



individual plan ppo  
summary of benefits  
20%/\$750/\$4,000

# Individual PPO

## 20%/\$750/\$4,000

Lovelace Insurance Company provides the following benefits when Medically Necessary. This summary contains highlights only and is subject to change. Some benefits are subject to limitations, including, but not limited to visit or dollar maximums. Please refer to the list of Limitations and Exclusions in this document. The specific terms of coverage and a detailed list of Limitations and Exclusions are contained in the Evidence of Coverage (EOC) Handbook. Some services may not be covered Out-of-Network. Additionally, some services require a Prior Authorization. Unless otherwise noted, Co-Payment amounts are due at the time of service. Services are paid according to the Tier level of the treating Provider. If you have any questions about a specific service or treatment, or would like to obtain an Evidence of Coverage (EOC) please contact the Lovelace Insurance Company Customer Care Center at 505.727.5683, toll free 800.808.7363, TTY 800.659.8331 or [www.lovelacehealthplan.com](http://www.lovelacehealthplan.com).

| Covered Services                              | Description  | Member Deductibles, Co-payment & Coinsurance |   |
|---|--|--|---|
|   |  | In-Network Participating Provider            | Out-of-Network Non-Participating Provider |
| <b>Pre-existing Condition Limitation</b>      | A condition is pre-existing if it is a physical or mental condition for which medical advice, medication, diagnosis, care or treatment was sought or recommended within a six-month period before the effective date of coverage. <b>No benefits are available for pre-existing conditions for six (6) months after the effective date of coverage, unless prior creditable coverage exists. This limitation does not apply for members under the age of 19.</b> |  |   |
| <b>Annual Deductible<sup>1</sup></b>          | Per individual/calendar year<br><br>In-Network: Family deductible is two times individual amount.<br><br>Out-of-Network: Family deductible is two times the individual amount.   | Individual \$750<br><br>Family \$1,500       | Individual \$1,500<br><br>Family \$3,000  |
| <b>Annual Out-of-Pocket Limit<sup>2</sup></b> | Per individual/calendar year.<br><br>Includes core medical coinsurance amounts only; does not include deductible; co-payments, penalty amounts, charges in excess of Usual, Customary and Reasonable charges, Premium payments or non-covered benefit charges. Out-of-Pocket maximum is on a calendar year basis.<br><br>In-Network: Family limit is two times individual amount.<br><br>Out-of-Network: Family deductible is two times the individual amount.   | Individual \$4,000<br><br>Family \$8,000     | Individual \$8,000<br><br>Family \$16,000 |
| <b>Lifetime Maximum on Essential Benefits</b> |  | None   |   |
| <b>Preventive Care Services<sup>3</sup></b>   | <ul style="list-style-type: none"> <li>• Routine Physicals</li> <li>• Adult &amp; Child Immunizations</li> <li>• Annual men's exam</li> <li>• Annual women's exam, including preventive mammogram</li> <li>• Health and family planning education</li> <li>• Well Baby/Child care</li> <li>• Vision and Hearing Screening (for members age 17 and under)</li> <li>• Colonoscopy</li> </ul>   | No Charge                                    | 40%                                       |

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| Covered Services                                      | Description   | Member Deductibles, Co-payment & Coinsurance                                    |   |
|---|---|---|---|
|   |   | In-Network Participating Provider   | Out-of-Network Non-Participating Provider |
| <b>Medical Office Visits</b>                          | Diagnosis & treatment of illness and injury<br><br>Medically Necessary surgical procedures performed in the physician's office  | Non-Specialist<br>\$20 co-payment/visit<br><br>\$40 Specialist co-payment/visit | 40%                                       |
| <b>Inpatient Hospital Services</b>                    | Services provided during an admission to an Inpatient Facility, including: <ul style="list-style-type: none"> <li>• Semiprivate Room and Board</li> <li>• Physician, Surgeon and Anesthesiologist services</li> <li>• Diagnostic and Therapeutic services</li> <li>• Lab &amp; X-ray</li> <li>• Hemodialysis (member must apply for Medicare benefits)</li> <li>• Operating, and Recovery rooms</li> <li>• Drugs and Medications</li> </ul>                                   | 20%   | 40%                                       |
| <b>Outpatient Surgical and Medical Services</b>       | Services provided in an outpatient facility setting including: <ul style="list-style-type: none"> <li>• Outpatient/Ambulatory surgery</li> <li>• Injections/Injectable medications</li> <li>• Norplant insertion &amp; removal</li> <li>• Transfusion of blood</li> <li>• Dialysis &amp; ESRD</li> <li>• Radiation Therapy</li> <li>• Chemotherapy</li> <li>• Operating, recovery &amp; other treatment rooms</li> <li>• Dialysis (member must apply for Medicare)</li> </ul> | 20%   | 40%                                       |
| <b>Emergency and Urgent Care Services<sup>4</sup></b> | Services provided at a hospital emergency room , emergency outpatient facility or designated urgent care facility<br><br>Emergency Care<br>Urgent Care  | \$200 Co-payment per visit<br>\$40 Co-payment per visit                         |   |
| <b>Acupuncture</b>                                    | Diagnostic and treatment services<br>Maximum benefit: \$1,500/calendar year   | 20%   | Not Covered                               |
| <b>Allergy Treatment</b>                              | Allergy Services including Testing, Treatment, Serum extracts and Injections  | 20%   | 40%                                       |
| <b>Ambulance Services</b>                             | Ground Transport  | \$50 Co-payment per trip  |   |
|   | Air Transport<br>Non-emergency Transport  | \$100 Co-payment per trip   |   |
|   |   | 20%   | 40%                                       |
| <b>Autism Spectrum Disorder<sup>5</sup></b>           | Speech, occupational and physical therapy<br>Applied behavioral analysis  | 20%   | 40%                                       |
| <b>Chiropractic</b>                                   | Diagnostic and treatment services<br>Maximum benefit: \$1,500/calendar year   | 20%   | Not Covered                               |

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| Covered Services  | Description  | Member Deductibles, Co-payment & Coinsurance      |   |
|---|--|---|---|
|   |  | In-Network Participating Provider                 | Out-of-Network Non-Participating Provider |
| <b>CT/MRI/PET Scans</b>                                       | Medically Necessary outpatient imaging tests   | 20%   | 40%                                       |
| <b>Diabetes Coverage</b>                                      | Office visits/treatment  | Non-Specialist or Specialist Co-payment applies   | 40%                                       |
|   | Diabetic supplies and medications  | Refer to Prescription Drug Benefit                | Refer to Prescription Drug Benefit        |
|   | Diabetic durable medical equipment (DME)   | 20%   | 40%                                       |
|   | Diabetic education   | No charge   | 40%                                       |
| <b>Diagnostic Services</b>                                    | Non-surgical diagnostic testing, including: <ul style="list-style-type: none"> <li>Blood tests</li> <li>Urinalysis</li> <li>Pathology tests</li> <li>X-rays and ultrasounds</li> </ul> | 20%   | 40%                                       |
| <b>Durable Medical Equipment</b>                              | Medically Necessary services, supplies and devices   | 20%   | Not Covered                               |
| <b>Endoscopic Procedures</b>                                  | Medically Necessary exams, tests and procedures  | \$40 Specialist co-payment/visit                  | 40%                                       |
| <b>External Prosthetic Appliances</b>                         | Medically Necessary services, supplies and devices   | 20%   | Not Covered                               |
| <b>Family Planning</b>  | Tests and counseling   | Non-Specialist or Specialist Co-pay               | 40%                                       |
|   | Surgical sterilization procedures <ul style="list-style-type: none"> <li>Inpatient Facility Charge</li> <li>Outpatient Facility Charge</li> <li>Physician's Office</li> </ul>          | 20%<br>20%<br>Non-Specialist or Specialist Co-pay |   |
|   | Contraceptive implant insertion/re-insertion fee   | 20%   |   |
|   | Contraceptive implant removal  | Non-Specialist or Specialist Co-pay               |   |
| <b>Hearing Aids and Related Services Children<sup>6</sup></b> | Fitting and dispensing services  | 20%   | 40%                                       |
|   | Hearing aids   |   |   |
| <b>Home Health Services<sup>7</sup></b>                       | Prescribed home physician services, and nursing care and rehabilitative therapy.<br><br>100 visits/calendar year combined maximum  | 20%   | 40%                                       |

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| Covered Services  | Description  | Member Deductibles, Co-payment & Coinsurance                            |   |
|---|--|---|---|
|   |  | In-Network Participating Provider                                       | Out-of-Network Non-Participating Provider |
| <b>Hospice Services<sup>8</sup></b>                     | Specified Hospice Care Services (which are reasonable and necessary for the palliation or management of terminal illness)                              | 20%   | 40%                                       |
| <b>Outpatient Short Term Rehabilitation<sup>5</sup></b> | Physical, Occupational, Cardiac, Pulmonary and Speech Therapy  | 20%   | 40%                                       |
| <b>Skilled Nursing<sup>7</sup></b>                      | Maximum of 60 days/calendar year   | 20%   | 40%                                       |
| <b>Sleep Studies</b>                                    | Includes overnight and non-overnight stay/visits   | 20%   | Not Covered                               |
| <b>Transplants</b>                                      | Refer to EOC for details of benefit, limitations and exclusions. Services must be obtained or provided by a Lovelace designated provider and facility. | Applicable co-payment or coinsurance applies based on place of service. | Not Covered                               |

### ENDNOTES:

(\*) Member is responsible for paying 100% of charges that exceed Usual, Customary and Reasonable Rates. "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.

- (1) Deductible must be met before benefit payments are made, unless otherwise noted. Additionally, the In-network and Out-of-Network deductibles are separate. Payments to In-network services contribute to the In-Network deductible only. Payments made to Out-of-Network services contribute to the Out-of-Network deductible only. Rx deductible is separate from the In-network and Out-of-Network deductibles.
- (2) After a member reaches the applicable out-of-pocket limit, Plan pays 100% of most of the covered In-network and Out-of-Network charges. Please refer to your EOC for details. The In-network and Out-of-Network maximums are separate. Payments to In-Network services contribute to the In-Network maximum only. Payments made to Out-of-Network services contribute to the Out-of-Network maximum only.
- (3) The Patient Protection and Affordable Care Act requires health plans to cover specific Preventive Care Services at no cost to our members when the services are provided by an In-Network Participating Provider. Though these specific services are covered at no charge, the provider may charge a co-payment for other services provided during the office visit. If you have questions regarding the Preventive Care Services that are covered under your plan or your cost for these services, please contact the Lovelace Customer Care Center.
- (4) Out-of-Network, Non-Urgent Care or Non-Emergent Services are subject to deductible and coinsurance.
- (5) These services must be Medically Necessary as defined by your Evidence of Coverage.
- (6) These services must be Medically Necessary as defined by your Evidence of Coverage. Services must be provided by an audiologist, hearing aid dispenser or physician. Coverage is limited up to age 21.
- (7) These services have maximum day or visit limitations. Total numbers of visits/days is combined and cross accumulates by service type and by provider/facility type (In-Network and/or Out-of-Network provider/facility).
- (8) The Lifetime Maximum benefit of \$7,500 is a combined maximum including services provided by In-Network and/or Out-of-Network providers/facilities.

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Prescription Drug Coverage \$10/\$35/\$55/20%

| Type of Coverage   | Your Cost   |
|--|---|
| <p><i>A prescription is:</i> a maximum of a 30-day supply, up to a maximum of 480 ml for liquids, 120 gm for topicals, 4 vials of insulin and the customary therapeutic regime for other products</p> <p>(Excluded are those drugs/medications indicated in the Exclusions section)</p>  | <p>\$10 per prescription or refill for <b>preferred generic</b> drugs</p> <p>\$35 per prescription or refill for <b>preferred name brand</b> drugs with no generic equivalent</p> <p>\$55 per prescription or refill for <b>preferred name brand</b> drugs with a generic equivalent or for <b>non- preferred drugs</b></p> <p>20% of medication cost (minimum \$60) up to \$250 for <b>preferred specialty medications</b></p> |
| <p><b>Mail Order 90-day Supply</b><br/>When obtained through the Lovelace Insurance Company participating mail order prescription drug program.<br/><b>Specialty medications are not available through our Mail Order Pharmacy. However, you may be able to order a 60-day or 90-day supply of a specialty medication through the Lovelace Specialty Pharmacy if drug therapy is stabilized.</b></p> | <p>\$20 per 90-day supply for <b>preferred generic</b> drugs</p> <p>\$70 per 90-day supply for <b>preferred name brand</b> drugs with no generic equivalent</p> <p>\$110 per 90-day supply for <b>preferred name brand</b> drugs with a generic equivalent or for <b>non- preferred drugs</b></p>   |
| <p><i>Prescription Diabetic Supplies</i> - Insulin, glucose test strips and other prescription diabetic supplies</p>   | <p>Covered (co-payment above)</p>   |
| <p>Birth Control - Contraceptive devices and Oral Contraceptives</p>   | <p>Covered (co-payment above)</p>   |

## Programs for Better Health

We are committed to helping you take charge of your health by providing you with health-wise information and resources. We encourage you to explore our Healthy Steps benefit features, our interactive online tools and make use of the services and education provided.

### Healthy Steps Programs

- Health Coaching
- Baby Love
- Healthy Trails

- Case Management
- S.T.O.P.
- NurseAdvice New Mexico
- Choose Healthy
- Health Literacy
- Healthy Weight
- Personal Health Assessment

Call 505.727.5344 or Toll-free 877.480.9368 for information on the Healthy Steps Program.

## When it Comes To Your Health, We've Got You Covered

Emergency Health Services are covered wherever you go, World-Wide, 24 hours a day, 7 days a week.

EMERGENCY HEALTH SERVICES are those services required to treat an accidental injury or the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could be expected by a reasonable layperson to result in jeopardy to a person's health, serious impairment of bodily functions, serious dysfunction of a bodily organ or part or disfigurement to a person.

Emergencies can vary widely. Some examples of medical emergencies are:

- Possible heart attack (severe chest pain or pressure)

- Uncontrollable bleeding
- Confusion or loss of consciousness, especially after a head injury
- Severe shortness of breath or difficulty breathing
- Severe or multiple injuries, including obvious fractures

If faced with a life-threatening emergency, always seek immediate care. Emergency rooms are highly specialized health care facilities. Go to the emergency room only for true emergencies, not for routine ailments or for convenience.

Inpatient hospitalization for any Emergency Service requires notification to Lovelace Insurance Company within 48 hours of admission.

## Have a Question or Concern?

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

Customer Care Center Representatives are available to assist you with your needs, including:

- Requesting a copy of the EOC
- Enrollment information
- Questions about Covered Services and Benefits
- ID Card replacement
- Procedures for obtaining care

- Complaints or concerns
- Information about Services that need to be Pre - Authorized by the Plan
- Appeals and Grievance procedures
- Status of claim payment

Se habla Español and most other languages. We have bilingual Spanish-speaking representatives and our Language Line translates more than 140 other languages.

**Customer Care Center**  
**505.727.5683 or toll-free 800.808.7363**  
**TTY 800.659.8331.**

## Great care. Great choices.

When you need care, you can feel confident knowing that our network of providers and practitioners is close to where you live and work. From your neighborhood health care centers to acute care hospitals, our statewide network of contracted physicians, hospitals and related medical services means you're covered all across New Mexico. For more information, please review our Provider Directory.

The Provider Directory includes a listing of physicians, hospitals, pharmacies, medical equipment providers, laboratory, x-ray and other network providers. You may also access the directory via our website at [www.lovelacehealthplan.com](http://www.lovelacehealthplan.com) or call the Customer Care Center for additional copies.

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### Exclusions and Limitations

#### EXCLUSIONS

Refer to the EOC Handbook for a complete listing of Plan Exclusions. Your Plan provides coverage for Medically Necessary services. Prior-Authorization by the Plan Medical Director may be required for certain services to be covered. Except as required by law, your Plan does not provide coverage for the following:

- Alternative treatments including but not limited to aroma, massage or hypno therapy
- Any treatment, procedure, service, facility, equipment, drugs, drug usage, device or supply determined not to be Medically Necessary, except for those that are Authorized by the Plan
- Artificial aids including but not limited to hearing aids, devices or computers to assist in communication or speech, except as required by law
- Autopsies and/or transportation costs for deceased members
- Benefits and services not specified as Covered in this document or the EOC Handbook
- Biofeedback
- Care for military service-connected disabilities for which the Member is legally entitled to and for which facilities are reasonably available to the Member
- Charges that are determined to be unreasonable by the Plan
- Cosmetic surgery or treatment except as Authorized by the Plan or as listed in the EOC Handbook
- Custodial, domiciliary or respite care
- Dental care, except as required by law and as written in the EOC Handbook Diapers and incontinence supplies
- Drugs/medicines purchased without a doctor's prescription.
- Expenses for services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Plan
- Experimental services, investigational or unproven procedures or protocols, including drugs or equipment, except as required by law
- Foot care including but not limited to cutting or removal of corns/calluses, nail trimming, cutting or debriding, unless determined to be Medically Necessary for the treatment of diabetes
- Immunizations, inoculations, exams, and other related services 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
- Infertility & reproductive services/procedures including but not limited to In-vitro, GIFT, ZIFT, surrogate parenting, reversal of voluntary sterilization, donor egg or sperm retrieval and storage
- Maternity Benefits including, but not limited to, any condition which is pregnancy related, prenatal care, delivery or voluntary pregnancy termination, and postnatal care.
- Nursing home care, except those services Authorized by the Plan and provided in a Plan approved skilled nursing facility

#### EXCLUSIONS continued

- Orthopedic shoes and foot orthotics, unless determined to be Medically Necessary for the treatment of diabetes
- Repairs for Durable Medical Equipment (DME), prosthetic or orthotic devices that were not provided by the Plan
- Services and procedures for sexual transformation
- Services for which other coverage is required to provide through other arrangements, including but not limited to workers' compensation, automobile insurance or similar coverage
- Services and benefits related to treatment of mental illness and substance abuse, including prescription drugs are excluded from coverage.
- Services of a provider which are not within his/her scope of practice
- Travel, lodging and other related expenses, except as defined in the EOC Handbook
- Treatment for sexual dysfunction, including but not limited to medications, counseling and clinics
- Treatment or services provided in connection with or to comply with involuntary commitments, police detention, court-orders or other similar arrangements
- Vision/eye refractive services and optical appliances, except as required by law and as written in the EOC Handbook
- Vitamins, minerals, food supplements (except Special Medical Foods as outlined in the EOC Handbook)
- Vocational rehabilitation services
- Weight loss, physical conditioning programs or exercise programs of any type

#### LIMITATIONS

Refer to the EOC Handbook for a complete listing of Plan Limitations. Except as required by law, your plan has limited coverage for the following services:

- Acupuncture
- Ambulance service
- Chiropractic services
- Circumstances beyond the Plan's control
- Consumable medical supplies
- Family planning evaluation and treatment services
- Growth Hormone therapy
- Home Health Services
- Long-term rehabilitative therapy
- Organ transplants, immunosuppressive drugs and transplant related travel and lodging
- Podiatric services
- Skilled nursing and Rehabilitation services
- Vision and hearing screening/care

Lovelace Insurance Company

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