



{classic ppo  
benchmark plan}  
summary of benefits  
\$XX/XX%/XX%/\$XXXX

Lovelace  
Insurance Company

# {Classic PPO Benchmark plan - Insert Plan Name Here}

Lovelace Insurance Company provides the following benefits only when Medically Necessary. Prior Authorization may be required by the plan before services are rendered. 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. 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-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 In-Network: Family deductible is two times individual amount  Out-of-Network: Family deductible is two and half (2.5) times the individual amount.	Individual (\$0 - \$10,000)  Family (\$0 - \$20,000)	Individual (\$0 to \$100,000)  Family (\$0 - \$200,000)
<b>Annual Out-of-Pocket Limit<sup>2</sup></b>	Per individual/calendar year  Includes core medical coinsurance amounts only; does not include deductible; co-payments, penalty amounts; Vision and Rx charges or Co-payments, 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.  In-Network: Family limit is two times individual amount.  Out-of-Network: Family limit is two and half (2.5) times the individual amount	Individual (\$0 - \$20,000)  Family (\$0 - \$40,000)	Individual (\$0 - \$150,000)  Family (\$0 - \$300,000)
<b>Lifetime Maximum</b>		None	None
<b>Medical Office Visits</b>	Preventive Care Services <ul style="list-style-type: none"> <li>• Annual Physicals</li> <li>• Well Baby/Child care</li> <li>• Immunizations</li> <li>• Periodic screenings and tests</li> <li>• Vision and Hearing Screening (for members age 17 and under)</li> <li>• Colonoscopy</li> </ul>	No Charge <sup>3</sup>	(0% - 100%)

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Covered Services	Description	Member Deductibles, Co-payment & Coinsurance	
		In-Network Participating Provider	Out-Network Non-Participating Provider
<b>Medical Office Visits (continued)</b>	Medically Necessary surgical procedures performed in the physician's office  Diagnosis & treatment of illness and injury	Non-Specialist (\$0 - \$100) co-payment/visit Specialist (\$0 - \$100) co-payment/visit	(0% – 100%)
<b>Inpatient Hospital Services</b>	Services provided during an admission to an Acute Care Inpatient Facility, Inpatient Rehabilitation Care or Long-term Acute Care Inpatient Facility <ul style="list-style-type: none"> <li>• Semiprivate Room and Board</li> <li>• Physician, Surgeon and Anesthesiologist services</li> <li>• Operating, and Recovery rooms</li> <li>• Drugs and Medications</li> </ul>	(0% – 100%)	(0% – 100%)
<b>Outpatient Surgical and Medical Services</b>	Services provided in an outpatient facility setting including: <ul style="list-style-type: none"> <li>• Pre-surgical testing</li> <li>• Operating, recovery &amp; other treatment rooms</li> <li>• Physician and surgeon services</li> <li>• Anesthetics and anesthesia services</li> <li>• Diagnostic laboratory tests, x-rays and pathology services</li> <li>• Administration of blood, blood plasma and other biologicals</li> <li>• Administration of Injections and Infusions</li> <li>• Blood transfusions</li> <li>• Radiation Therapy and Chemotherapy</li> <li>• Dialysis (member must apply for Medicare)</li> </ul>	(0% – 100%)	(0% – 100%)
<b>Emergency and Urgent Care Services</b>	Services provided at a hospital emergency room, emergency outpatient facility or designated urgent care facility	(\$0 - \$500) co-payment per visit (\$0 - \$100) co-payment per visit	
	Emergency Care Urgent Care  Non-emergent or non-urgent follow-up care	(0% – 100%)	(0% – 100%)
<b>Acupuncture</b>	Diagnostic and treatment services Maximum benefit: \$1,500 combined per calendar year	(0% – 100%)	(0% – 100%) {After (\$#) deductible}
<b>Allergy Treatment</b>	Allergy Services including Testing, Treatment, Serum extracts and Injections	(0% – 100%)	(0% – 100%)

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Covered Services	Description	Member Deductibles, Co-payment & Coinsurance	
		In-Network Participating Provider	Out-of-Network Non-Participating Provider
<b>Ambulance Services</b>	Ground Transport	(\$0 - \$500) co-payment per trip	
	Air Transport Non-emergency Transport	(\$0 - \$500) co-payment per trip	
		(0% – 100%)	(0% – 100%)
<b>Autism Spectrum Disorder</b>	Speech, occupational and physical therapy Applied behavioral analysis	(0% – 100%)	(0% – 100%) {After (\$#) deductible}
<b>Behavioral Health/Mental Health Treatment</b>	Inpatient services	(0% – 100%) (0% – 100%)	
	<ul style="list-style-type: none"> <li>Hospitalization</li> <li>Partial hospitalization (waived if following inpatient hospitalization)</li> </ul> Electroconvulsive Therapy (ECT)	Included in inpatient admission charge	
	Outpatient services		(0% – 100%)
	<ul style="list-style-type: none"> <li>Individual, family or couples therapy</li> <li>Intensive outpatient program (IOP)</li> <li>Group therapy</li> <li>Electroconvulsive Therapy (ECT)</li> </ul>	(\$0 - \$100) co-payment/visit (\$0 - \$100) co-payment/visit (\$0 - \$100) co-payment/visit (\$0 - \$100) co-payment/visit	
<b>Chiropractic</b>	Diagnostic and treatment services		(0% – 100%) {After (\$#) deductible}
	Maximum benefit: \$1,500 combined per calendar year	(0% – 100%)	
<b>CT/MRI/PET Scans</b>	Medically Necessary outpatient imaging tests	(0% – 100%)	(0% – 100%)
<b>Diabetes Coverage</b>	Office visits/treatment	Non-Specialist or Specialist co-payment applies	(0% – 100%)
	Diabetic supplies and medications	Refer to Prescription Drug Rider	
	Diabetic durable medical equipment (DME)	(0% – 100%)	
	Diabetic education	No charge	
<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> <li>Mammograms</li> </ul>	No charge; included with co-payment for applicable visit/facility charge	(0% – 100%)
<b>Durable Medical Equipment</b>	Medically Necessary services, supplies and devices	(0% – 100%)	(0% – 100%) {After (\$#) deductible}
<b>Endoscopic Procedures</b>	Medically Necessary exams, tests and procedures	(\$0 - \$100) co-payment/visit	(0% – 100%)

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Covered Services	Description	Member Deductibles, Co-payment & Coinsurance	
		In-Network Participating Provider	Out-of-Network Non-Participating Provider
<b>External Prosthetic Appliances</b>	Medically Necessary services, supplies and devices	(0% – 100%)	(0% – 100%) {After (\$#) deductible}
<b>Family Planning</b>	Tests and counseling  Surgical sterilization procedures <ul style="list-style-type: none"> <li>• Inpatient Facility Charge</li> <li>• Outpatient Facility Charge</li> </ul> <ul style="list-style-type: none"> <li>• Physician's Office</li> </ul> Women's Preventive Services <sup>9</sup> <ul style="list-style-type: none"> <li>• Surgical sterilization procedures for women's sterilization; must be FDA approved methods               <ul style="list-style-type: none"> <li>• Inpatient Facility Charge</li> <li>• Outpatient Facility Charge</li> <li>• Physician's Office</li> </ul> </li> </ul> Contraceptive implant insertion/re-insertion fee  Contraceptive implant removal	Non-Specialist or Specialist co-payment  (0% – 100%) (0% – 100%)  Non-Specialist or Specialist co-payment  No Charge	(0% – 100%)
<b>Hearing Aids and Related Services for Dependent Children<sup>4</sup></b>	Fitting and dispensing services  Hearing aids	Non-Specialist or Specialist co-payment applies  (0% – 100%)	(0% – 100%)
<b>Home Health Services</b>	Prescribed home physician services, and nursing care and rehabilitative therapy.  100 visits/calendar year combined maximum <sup>6</sup>	(0% – 100%)	(0% – 100%)
<b>Hospice Services</b>	Specified Hospice Care Services (which are reasonable and necessary for the palliation or management of terminal illness)  Lifetime Maximum benefit: \$10,000 <sup>6</sup>	(0% – 100%)	(0% – 100%)
<b>Infertility</b>	Diagnosis and medically indicated treatments for physical conditions causing infertility  Office Visit  Treatment/Surgery – Infertility benefit are limited to services for testing, diagnosis and corrective procedures only	Non-Specialist or Specialist co-payment applies   (0% – 100%) after deductible	(0% – 100%) {After (\$#) deductible}   (0% – 100%) {After (\$#) deductible}

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Covered Services	Description	Member Deductibles, Co-payment & Coinsurance	
		In-Network Participating Provider	Out-of-Network Non-Participating Provider
<b>Infertility (continued)</b>	In-vitro fertilization and costs connected with collection, preparation, storage of sperm for artificial insemination, including donor fees  Infertility drugs  Reversal of prior voluntary sterilization surgery	Not Covered  Refer to Prescription Drug Rider  Not Covered	Not Covered  Refer to Prescription Drug Rider  Not Covered
<b>Maternity Care</b>	Prenatal and postpartum care  Delivery – all physician and hospital services for mother during confinement, including full term delivery, miscarriage or termination of pregnancy  Breast feeding support, supplies and counseling <sup>3</sup>  PLEASE NOTE: Newborn child is covered from birth only if enrolled within 31 days of birth <sup>7</sup>	Non-Specialist or Specialist co-payment/visit  (0% – 100%)  No Charge	       (0% – 100%)
<b>Outpatient Rehabilitation/Habilitation Therapy Services</b>	Physical, Occupational, and Speech Therapy  Cardiac Rehabilitation Pulmonary Rehabilitation	     (0% – 100%)	(0% – 100%) {After (\$#) deductible}
<b>Skilled Nursing</b>	Maximum of 60 days combiner per calendar year <sup>6</sup>	(0% – 100%)	(0% – 100%)
<b>Sleep Studies</b>	Including Overnight and non-overnight stay/visits	(0% – 100%)	(0% – 100%) {After (\$#) deductible}
<b>Smoking/Tobacco Cessation</b>	Prescription drugs  Counseling	Refer to Prescription Drug Rider  Non-Specialist or Specialist co-payment applies	    (0% – 100%)

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Covered Services	Description	Member Deductibles, Co-payment & Coinsurance	
		In-Network Participating Provider	Out-of-Network Non-Participating Provider
<b>Substance Abuse Services</b>	<p>Inpatient Services</p> <ul style="list-style-type: none"> <li>Alcohol and drug abuse detoxification</li> <li>Rehabilitation<sup>8</sup></li> <li>Partial hospitalization (waived if following inpatient hospitalization)</li> </ul> <p>Outpatient Services</p> <ul style="list-style-type: none"> <li>Outpatient Detoxification</li> <li>Individual, Family or Marital Therapy</li> <li>Intensive Outpatient Program (IOP)</li> <li>Group Therapy</li> </ul>	<p>(0% – 100%)</p> <p>(0% – 100%)</p> <p>(0% – 100%)</p> <p>(\$0 - \$100) co-payment/visit</p> <p>(\$0 - \$100) co-payment/visit</p> <p>(\$0 - \$100) co-payment/visit</p> <p>(\$0 - \$100) co-payment/visit</p>	<p>(0% – 100%)</p>
<b>Transplants</b>	<p>Refer to EOC for details of benefit, limitations and exclusions. Services must be obtained or provided by a Lovelace designated provider and facility.</p> <p>LIFETIME MAXIMUM (combined both In-Network and Out-of-Network): \$1,000,000</p>	<p>Applicable co-payment or coinsurance applies based on place of service.</p>	<p>(0% – 100%) {After (\$#) deductible}</p>

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## **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.
- (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 insurance issuers 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 or other applicable fees for other services provided during the office visit. Additionally, some covered Family Planning services, for example male vasectomies, continue to require some member cost sharing. If you have questions regarding the Preventive Care Services that are covered under your plan, including Family Planning services, or your cost for these services, please refer to your EOC or contact the Lovelace Customer Care Center.
- (4) 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.
- (5) 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).
- (6) The Lifetime Maximum benefit of \$10,000 is a combined maximum including services provided by In-Network and/or Out-of-Network providers/facilities.
- (7) Newborn child is covered from birth only if enrolled within 31 days. Please refer to your EOC Handbook for enrollment information
- (8) Excludes rehabilitation at Residential Treatment Center (RTC's) or other facilities using social models to provide rehabilitation.
- (9) Patients are responsible for copayments related to place of service, ancillary services, and additional procedures performed at the same time. Prior authorization rules still apply.

## 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. Pre-Authorization by the Plan Medical Director may be required for certain services to be covered. Your Plan does not provide coverage for the following, except as required by law:**

- 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
- 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 (an optional benefit may be selected by your employer group)
- Diapers and incontinence supplies
- Drugs/medicines purchased without a doctor's prescription. Prescription drugs are covered only when your employer group has selected the optional drug benefit, except as defined in the EOC Handbook, or as required by law
- 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
- 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/benefits related to the treatment of mental illness and substance abuse conditions that are not described in the Benefits and Services or Limitations sections of the EOC Handbook; Excluded services/benefits include but are not limited to residential treatment center (RTC) and treatment foster care (TFC) services
- 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 (an optional benefit may be selected by your employer group)
- Vitamins (except Medically Necessary prenatal 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. Your plan has limited coverage for the following services:**

- Acupuncture
- Ambulance service
- Biofeedback
- Breastfeeding Support, Supplies and Counseling
- 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
- Tobacco cessation
- Vision and hearing screening/care

**Lovelace Insurance Company**

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