualify as an eligible Dependent under the Plan; or
- If the Plan provides coverage for retired Subscribers and eligible Dependents, a qualifying event will also mean a substantial loss of that retiree coverage due to the employer filing for Chapter 11 Bankruptcy. (The substantial loss can occur within 1 year [365 days] before or after the filing for Chapter 11 Bankruptcy.)

When there is a divorce or legal separation or a child ceases to qualify as an eligible Dependent, the Subscriber or eligible Dependent is responsible for notifying the employer within sixty (60) days after the date of the qualifying event. If the employer is not so notified, the person will not be given the opportunity to continue coverage.

After notification of his or her COBRA rights, the Subscriber or eligible Dependent has a limited amount of time to elect continuation. Continued health care coverage is not automatic.

Continuation of coverage under COBRA must be elected within sixty (60) days of the later of the following:

- The date of the Subscriber or eligible Dependent loses coverage as a result of the qualifying event; or
- The date of the Subscriber or eligible Dependent is notified by the employer of the right to continued coverage.

Failure of your employer group or the employer group's representative to provide the member with appropriate election information will not obligate the Plan to provide continuation coverage.

Notice of the right to continue coverage to your spouse will be deemed notice to any Dependent child residing with you or your spouse.

The Subscriber or eligible Dependent may be required to pay a Premium to continue coverage. If the Subscriber or eligible Dependent elects to continue coverage, the Subscriber or eligible Dependent will have forty-five (45) days from the date of election to pay the initial Premium due. All subsequent Premiums will be due on a monthly basis. There is a thirty (30)-day grace period to pay Premiums. If the Premium is not paid before the expiration of the grace period, COBRA continuation benefits will end.

If elected, the maximum period of continued coverage for a qualifying event involving termination of employment or reduced working hours is eighteen (18) months from the date of the qualifying event. However, if a second qualifying event occurs (such as a divorce or death of the Subscriber) within this eighteen (18) month period, the period of coverage for any affected Dependent may be extended to up to thirty-six (36) months from the date of the initial (first) qualifying event.

If a qualified beneficiary is totally disabled under the Social Security Act on the date of the qualifying event, or at any time during the first sixty (60) days of continued coverage, the 18 month period may be extended to up to twenty-nine (29) months. If there are non-disabled family members of this qualified beneficiary who have elected COBRA continuation coverage, they are also entitled to this additional 11 months of coverage. In order for this additional 11 months of coverage to be effective, the Subscriber or eligible Dependent must provide the employer with a copy of the Social Security Administration's determination of total disability within sixty (60) days of receiving such notice. The notice must also be provided to the employer within the initial 18 months of COBRA continuation coverage.

If a covered Subscriber has a qualifying event (termination of employment or reduction in hours worked) and he/she had become entitled to Medicare before the date of this qualifying event, then:

- The Subscriber may continue the group health coverage for up to eighteen (18) months from the date of termination or reduction in hours worked, and
- Any other qualified beneficiary (the spouse and/or children) will be entitled to the greater of (i) thirty-six (36) months from the date the Subscriber first became entitled to Medicare, or (ii) eighteen (18) months from the covered Subscriber's termination or reduction in hours.

The maximum period of continued benefits for a qualifying event involving retired Subscribers of employers under Chapter 11 Bankruptcy and their Dependents will be:

- The date of death of the retired Subscriber; or
- For a surviving spouse or eligible Dependent, thirty-six (36) months after the date of death of the retired employee.

For all other qualifying events, the maximum period is thirty-six (36) months, except as provided below.

If the employer provides continuation options in addition to COBRA, the Subscriber or eligible Dependent may elect one of them in lieu of COBRA, but the Subscriber or eligible Dependent may not have both. The election of another continuation option is a waiver of COBRA.

However, if the Plan provides for continuation of existing coverage for a certain period of time after any qualifying event, the Subscriber may receive a COBRA election form when the existing coverage actually ends. The Subscriber or eligible Dependent may elect COBRA continuation coverage for the balance of the applicable 18, 29 or 36 month period.

Other events will cause COBRA continuation coverage to end sooner. This will occur on the earliest of any of the following:

- The date the employer ceases to provide any group health plan to any employee;
- The date the Subscriber or eligible Dependent fails to timely pay any required Premium ;
- The first day after the date of election on which the qualified beneficiary first becomes covered under any other group health plan which does not contain any exclusions or limitations with respect to any pre-existing Condition for such person; or the date such exclusion or limitation no longer applies to the Subscriber or Dependent;
- The first day after the date of election on which the qualified beneficiary first becomes entitled to Medicare (except for a Chapter 11 Bankruptcy qualifying event); or
- With respect to a qualified beneficiary whose coverage is being extended for the additional 11 months due to a disability as described above, coverage will terminate on the first day of the month that is more than thirty (30) days after the date in which the disabled individual is no longer disabled for Social Security purposes.

### **COBRA Premium Reduction Provisions under ARRA**

President Obama signed the American Recovery and Reinvestment Act (ARRA) on February 17, 2009. ARRA, as amended, provides premium reductions for health benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly called COBRA. COBRA premium reduction for eligible individuals who are involuntarily

terminated from employment through the end of May 2010 who satisfy the definition of "Assistance Eligible Individuals." Due to the statutory sunset, the COBRA premium reduction under ARRA is not available for individuals who experience involuntary terminations after May 31, 2010. However, individuals who qualified as Assistance Eligible Individuals on or before May 31, 2010 may continue to pay reduced premiums for up to 15 months, as long as they are not eligible for another group health plan or Medicare.

The Unemployment Compensation Extension Act of 2010 signed by the President on July 22, 2010, did not extend the COBRA premium reduction.

To be considered an Assistance Eligible Individual and receive reduced premiums, you must be the employee or a member of his/her family who:

- Elects COBRA coverage timely following a qualifying event related to an involuntary termination of employment that occurs at any point from:
  - September 1, 2008 through May 31, 2010; or
  - March 2, 2010 through May 31, 2010 if:
    - The involuntary termination follows a qualifying event that was a reduction of hours; and
    - The reduction of hours occurred at any time from September 1, 2008 through May 31, 2010. (A reduction of hours is a qualifying event when the employee and his/her family lose coverage because the employee, though still employed, is no longer working enough hours to satisfy the group health plan's eligibility requirements.)
- Has COBRA continuation coverage election opportunity related to an involuntary termination of employment that occurred at some time from September 1, 2008 through May 31, 2010 (or later if extended);
- Is not eligible for Medicare; and
- Is not eligible for coverage under any other group health plan, such as a plan sponsored by a successor employer or a spouse's employer.
- If you are already enrolled into COBRA Continuation coverage due to an involuntary termination of employment after September 1, 2008, you may be eligible for a premium credit after March 1, 2009.
- Generally, the maximum period of continuation coverage is measured from the date of the original qualifying event (for Federal COBRA, this is generally 18 months). However, ARRA, as amended, provides that the 15 month premium reduction period begins on the first day of the first period of coverage for which an individual is "assistance eligible." This is of particular importance to individuals who experience an involuntary termination following a reduction of hours. Only individuals who have additional periods of COBRA (or state continuation) coverage remaining after they become assistance eligible are entitled to the premium reduction.
- For purposes of ARRA, COBRA continuation coverage includes continuation coverage required under Federal law (COBRA or Temporary Continuation Coverage) or a State law that provides comparable continuation coverage (for example, so-called "mini-COBRA" laws).
- Those who are eligible for other group health coverage (such as a spouse's plan or new employer's plan) or Medicare are not eligible for the premium reduction. There is no premium reduction for periods of coverage that began prior to February 17, 2009.
- Assistance eligible individuals who pay 35 percent of their COBRA premium will be treated as having paid the full amount.

If, after you elect COBRA Continuation Coverage and while you are paying the reduced premium, you become eligible for other group health plan coverage or Medicare you MUST notify Lovelace Health Plan in writing. If you do not, you may be subject to a tax penalty.

Some people who are eligible for the COBRA subsidy also qualify for the health coverage tax credit (HCTC) and may want to choose this more generous benefit instead. The HCTC pays 80 percent of health insurance premiums for those who qualify. Eligible individuals must receive Trade Adjustment Assistance benefits or be between the ages of

55 and 65 and receive pension payments from the Pension Benefit Guaranty Corporation. Individuals must also be enrolled in a qualified health plan.

Electing the premium reduction disqualifies you for the Health Coverage Tax Credit. If you are eligible for the HCTC, you will have received a notification from the IRS. The amount of the premium reduction is recaptured for certain high income individuals. If the amount you earn for the year is more than \$125,000 (or \$250,000 for married couples filing a joint federal income tax return) all or part of the premium reduction may be recaptured by an increase in your income tax liability for the year. If you think that your income may exceed the amounts above, you may wish to consider waiving your right to the premium reduction. For more information, consult your tax preparer or visit the IRS webpage on ARRA at [www.irs.gov](http://www.irs.gov).

For specific information, please contact Customer Care at 1-800-808-7363. If you are denied treatment as an Assistance Eligible Individual you may have the right to have the denial reviewed. For more information regarding reviews or for general information about the ARRA Premium Reduction go to: [www.cms.hhs.gov/COBRAContinuationofCov](http://www.cms.hhs.gov/COBRAContinuationofCov) or [NewCobraRights@cms.hhs.gov](mailto:NewCobraRights@cms.hhs.gov).

### **Continuation of Group Coverage Under New Mexico State Law**

If enrollment through the Employer Group is no longer available due to termination of employment and your Employer Group does not offer COBRA, you still may continue coverage with the Employer Group for a period of six (6) months, after which you may convert to individual conversion coverage. Coverage may be continued under this section only if the required Premiums are paid when due, and is subject to all future Plan changes. Persons are not eligible for conversion coverage if he/she resides outside the United States for over six (6) months.

### **COBRA Premium Reduction Provisions under ARRA**

President Obama signed the American Recovery and Reinvestment Act (ARRA) on February 17, 2009. The law gives "Assistance Eligible Individuals" the right to pay reduced **COBRA** coverage premiums for periods of coverage beginning on or after February 17, 2009 and can last up to 9 months, unless otherwise specified under federal law and described in the notice provided to subscribers when they or their eligible dependents become eligible for COBRA continuation coverage. To be considered an Assistance Eligible Individual and receive reduced premiums, you must:

- Be eligible for COBRA continuation coverage at any time during the period from September 1, 2008 through December 31, 2009, or, as may be amended by law, and elect the coverage;
- Have COBRA continuation coverage election opportunity related to an involuntary termination of employment that occurred at some time from September 1, 2008 through December 31, 2009;
- Not be eligible for Medicare; and
- Not be eligible for coverage under any other group health plan, such as a plan sponsored by a successor employer or a spouse's employer.
- If you are already enrolled into COBRA Continuation coverage due to an involuntary termination of employment after September 1, 2008, you may be eligible for a premium credit after March 1, 2009.

If, after you elect **COBRA** Continuation Coverage and while you are paying the reduced premium, you become eligible for other group health plan coverage or Medicare you **MUST** notify Lovelace Health Plan in writing. If you do not, you may be subject to a tax penalty.

Electing the premium reduction disqualifies you for the Health Coverage Tax Credit. If you are eligible for the Health Coverage Tax Credit, which could be more valuable than the premium reduction, you will have received a notification from the IRS. The amount of the premium reduction is recaptured for certain high income individuals. If the amount you earn for the year is more than \$125,000 (or \$250,000 for married couples filing a joint federal income tax return) all or part of the premium reduction may be recaptured by an increase in your income tax liability for the year. If you

think that your income may exceed the amounts above, you may wish to consider waiving your right to the premium reduction. For more information, consult your tax preparer or visit the IRS webpage on ARRA at [www.irs.gov](http://www.irs.gov).

For specific information, please contact Customer Care at 1-800-808-7363. If you are denied treatment as an Assistance Eligible Individual you may have the right to have the denial reviewed. For more information regarding reviews or for general information about the ARRA Premium Reduction go to: [www.cms.hhs.gov/COBRAContinuationofCov](http://www.cms.hhs.gov/COBRAContinuationofCov) or [NewCobraRights@cms.hhs.gov](mailto:NewCobraRights@cms.hhs.gov).

### **Conversion to Non-Group (Individual) Coverage**

If you do not elect COBRA or State continuation coverage, fail to properly elect COBRA or State continuation coverage, are ineligible to elect COBRA continuation coverage, or had COBRA or State continuation coverage for which the maximum coverage period has expired, you may apply to Lovelace Health Plan for conversion to non-group (individual) coverage. You must continue to reside in the Service Area in order to be eligible for non-group (individual) coverage. Coverage may be continued under Conversion only if the required Premiums are paid when due and will be subject to future Plan changes. Persons are not eligible for conversion coverage if he/she resides outside the United States for over six (6) months.

### **Loss of Subscriber Eligibility**

If you, as the Subscriber, are no longer eligible for coverage under this Policy for any reason other than the reasons stated in the "Termination for Cause" or "Termination of Policy" provisions of "Termination of Your Coverage," you may apply for conversion to non-group (individual) coverage. You must apply and pay the applicable Premium within thirty-one (31) days of the loss of Employer Group coverage. At the time of conversion to non-group (individual) coverage, you may also apply for non-group (individual) coverage for Dependents who were Members at the time of your loss of eligibility. If your application and all non-group fees, including all fees for the period since the termination of Employer Group coverage, are submitted within thirty-one (31) days of the loss of Employer Group coverage your non-group (individual) coverage will be effective as of the date of such termination. Loss of Subscriber Eligibility includes:

- **Conversion Upon Death or Divorce of Subscriber**  
If you are a Dependent who has lost eligibility for coverage under this Policy due to the death or divorce, annulment or dissolution of marriage or legal separation of the Subscriber, you may apply for conversion to non-group (individual) coverage.
- **Conversion Upon Meeting Age Limitation**  
If you are a Dependent who has lost eligibility for coverage under this Policy due to your attainment of an age limitation identified in the Policy, you may apply for conversion to non-group (individual) coverage.
- **Conversion after Expiration of COBRA Continuation Coverage**  
A Member whose COBRA continuation coverage has expired after the maximum coverage period may apply for conversion to non-group (individual) coverage. However, no conversion will be provided if the qualified beneficiary does not actually maintain COBRA coverage to the expiration date. The benefits, terms and conditions of the non-group (individual) coverage, including Premiums, Co-Payment/Co-Insurance amounts and deductibles, if any, shall be in accordance with the rules of Lovelace Health Plan in effect at the time of conversion and will not necessarily be identical to benefits provided under this Policy.
- **Conversion after Expiration of Continuation Coverage under New Mexico Law**  
A Member, whose continuing coverage under New Mexico law has expired after the maximum coverage period, may apply for conversion to non-group (individual) coverage. The benefits, terms and conditions of the non-group (individual) coverage, including Premiums, Co-Payment/Co-Insurance amounts and deductibles, if any, shall be in accordance with the rules of the Lovelace Health Plan in effect at the time of conversion and will not necessarily be identical to the benefits provided under this Policy.

### **Continuation of Coverage under FMLA**

If the Employer Group is subject to the requirements of FMLA (Family and Medical Leave Act of 1993, as amended), the Subscriber shall have coverage under this Policy during a leave of absence if the Subscriber is an eligible employee under the terms of the FMLA and the leave of absence qualifies as a leave of absence under FMLA. The Subscriber shall pay to the Employer Group the portion of the Premium, if any that the Subscriber would have paid had the Subscriber not taken leave and the Employer Group shall pay Lovelace Health Plan the Premium for the Subscriber as if the Subscriber had not taken leave.

## **ERISA PROVISIONS**

### **Plan Modification, Amendment and Termination**

The Employer Group as Plan Sponsor has the right, at any time, to change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other Plan term or condition, and to terminate the whole Plan or any part of it. The procedure by which the eligibility of classes of employees may be changed or terminated, or by which part or the whole Plan may be terminated, is contained in the employer's plan document, which is available for inspection and copying from the Plan Administrator designated by the employer. No consent of any Member is required to terminate, modify, amend, or change the Plan.

For purposes of ERISA, the Employer Group is the Plan Administrator of this Plan.

### **Statement of Rights**

As a person covered under this Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974. This law called ERISA, provides that all people covered by the Plan are entitled to:

- Examine, without charge, all Plan documents, including insurance policies, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- Obtain copies of all Plan documents and other Plan information by writing to the Plan Administrator and asking for them. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report if the Plan covers 100 or more people. The Plan Administrator is required by law to furnish each person under the Plan with a copy of this summary financial report.

In addition to creating rights for persons covered by the Plan, ERISA imposes duties upon the people who are responsible for the operation of the benefit portion of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and in the interest of the other people covered by the Plan and beneficiaries.

The law provides that no one may fire you or otherwise discriminate against you in any way to prevent you from getting a benefit or exercising your rights under ERISA. The law provides that if your claim for a benefit is denied in whole or in part, you will receive a written notice, explaining why your claim was denied. You have the right to have your claim reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request copies of documents from the Plan and do not receive them within thirty (30) days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the documents and pay up to \$110 a day until you receive them, unless they were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that the people who operate the Plan misuse the Plan's money or if you are discriminated against for asserting your rights, you may ask the U.S. Department of Labor for help, or you may file suit in federal court. The court will decide who should pay court costs and legal fees. If your suit is successful, the court may order the person you have sued to pay costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

If you have any questions about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory). If you have any questions about your Plan, you should see your Plan Administrator.

### **Discretionary Claim Authority**

The Plan Administrator/Employer delegates to Lovelace Health Plan the discretionary authority to interpret and apply the terms of the Plan and to make factual determinations in connection with its review of claims under the Plan.

Such discretionary authority is intended to include, but is not limited to, the determination of the eligibility of persons desiring to claim benefits under the Agreement, the determinations of whether a person is entitled to benefits under the Agreement, and the computation of any and all benefit payments. The Plan Administrator/Employer also delegates to Lovelace Health Plan the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

## **GENERAL POLICY PROVISIONS**

Your Employer has selected a health maintenance organization benefit plan. The provisions outlined below provide additional information and clarification to Members of Lovelace Health Plan. If you have any questions about these provisions, please contact the Customer Care Center or your Employer's benefits office.

### **Amendments**

The provisions of the Plan discussed in this EOC Handbook are 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 New Mexico Health Insurance Alliance. By electing coverage or accepting benefits under this Policy, all Members legally capable of contracting, agree to all the terms, conditions, and provisions of this Policy.

### **Application for Coverage**

The parties acknowledge and agree that the Subscriber's signature or execution of the enrollment application form shall be deemed to be acceptance of the Policy. All statements, in the absence of fraud or false misrepresentation made by an applicant shall be deemed representations and not warranties. No such statements shall void coverage or reduce benefits unless contained in a written application for coverage.

### **Assignment of Benefits**

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

### **Claim Forms and Proof of Loss**

Written proof of loss must be furnished to Lovelace Health Plan in accordance with the claim procedures specified in this EOC Handbook. Electronic submission of proof of loss is as acceptable as submission on paper. 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. When we receive a request for a claim form or the notice of a claim, we will give to the claimant, or to the policyholder for the claimant, the claim forms which we use for filing proof of loss. If the claimant does not receive these claim forms within 15 days after Lovelace Health Plan receives notice of claim or the request for a claim form, the claimant will be considered to meet the proof of loss requirements of the Policy if the claimant submits written proof of loss within 365 days after the date of the first service. Foreign claims must be translated in U.S. currency prior to being submitted to Lovelace Health Plan for payment.

### **Circumstances beyond the Plan's Control**

If a disaster occurs, we 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. Examples of disasters are earthquakes, epidemics, war, and riots.

### **Disclaimer of Liability**

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

## **Entire Contract**

The EOC Handbook, the Summary of Benefits, Employer Group Contract/Agreement, any supplements, amendments, or riders, and the Enrollment Application Form of each Subscriber covered hereunder constitute the Entire Contract between Lovelace Health Plan and the Employer Group, and, as of the effective date of the Contract, supersede all other agreements between the parties.

## **Evaluating New Technology for Inclusion as a Covered Benefit**

We exclude 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 and new Technology 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.

## **Extension of Benefits**

The Plan will provide a reasonable extension of benefits of at least twelve (12) months in the event a Member becomes totally disabled on the date of the discontinuance of the group contract.

## **Governing Law**

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

## **Identification Cards**

Identification (ID) Cards are issued by Lovelace Health Plan to Members for identification purposes only. Possession of a Lovelace Health Plan ID Card confers no rights to services or other benefits under this Policy. To be entitled to such services or benefits, the holder of the card must, in fact, be the Member on whose behalf all applicable Policy charges have actually been paid. If any Member permits the use of his/her ID card by any other person, all rights of such Member and other Members of his/her family unit to this Policy may be immediately terminated at the discretion of Lovelace Health Plan.

## **Non-Binding Arbitration Required**

Any controversy between the Lovelace Health Plan and the New Mexico Health Insurance Alliance, or a Member (including any legal representative action 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.

## **Legal Action**

No legal action shall be brought to recover on this Plan by the Group or a Member 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.

## **Members Eligible for Medicaid**

Lovelace Health Plan will pay the New Mexico Human Services Department (“HSD”) directly for medical assistance benefits paid under the state’s Medicaid program for a Member eligible for Medicaid if:

- HSD has paid or is paying benefits on behalf of the Member
- HSD has paid or is paying the provider of medical care to the Member
- HSD has notified LINC that benefits must be paid directly to HSD

Otherwise, Lovelace Health Plan will pay the provider for medical care covered by the Plan. If a Member who is a Medicaid recipient has already paid an Out-of-Network Provider for emergency care or for care performed outside the Service Area, then Lovelace Health Plan will pay the Provider according to state law and the Member must seek reimbursement directly from the provider.

## **Members Eligible for Medicare**

Each Member entitled to coverage under Medicare must notify Lovelace Health Plan in writing. If a Member enrolled in Medicare is an active employee of an employer group, as the Subscriber or the Dependent of such a Subscriber, the benefits of this Plan are primary to Medicare and will be paid based on the terms of the Member’s employer group agreement with Lovelace Health Plan. For Members who become eligible for Medicare Part A by reason of age, disability or end stage renal disease, LHP will take into account what Medicare Part A (and Medicare Part B for those who choose to enroll/pay for it) will pay to the extent permitted by law. This means that Lovelace Health Plan will determine coverage available to the member under his/her Plan after subtracting the amounts that Medicare Part A (and Medicare Part B for those who choose to enroll/pay for it) will pay at the time of initial eligibility, depending upon whether Medicare would be the primary or secondary payer under applicable laws and regulations.

## **Member Incentives**

Lovelace Health Plan may offer incentives, from time to time, as part of our health promotion efforts to help motivate our members to change negative health behaviors and maintain positive health behaviors. Our focus is to encourage members to obtain the recommended age and gender appropriate preventive services, using preventive care guidelines which are based on the United States Preventive Services Task Force guidelines.

## **Misrepresentation of Information**

As a result of the Patient Protection and Affordable Care Act, effective September 23, 2010, if Lovelace Health Plan determines that information was intentionally omitted from a Member’s coverage application or is inaccurate, there are serious consequences. Lovelace Health Plan can rescind a Member’s HMO coverage if he or she commits an action, practice or omission that constitutes fraud or makes an intentional misrepresentation of a material fact in connection with the enrollment form, enrollment process or in seeking benefits under the HMO plan. Rescinding a Member’s HMO coverage means that the coverage shall be cancelled and null and void retroactively from the effective date of coverage. The Member must pay for any services or other benefits that have been provided by Lovelace Health Plans.

Before a Member’s rescission is effective, Lovelace Health Plan shall furnish the Member with at least 30 calendar days prior notice that his or her coverage is being rescinded. During this 30-day notice period, Members are advised to seek alternative health care coverage or explore their rights to contest the rescission, as appropriate. However, this notice requirement does not mean that the Member’s HMO coverage will not be voided on a retroactive basis.

## **New Mexico Law Regarding Mothers and Newly Born Children**

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 or Provider in consultation with the mother.

### **New Mexico Law Regarding Mastectomies**

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 are covered. Also covered are benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema.

### **The Rights of Custodial Parents**

When a child has health coverage through a noncustodial parent, Lovelace Health Plan will provide such information to the custodial parent as may be necessary for the child to obtain benefits through that coverage; permit the custodial parent or the provider, with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent; and make payments on claims submitted in accordance with New Mexico law directly to the custodial parent, the provider or the state Medicaid agency.

### **The Rights of Non- Custodial Parents**

Lovelace Health Plan acknowledges the rights of the Non-Custodial Parents of children who are covered under a Custodial Parent's policy unless these rights have been rescinded per court order or divorce decree. Non-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

### **Payment of Claims**

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

### **Physical Examination**

Lovelace Health Plan, at its own expense, will have the right to arrange for the examination of any person for whom claim is pending as often as it may reasonably require.

### **Premium Increases**

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

### **Reinstatement**

Lovelace Health Plan may reinstate this Policy after termination without the execution of a new application or the issuance of a new ID Card or any notice to the Subscriber, other than the unqualified acceptance of an additional payment from the Group.

### **Recovery of Excess Benefit Overpayments**

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

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

### **Time of Payment of Claims**

Claims under this Policy may be submitted for a loss within thirty days for an electronically submitted claim and forty-five days for a paper/hard copy claims upon receipt of due written loss. Payment of claims requires that the electronic or written documentation submitted contains all required information for processing without the need for additional information from outside Lovelace Health Plan. Interest penalties will not be applied to claims not paid within the timeframes stated.

### **Waiver of Agents**

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

## 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:** Refers to the Group Health Service Agreement and its Attachments; the Agreement is a contract between Lovelace Health Plan and the New Mexico Health Insurance Alliance for the provision of health care coverage for the New Mexico Health Insurance Alliance membership.

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

**Allowable Charge:** The amount Lovelace Health Plan will use to calculate payment to an In-Network Provider for a Covered Service. In-Network Providers may not bill more than the Allowable Charge.

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

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

**Biological:** 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 New Mexico Board of Nursing.

**Co-Insurance:** The percentage of allowable charges that you must pay for Covered Services after the Deductible has been met. The Co-Insurance will be applied to the total allowable charges for the service. Refer to your Summary of Benefits or Rider, if applicable, to see what your Co-Insurance amounts are.

**Concern or Complaint:** The contact of a Member with the Customer Care Center expressing dissatisfaction about Coverage or benefits under the Plan.

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

**Co-Payment:** A flat-dollar amount that is the Member's share of the fee for Covered Services, as described in the Summary of Benefits or Rider, if applicable., which is payable at time of service.

**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 Covered Persons.

**Contract Year:** The period of time for which the Agreement is in effect.

**Core Medical Benefits:** Benefits and services covered under your medical plan, not including prescription drug or vision benefits.

**Covered Benefit or Covered Services:** Benefits, services and supplies as described in the EOC Handbook and/or the Summary of Benefit and Rider(s) if applicable. In order for a Member to receive Covered Benefits and Covered Services, the Member must meet eligibility requirements and services must be Medically Necessary. Some Covered Services require Prior Authorization by the Plan.

**Covered Person:** An individual entitled to receive health care benefits provided by a health benefits plan, and includes individuals whose health insurance coverage is provided by an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act.

**Cytological Screening:** A papanicolauo test or liquid based cervical cytopathology, a human papillomavirus test and a pelvic exam for symptomatic as well as asymptomatic female patients.

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

**Division:** The New Mexico Division of Insurance.

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

**Emergency Medical Condition:** A medical Condition which manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent lay person, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1) Serious jeopardy to 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 Care/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:** A Covered Person who receives health care benefits through this plan.

**Essential Benefits:** Benefits and services regulated under the Patient Protection and Affordable Care Act (PPACA), for which Lovelace Insurance Company is not allowed set lifetime limits. Essential Benefits under PPACA refer to coverage for ambulatory patient services, emergency services, hospitalization, maternity/newborn, Behavioral Health/Substance Abuse conditions, prescription drugs, rehabilitative and habilitative services and devices, lab services, preventive/wellness services, chronic disease management, pediatric services (including oral and vision care).

**Evidence of Coverage (EOC) Handbook:** This Evidence of Coverage (EOC) Handbook, along with the Summary of Benefits is a Certificate of Coverage for the Subscriber to whom it is issued. It is a clear and conspicuous written document of the essential features and medical services covered by the Plan and is given to the Subscriber by the Plan.

**FDA:** The United States Food and Drug Administration.

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

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

**Group:** The employer or Agreement holder.

**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 home health agency; a diagnostic, laboratory or imaging center; and a rehabilitation or other therapeutic health setting.

**Health Care Insurer:** The insurance provider.

**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.

**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 Covered persons on a prepaid basis, except for the Covered person's responsibility for copayments or deductibles.

**Independent Quality Review Organization:** An organization that is not owned by Lovelace Health System, Inc. but that is appointed to review the insurer's practices in order to improve and enhance their operations and improve their quality of health care.

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

**Lovelace Health System, Inc.:** 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.

**Managed Care:** A system or technique generally used by third party payors or their agents to affect access to and control payment for Health care services. Managed care techniques most often include 1) prior, concurrent and

retrospective review of the medical necessity and appropriateness of services or site of services; or 2) contracts with selected health care Providers; or 3) financial incentives or disincentives for Covered Persons to use specific Providers, services, prescription drugs or service sites; or 4) controlled access to and coordination of services by a case manager; and/or 5) payor efforts to identify treatment alternatives and modify benefit restrictions for high cost patient care.

**Managed Care Health Plan:** A policy, contract, certificate or agreement offered or issued by a Health care insurer, Provider service network, or plan administrator to provide, deliver, arrange for, pay for, or reimburse the costs of Health care services, except as otherwise provided in this subsection. A MHCP either requires a Covered person to use, or creates incentives, including financial incentives, for a Covered person to use health care Providers managed, owned, under contract with or employed by the Health care insurer, Provider service network, or plan administrator. Effective immediately, a MHCP does not include a traditional fee-for-service indemnity health benefit plan or a health benefit plan that covers only short-term travel, accident-only, limited benefit, an indemnity, PPO dental or non-profit dental benefit plan, student health plan, or specified disease policies.

**Medical Director (Plan):** 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 Plan and manage the provision of health care services to Members.

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

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

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

**Member:** Any Subscriber or Dependent who elects the Plan coverage and for whom the required Premium has been received by the Plan and who meets all the enrollment and eligibility requirements as defined.

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

**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 if Prior Authorized by Lovelace Health Plan.

**Non-Specialist/ Primary Care Practitioner (PCP):** A practitioner who provides general medical services. 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.

**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.

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

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

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

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

**Plan:** The benefit plan established by Lovelace Health Plan and selected by the New Mexico Health Insurance Alliance to provide health care coverage to Members, as it exists on the effective date of the Policy or as subsequently amended as provided in the Policy.

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

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

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

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

**Primary Care Practitioner:** A Health care professional who, within the scope of his or her license, supervises, coordinates, and provides initial and basic care to Covered persons, who initiates their referral for specialist care, and who maintains continuity of patient care. Primary care practitioners shall include but not be limited to general practitioners, family practice physicians, internists, pediatricians, and obstetricians-gynecologists.

**Primary Care Services:** Services provided by your Primary Care Physician or your primary provider of health care services. These services include annual examinations, routine immunizations and treatment of non-emergency acute illnesses and injuries.

**Prior Authorization:** A system whereby a Provider must receive benefit authorization from the Plan's Medical Director before a Member receives specialty care in order for certain health care services and benefits to be Covered Services. Examples of services requiring Prior Authorization include, but are not restricted to: non-emergency inpatient hospitalization, outpatient surgical procedures, short-term rehabilitation, MRI, DME and Skilled Care.

**Prospective Enrollee:** An employee or a dependent of an employee who is not enrolled on the healthcare plan, but is eligible or will be eligible for the group's medical plan coverage.

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

**Provider Network:** Providers who have contracted with Lovelace Health Plan.

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

**Registered Lay Midwife:** Any person who practices lay midwifery and is registered as a lay midwife by the New Mexico Department of Health.

**Rider:** An addition that is made to the policy that refers to benefits not noted in the Summary of Benefits. It is a part of the policy and subject to the same general conditions of the regular policy. It is not a separate policy. It contains information regarding benefits in addition to those in the Summary of Benefits. Lastly, it is paid for by an addition to the basic premium.

**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 radiation 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 encompassing the state of New Mexico.

**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 the Group or entitled as a retiree or otherwise, to participate in the medical benefits arranged by the Group or any other individual, who meets the established eligibility requirement 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, Co-Insurance and Deductible (if applicable) amounts for the Plan selected by the New Mexico Health Insurance Alliance for the membership of the New Mexico Health Insurance Alliance.

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

**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.

**Traditional fee-for-service indemnity benefit:** A fee-for-service indemnity benefit as defined at 13.10.17.7 NMAC, as a fee-for-service indemnity benefit, not associated with any financial incentives that encourage Covered persons to utilize preferred Providers, to follow pre-authorization rules, to utilize prescription drug formularies or other cost-saving procedures to obtain prescription drugs, or to otherwise comply with a plan's incentive program to lower cost and improve quality, regardless of whether the benefit is based on an indemnity form of reimbursement for services.

**Urgent Care:** Medically necessary health care services provided in emergencies or after a primary care Provider's normal business hours for unforeseen conditions due to illness or injury that are not life-threatening but require prompt medical attention.

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

**Usual, Customary and Reasonable Charges:** The amount determined by Lovelace Health Plan to be payable under the Plan for services rendered to Members by non-Participating Providers. "Usual, customary and reasonable rates" means health care services, medical supplies and payment rates for health care services provided by a health care practitioner at or near the median rate paid for similar health care services within a surrounding geographic area where the charges were incurred. Surrounding geographic area may be determined by the type of service and access to that service in the geographic area.

**Utilization Review/Management:** The process of helping individual Members get the right care at the right level by the right Provider at the right time, for the purpose of maximizing Plan benefits and ensuring quality health care.

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

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