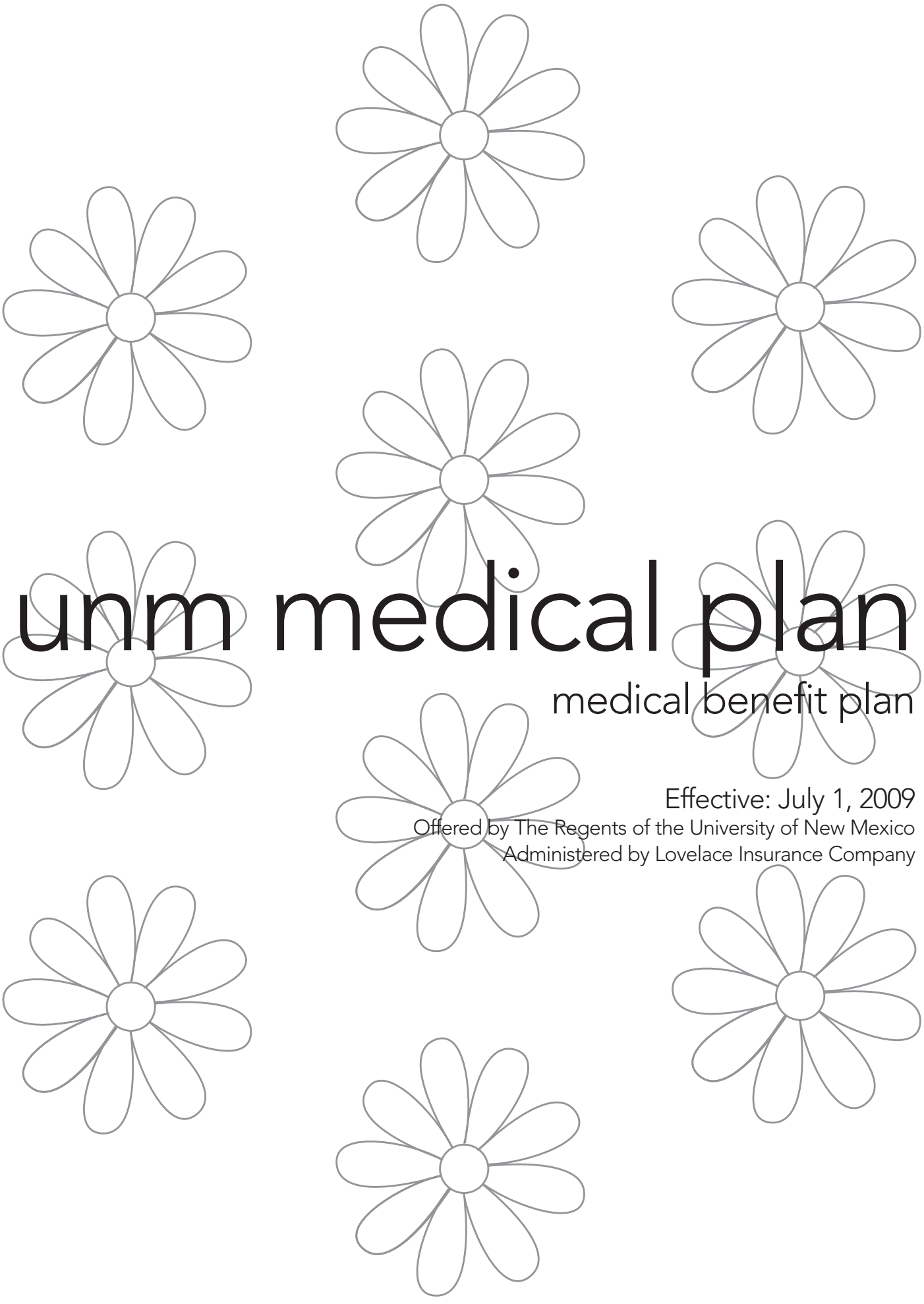
MEDICAL PLAN

2009 Participant Benefit Booklet



unm medical plan

medical benefit plan

Effective: July 1, 2009

Offered by The Regents of the University of New Mexico

Administered by Lovelace Insurance Company

Lovelace Insurance Company

CUSTOM UNM PPO
EVIDENCE OF COVERAGE (EOC)
HANDBOOK

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SUMMARY OF BENEFITS

The following are the highlights of the UNM Medical Plan for the University of New Mexico employees administered by Lovelace Insurance Company. This Participant Benefit Booklet (PBB) covers only medical benefits. Pharmacy, Dental and Vision Benefits are covered in a separate document. These benefits are effective 7/1/2009 through 6/30/2010. Any services received must be Medically Necessary to be covered. The specific terms of coverage, limitations and exclusions are detailed in Sections 3, 5, and 6 of this PBB booklet.

Type of Service/Benefits:	Participant Cost		
	LoboCare Network Tier 1	Lovelace Expanded Network -Tier 2	Out-of-Network Tier 3
Annual Deductible	None	$100 per person ($300 family)	$750 per person ($2,250 family)
Annual Out-of-Pocket Maximums	$1,000 per person ($3,000 family)	$1,500 per person ($4,500 family)	$5,000 per person ($15,000 family)
Hospital Inpatient [3] -includes X-Ray, Lab Work, Surgery, Anesthesia, physician visits at facility	$150[2]	20%[1,2]	40%[1,2]
Outpatient Procedures	$75[2]	20%[1,2]	40%[1,2]
Physician Services: Primary Care (PC) Office Visits Specialist Office Visits Immunization/Inoculation Gynecological Exam Periodic Health Exam Well Baby Care Colonoscopy	$10 co-pay $20 co-pay No charge $10 PCP/$20 Specialist $10 PCP/$20 Specialist $10 PCP/$20 Specialist No charge	$20 co-pay $35 co-pay No charge $20 PCP/$35 Specialist $20 PCP/$35 Specialist $20 PCP/$35 Specialist No charge	40%[1,2] 40%[1,2] Not covered 40%[1,2] Not covered Not covered 40%
Allergy Services Office visits, testing & treatment Injections	$10 PCP/$20 specialist $50 allergy extract preparation	$20 PCP/$35 specialist $50 allergy extract preparation	40% 40
Outpatient Diagnostic Test, Labs & Imaging Services – including X-rays, mammograms and lab work	No additional charge included with applicable visit/facility charge	No additional charge included with applicable visit/facility charge	40%[1,2]
CT Scans, PET Scans, MRI (including Nuclear Med) [3]	$75[2]	20%[1,2]	40%[1,2]
Durable Medical Equipment [3] (Prior authorization required; includes prosthetics; orthotics not covered)	Not applicable	20%[1,2]	40%[1,2]
Behavioral/Mental Health Inpatient [3] Outpatient	$150[2] $20	20%[1,2] $35	40%[1,2] 40%[1,2]
Substance Abuse Inpatient (30 days combined per Contract Year) [3] Outpatient (60 days combined per Contract Year)	$150[2] $20	20%[1,2] $35	40%[1,2] 40%[1,2]

SUMMARY OF BENEFITS

Type of Service/Benefits:	Participant Cost		
	LoboCare Network Tier 1	Lovelace Expanded Network -Tier 2	Out-of-Network Tier 3
Home Health Care [3] (100 combined Visits Per Contract Year)	Not applicable	20%[1,2]	40%[1,2]
Skilled Nursing Care [3] (60 days combined per Contract Year)	Not applicable	20%[1,2]	40%[1,2]
Speech / Physical / Occupational Therapy[3] (20 visits each therapy combined per Contract Year)	$20	$35	40%[1,2]
Hospice[3,4]	No Charge	20%[1,2]	40%[1,2]
Ambulance	20%	20%[1,2]	20%[1,2]
Worldwide Emergency Services	$150 co-pay	$150 co-pay	$150 co-pay
Urgent Care	Not Applicable	$50 co-pay	40%[1,2]
Acupuncture [3] (20 visits each therapy combined per contract year)	$20	$35	40%[1,2]
Chiropractic [3] (20 visits each therapy combined per contract year)	Not applicable	$35	40%[1,2]

This Summary is a highlight of your benefits. Please note, some services are not available on Tier 1, please refer to Tier 2 or Tier 3 for coverage. Please review the details within your Participant Benefit Booklet (PBB) below for more information.

1 Deductible must be met before plan coverage begins
2 Amounts paid apply to annual out-of-pocket maximum
3 Prior Authorization required for certain services; refer to PBB below for additional information
4. LoboCare has pediatric hospice only.

SECTION 1 – INTRODUCTION

The University of New Mexico provides group health care coverage through the UNM Medical Plan (referred to as "Plan" throughout this booklet). This Plan is administered by Lovelace Insurance Company (LINC). By enrolling in this Plan you have agreed to the benefits provided and the terms of the benefit plan offered by the University of New Mexico. This Participant Benefit Booklet covers only those Medical Plan benefits offered under the Plan. Pharmacy Benefits are administered by Express Scripts. Vision Benefits are offered by VSP and dental benefits are administered by Delta Dental. Pharmacy, Dental and Vision benefits administered are not part of this plan nor described in this document.

As a Participant of this Plan, you are able to receive Covered Services from Participating Providers or, as an option under this plan to obtain services out-of-network at a greater cost to you. The Participating Provider networks have contractual agreements with LINC that allow lower out-of-pocket expenses and additional benefits for covered persons. The network of Participating Providers includes Physicians, Hospitals, and other Health Care Professionals or Facilities that provide Health care Services.

When you see the terms "you", "yours", or beneficiary it means the University of New Mexico eligible employee or eligible dependent covered by this Plan. When the terms "we" or "us" or "Plan" are used in this document it is referring to The University of New Mexico Medical Plan. When this booklet refers to Lovelace Insurance Company it will use the terms "LINC" or "Lovelace".

HOW TO USE THIS BOOKLET

This booklet is your Participant Benefit Booklet (PBB). Along with your Summary of Benefits, it describes the health care benefits available to you and your covered Dependents. It is designed to make it easy for you to make the most of the benefits and services available and help to guide your decision on the level of services you choose to receive along with the associated copayments, and/or deductibles and co-insurances and guide you in using the Plan benefits by helping you to understand:

- How your Plan works;
- How to file claims (if applicable),
- What services are or aren't covered by your Plan;
- How to request reconsideration of a claim;
- How to file for an adjustment of a benefit payment; and
- Where to turn when you need assistance.

We encourage you to read this PBB and your Summary of Benefits carefully. We especially encourage you to review the Benefit Limitations and Exclusions sections of this booklet. Many of the sections are related to other sections of the document; so 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 booklet 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 PBB.

Safe Keeping

We encourage you to keep this document, the Summary of Benefits and any other Plan materials you may receive, for your future reference. Please be aware that your health care providers do not have a copy of your PBB nor the Summary of Benefits, and are not responsible for knowing or communicating your Covered Benefits. **It is best to call for clarification before services are rendered to ensure that the proper procedures are followed in order to afford you with the maximum level of benefits available under the Plan.**

If you need more information about your Plan coverage or need additional copies of your Plan materials, please contact the Plan Administrator, Lovelace Customer Care Center:

Customer Care Center
505.727.LOVE (5381) or 800.808.7363 (toll-free)
Or by email: lovelacehealthplan.com
TTY Services provided by Relay New Mexico 800.659.8331

You may also visit the Lovelace web site at:
lovelacehealthplan.com for more useful information about your benefits and services.

Lovelace Insurance Company

Physical Address:
4101 Indian School Road NE #110 South
Albuquerque NM 87110-3988

Lovelace Participant Correspondence Mailing Address:
P. O. Box 27107
Albuquerque NM 87125-7107

Lovelace Medical and Behavioral Health Claims Address:
PO Box 30536
Salt Lake City, UT 84123

UNM Benefit Office
1700 Lomas Boulevard, Suite 1400,
MSC01 1220
Albuquerque, NM 87131
505-277-6947

SECTION 2 – ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

Eligibility and enrollment requirements for this Plan are determined by the University of New Mexico. Lovelace Insurance Company administers enrollment activities based upon the guidelines and requirements provided by UNM. Contact your UNM Benefits Office at 277-6947 for eligibility guidelines that apply to you.

WHO IS ELIGIBLE?

Eligible employees include:

Staff must be:

- Regular full-time or part-time employees;
- Working at least 20 hours per week; AND
- At an appointment percent of 50% or greater.

Faculty must be:

- At least nine-month academic year contract;
- Regular full-time or part-time employee; AND
- At an appointment percent of 50% or greater.

Post-doctoral Fellows must be:

- At least nine-month academic year contract;
- Regular full-time or part-time employee; AND
- At an appointment percent of 50% or greater.

Eligible Dependents include:

- The employee's spouse through legal marriage and not legally separated from the employee

- Domestic Partners*The University defines domestic partners as two (2) individuals who live together in a long-term relationship of indefinite duration .There must be an exclusive mutual commitment similar to that of marriage for the last 12 months in which the partners agree to be financially responsible for each other's welfare and share financial obligations. Partners must share the same primary residence and must be 18 years or older and must not be a blood relative any closer than would prohibit legal marriage. An Affidavit of Domestic Partnership form (found on UNM HR's website forms page) signed to that effect and proof of three (3) of the following must be submitted to the Employee Benefits Office:
    - A joint mortgage or lease.
    - Joint ownership of a motor vehicle, joint bank account, or joint credit account.
    - Domestic partner named as beneficiary of life insurance.
    - Domestic partner named as beneficiary of retirement benefits.
    - Domestic partner named as primary beneficiary in the employee's or student's will.
    - Domestic partner assigned durable property or health care power of attorney.
    - Household expenses are shared by both partners.

The University may require proof that those applying for status of domestic partnership meet the above requirements. Providing false information may result in disciplinary action, dismissal, and reimbursement of costs involved in providing benefit coverage.

SECTION 2 – ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

Individuals may qualify for and be recognized as domestic partners by The University of New Mexico by presenting to the Human Resources Service Center a valid marriage license from a jurisdiction in which same-sex marriage is legally recognized.

If Enrolling a Domestic Partner outside of your initial eligibility or Open Enrollment, you must provide proof that you are enrolling your Domestic Partner within 31 calendar days from the date you meet the criteria as Domestic Partners.

NOTE:
You are not eligible to enroll as a Domestic Partner if either you or the Participant have signed a Domestic Partner Affidavit or Declaration with any other person within twelve 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.

- Unmarried children under age 25. Children include natural children, children placed for the purpose of adoption, legally adopted children, stepchildren or children for whom you have court approved legal guardianship, and children for whom you have been ordered by a court of law or through administrative order to provide health care coverage, and are dependent upon you for support and maintenance. You may be required to provide documentation for proof of eligibility and a Power of Attorney is not considered court approval;

- Children for whom you are legally responsible to provide health care coverage under a qualified medical child support order. A qualified medical child support order is a judgment, decree or order (including approval of a settlement agreement) that states you are legally responsible to provide health care coverage for that child;

Unmarried children who were enrolled as Dependents before age 25. However, the attainment of such age shall not terminate the coverage under the Plan of a Dependent unmarried child who is incapable of self-sustaining employment because of behavioral/mental or physical impairment if they are chiefly dependent upon you for maintenance and support. You must provide proof of the child's incapacity and dependency within 31 days of the child reaching age 25, and every year after that upon request by the Plan; and during initial enrollment, you must provide proof of incapacity and dependency to your Human Resources representative. Thereafter, proof of incapacity and dependency may be requested periodically by the Claim Administrator.

- Children of Domestic Partners. Benefits are also available to domestic partner's children provided one or both of the domestic partners is the biological child of the parent, adoptive parents of the child, or the child has been placed in the Domestic Partners' household as part of an adoptive placement, legal guardianship, or court order; with the exclusion of foster children.

Benefits are not provided for Hospital room and board or Inpatient Physician care for any Hospital Admission or portion of an Admission that is for a Participant who is not covered or who, at the beginning of the Admission was not a Participant, an eligible Dependent, or the natural-born child of an employee.

SECTION 2 – ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

When two or more family members, including Domestic Partners, are employed by the University of New Mexico, the employee may be covered as an employee (only) or as a Dependent (only), but not both. This plan does not allow dual coverage as both nor internal coordination of benefits.

A Dependent, other than your spouse, who is also employed by the University of New Mexico and covered under this Plan as an employee, is not eligible for coverage as a Dependent. If more than one parent is insured under this Plan as an employee, the Dependent children may be enrolled as Dependents of only one parent.

ENROLLING FOR COVERAGE

You must complete and return an enrollment form within 60 calendar days of your initial eligibility date. If you don't elect coverage within 60 calendar days of your initial eligibility date and later want coverage, you must wait until the next open enrollment period to receive coverage – unless you have a qualified change in status or you are eligible as a result of a special enrollment event. If you have a qualified change in status or special enrollment event, you will be able to elect coverage within 31 calendar days of the change. If you do not enroll within 31 calendar days, you must wait until the next open enrollment period to enroll. Once you enroll in the Plan, your enrollment remains in effect through the plan year – from July 1 to June 30, unless you make changes due to a qualifying change in status.

HOW TO ENROLL DEPENDENTS

You may apply for coverage of your eligible Dependents, which may result in a change of coverage level (double to family or employee only to employee + child(ren). Each additional Dependent added to your coverage must be enrolled within 31 calendar days of becoming eligible for the Plan. Newborn or Newly adopted children are effective on the date of birth or placement for adoption and must be enrolled within 31 calendar days of that date.

New Spouse or Domestic Partner coverage is effective the beginning of the month after enrollment occurs, as long as enrollment is received within 31 calendar days from date of marriage or eligibility for Domestic Partnership.

It is your responsibility to be sure that all of the dependents you enroll and continue to cover are eligible for the benefit in accordance with the terms and conditions of the plan. If you enroll a dependent who does not meet eligibility requirements, or if you do not drop a dependent who no longer meets eligibility requirements, you may be responsible for any expenses incurred. **You MUST disenroll your ineligible dependent and notify the UNM Benefits Office as soon as possible, or within 31 calendar days of any of the above qualifying events. To disenroll your dependent, you must submit an enrollment/change form to the UNM Benefits Office. An eligible dependent's coverage ends on the last day of the month in which the event occurred.**

WHEN COVERAGE STARTS

In order to have health insurance, *you must enroll within 60 calendar days of your initial eligibility date or during Open Enrollment. There are no late enrollments.*

For initial enrollment:

- Coverage begins the first of the month after your enrollment form is received at the HR Service Center (must be date stamped by an HR Services Representative).

SECTION 2 – ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

- You may elect for your medical insurance to be effective the date your enrollment form is received and dated stamped by the HR Service Center. However, you will not receive a prorated premium for the month. You will pay a full month's employee portion of the premium regardless of the effective date of coverage.
- You are not eligible for benefits before your date of hire or date of eligibility.

If you fail to enroll yourself/dependents within the initial eligibility period, you will not be able to enroll unless there is a qualifying status change or until Open Enrollment, which is in May. Enrollment during Open Enrollment will not become effective until the following July.

Contact the UNM Benefits Office for further details.

Generally, eligible Dependents become insured on the same day that the employee becomes insured.

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA)

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan. You must request enrollment within 31 days after your other coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents, provided that you request enrollment within 31 calendar days after marriage, birth adoption, or placement for adoption. If you have any questions about this law, contact your agency group representative.

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.

Effective April 1, 2009, CHIP created a new midyear special enrollment period related to two new qualifying events for employees or dependents to enroll in employer group health plans, noted below.

- 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 offer a premium assistance program – participants should check with the state.)

This means that in addition to enrolling upon hire, at open enrollment, or as the result of existing qualifying events, employees and their dependents now have additional opportunities to enroll in UNM Medical Plan.

The qualifying event is the Employees' or dependents' loss of Medicaid or CHIP coverage due to loss of eligibility.

Employees must request coverage within 60 calendar days of the new qualifying event(s). (For all other qualifying events, e.g., birth of a child, marriage, or loss of other coverage, employees are still required to request coverage within 31 calendar days of the qualifying event.)

Please contact UNM Benefits Office at 277-6947 if you have experienced a qualifying event.

SECTION 2 – ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

CHANGING YOUR COVERAGE

Once you elect coverage, you generally cannot change your elections until the following Open Enrollment period. However, there are certain circumstances when you may be eligible to change coverage earlier. You must submit an enrollment form requesting the change in coverage to the UNM Benefits Office within 31 calendar days of the event causing the change. Any change must be consistent with the reason the change was permitted.

Situations governed by HIPAA special enrollment rules.

- You, your spouse, or your Dependent children become eligible for COBRA continuation coverage.
- Judgment, decree, or order that requires accident or group health coverage for your child.
- You, your spouse, or Dependent children become entitled to Medicare or Medicaid. (You may cancel coverage for the individual who becomes eligible for Medicare or Medicaid coverage.)
- A significant cost or coverage change in the health care provided to you or your Dependents through a third party, such as your spouse's employer.
- Change in status event, but only when the change causes you or your Dependent to gain or lose other coverage. The change must correspond with the gain or loss of coverage.

In addition there are other Special situations where you may be elgible for a Special Enrollment Period.

SPECIAL ENROLLMENT/NOTICE OF EMPLOYEE RIGHTS

Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, if you are declining enrollment for yourself or your Dependents (including your spouse and eligible children) because of other group health insurance coverage, you may in the future be able to enroll yourself or your Dependents in the Plan. You must request enrollment within 31calendar days after you or an eligible Dependent lose coverage under another group health plan either because:

- Eligibility ends;
- COBRA benefits are exhausted;
- You return to work after serving active military/reserve duty; or
- Employer contributions end.

In addition, if you have a new Dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your Dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. An otherwise eligible employee and Dependent(s) who did not apply for coverage when initially eligible because of other group coverage at another place of employment, but who later lost their coverage due to a change in employment status, may apply within 31 days if the loss of coverage is due to loss of employment/change in job status, or death of a spouse, or divorce from a spouse. This provision also applies to employees who return to work after serving active military/reserve duty.

Note: It is your responsibility to notify the UNM Benefits Office in writing within 31 calendar days of a Qualifying Change of Status event. Failure to do so will disqualify your enrollment.

SECTION 2 – ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

FAMILY STATUS OR EMPLOYMENT STATUS CHANGES (QUALIFYING EVENTS)

You may make certain changes to your benefit elections within 31 calendar days of a change in family/employment status. Changes to your plan must be made within 31 calendar days of the qualifying change in status event. You must submit an Enrollment/Change Form within the 31 calendar day period along with the supporting documentation as applicable. If you are unable to provide documentation within the 31 calendar days, please submit the change form along with an explanation that you are in the process of getting the required documentation. Your documentation must support your enrollment form in that the enrollment form was received within 31 calendar days of the qualifying change, regardless of when the documentation was received. The only exceptions would be birth and adoption, where the additional coverage would take place retroactively to date of birth or adoption as long as your enrollment for is received within 31 calendar days from the date of birth or adoption. The following family/employment status changes are recognized by the University of New Mexico:

- Marriage or divorce;
- Legal Separation;
- Birth or adoption of a child;
- Death of a spouse or Dependent child;
- Loss of other group coverage through a spouse or domestic partner's employer A change in your spouse's employment (loss of job, or a new job that provides health care coverage)
- A change in legal responsibility for a child;
- Dependent turns 25
- Marriage of a Dependent child;
- Qualification or disqualification of a domestic partner; and
- Change in employment status (regular part-time to regular full-time or vice versa)
- Loose eligibility on a Medicaid plan.

SECTION 3 – HOW YOUR PLAN WORKS

As a Participant of this Plan, you will be getting most or all of your health services from the doctors, hospitals, and other health care providers that are part of the LoboCare Network or the Lovelace Expanded Network. These doctors, hospitals, and other Participating Providers are contracted to provide your care, so they are the ones you should use except in special situations such as emergencies or unless you choose to use your Out-of-Network benefits and incur greater expenses.

When you and your covered family participants use Participating Providers in either the LoboCare Network or the Lovelace Expanded Network, the provider will receive payment from your Plan for covered services, except for any applicable Deductibles, Co-Payment/Co-Insurance amounts that you are responsible for paying. The amount of your Deductible, Co-Payment/Co-Insurance for each service can be found in the Summary of Benefits, starting on page 5 above.

Certain procedures or services require Benefit Certification for the services to be covered. Your PCP or the Participating Provider/Facility in either the LoboCare Network or the Lovelace Expanded Network must obtain this Benefit Certification from the Plan Administrator, Lovelace Insurance Company, before providing these services to you. Should you choose to utilize your Out-of-Network benefits, MultiPlan including the Private Health Care Systems (PHCS) network outside of New Mexico (see below), you will be responsible for obtaining this Benefit Certification prior to those services being rendered to you.

Participating Providers in either the LoboCare Network or the Lovelace Expanded Network (excluding the MultiPlan/PHCS network) are also responsible for filing all claims to the Plan Administrator, Lovelace Insurance Company. You will not have any claims to file or papers to fill out in order to have the medical services rendered paid for when obtained from Participating Providers. Your Participating Provider will bill us directly.

If you choose to utilize your Out-of-Network benefit providers or the MultiPlan/PHCS network you may be responsible for initial payment for the medical services rendered and for submitting paperwork for these services prior to being reimbursed by UNM. **If you do not obtain the required prior authorization for these services provided by Out-of-Network providers or MultiPlan/PHCS prior to the services being rendered you may not be reimbursed for the services**

UNM PROVIDER DIRECTORY

When you need care, you can feel confident knowing that the UNM Medical Plan network includes Participating Providers close to where you live and work. From your neighborhood health care center to acute care hospitals - the statewide network of contracted physicians, hospitals and related medical services means you're covered all across New Mexico.

The UNM Medical Plan utilizes the Lovelace Network of Participating Providers. Before joining the UNM Medical Plan network through Lovelace, Participating Providers must meet Lovelace standards through a process called credentialing. Lovelace regularly reviews providers' credentials to help ensure they continue to meet these standards.

The UNM Medical Plan Provider Directory includes a listing of physicians, hospitals, pharmacies, medical equipment Providers, laboratory, x-ray, and other network Participating Providers contracted with Lovelace Insurance Company. The Provider Directory is subject to change as new Providers contract with Lovelace and some Participating Provider contracts end. A Provider's listing in the directory does not guarantee that the Provider is still contracted with Lovelace Insurance Company or accepting new patients.

The most current contracting status of any Participating Provider may be obtained by accessing the UNM Medical Plan Online Provider directory via the Lovelace website at lovelacehealthplan.com or by contacting the Lovelace Customer Care Center.

NETWORK OF PROVIDERS OUTSIDE OF NEW MEXICO

Lovelace Insurance Company partners with MultiPlan/Private Health Care Systems (PHCS) to provide the UNM Medical Plan access to high-quality medical care to UNM participants who are outside of the local service area. If you choose to receive care outside of New Mexico, you can receive seamless care through the Lovelace partnerships with MultiPlan/PHCS and the complementary Multiplan network. This provides you access to more than 600,000 providers in all 50 states plus the District of Columbia to offer medical services to participants when you are outside of New Mexico. To locate a PHCS/Multiplan participating provider, you can access their online provider directory at multiplan.com.

PLEASE NOTE: Participants will be required to obtain Benefit Certification/Benefit Notification for all inpatient admissions to Multiplan/PHCS facilities or other services that may require a Benefit Certification. Please refer to the "Benefit Certification" section of this PBB and/or call the Lovelace Customer Care Center for any questions you may have.

Primary Care Physicians

Primary Care Physicians (PCPs) are Physicians who have a contract with Lovelace Insurance Company to provide, coordinate, and manage your health care needs. The Plan believes a strong relationship with your PCP will help you and your family obtain the most value from your Plan benefits. PCPs provide you primary care services. These services include annual examinations, routine immunizations and treatment of non-emergency acute illnesses and injuries.

PCPs include, but are not limited to, family practice physicians, general practitioners, internists, pediatricians or obstetricians/gynecologists. Female participants may choose to have an OB/GYN as their Primary Care Physician, if desired.

Specialists

A Specialist is a doctor who has obtained additional medical certifications through additional training in specified or specialized areas of medicine and 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). No referral is required to see any Participating Specialist.

Physicians' Qualifications

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

LOVELACE CUSTOMER CARE CENTER

Lovelace Insurance Company administers the UNM Medical plan on behalf of UNM and values your questions and comments about your Plan or your health care. The Customer Care Center staff at Lovelace will work with you to resolve any problems that you may experience. It is their goal to resolve any concerns you have as quickly and as satisfactorily as possible.

Online Participant Options

The Lovelace interactive website is a valuable source of information. As a participant enrolled in the UNM Medical 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 the Lovelace website at lovelacehealthplan.com for more information.

Why Contact one of the Lovelace Customer Care Representatives?

Lovelace 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 Benefit Certifications
- Status of claim payment
- Complaints or Concerns
- Appeals and Grievance procedures

Where to Contact Lovelace

If you have a question or Concern, contact the Lovelace Customer Care Center at 505.727.5381 (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 Time). 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.

Language Line

Sé hablá Español. Lovelace has translation services available upon request for over 140 languages. Lovelace also has on-staff bilingual Spanish-speaking representatives. Need translation services during your visit to your physician's office? Contact the Lovelace Customer Care Center and they will arrange for assistance during your doctor's 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 answer your questions.

YOUR PLAN ID CARD

You have been issued a UNM Medical Plan ID card (two cards per couple or family). If additional cards are needed, contact the Lovelace 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 Deductible, Co-Payment/Co-Insurance amounts. Additional Deductible, Co-Payment/Co-Insurance amount information can be found in your Summary of Benefits. If you are unsure of the benefits covered under your Plan or the Deductible, Co-Payment/Co-Insurance amounts, contact the Lovelace Customer Care Center for assistance. The Co-Payment/Co-Insurance amounts found on your Plan ID card do not constitute an all-inclusive list.

Abbreviations of Benefits

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

PRIMARY CARE	=	Primary Care Physician Office Visit Co-Payment amount
SPECIALIST	=	Specialist Office Visit Co-Payment amount
EMERGENCY	=	Emergency Room Co-Payment amount
URGENT CARE	=	Urgent Care Co-Payment amount
HOSPITAL	=	Hospital Admission Co-Payment amount
OP SURGERY	=	Outpatient Surgery Co-Insurance amount

ID Card Rules

You are entitled to Plan services and benefits if all applicable Premiums and Co-Payment/Co-Insurance, and deductibles if applicable, 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-Participant to use your Plan ID card. By doing so, you will be responsible for the cost of services provided to the non-Participant. In addition, your Plan membership and that of your covered Dependents may be terminated. Contact the Lovelace Customer Care Center immediately if your Plan ID card is lost or stolen.

COST SHARING FEATURES

The Plan shares the cost of your health care expenses with you. The following describes the different cost-sharing methods available, as detailed 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. For most Covered Services on the LoboCare Network, Tier 1, you pay a Co-payment and the Plan pays the remainder. Review your Summary of Benefits to see what your Co-Payment amounts are.

Hospital Admission – Medical

The per-Admission Co-payment amount is listed in the Summary of Benefits. In the event you are hospitalized and subsequently transferred within the facility, no new Co-payment will be required.

Hospital Admission – Behavioral/ Mental Health and/or Substance Abuse

The per-Admission Co-payment or Deductible and Co-insurance amounts are listed in the Summary of Benefits. In the event you are hospitalized and subsequently transferred within the facility, no new Co-payment or Deductible/Co-insurance will be required.

Note: PCP Providers accept the Lovelace Insurance Company Negotiated Fee-for-Service as their maximum fee. You pay only the Co-payment and any non-covered expenses.

Co-Insurance

Co-Insurance is the amount of the Covered health care expense 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. This Co-insurance is in addition to the Contract Year Deductible you are responsible for and continues to be your responsibility after the Contract Year Deductible is met. Review your Summary of Benefits to see what your Co-Insurance amounts are.

Co-Payments or Co-Insurance amounts are due for every visit, even if you have more than one appointment in one (1) day. Keep your receipts as proof of payment. If you are in doubt as to whether a Co-Payment is due, contact the Lovelace Customer Care Center before your visit.

NOTE: If a Participant is readmitted to the hospital within seventy-two (72) hours after discharge, no additional Co-payment amount will be required.

Plan Year Deductible

Some services are subject to a Contract Year Deductible. The amount of your Contract Year Deductible can be found in the Summary of Benefits. This Deductible must be paid by you each Contract Year toward Covered Services before health benefits for that Participant will be paid by the Plan (except for those services listed as not subject to the Deductible on the Summary of Benefits).

The deductible amounts are calculated as:

- For single coverage, the Annual Deductible requirement is met when the participant meets the Single Deductible requirement during the Contract year.
- For coverage with two (2) enrolled Participants, the 2-Party Annual Deductible requirement is met when both covered Participants have each met their applicable per person Deductible during the Contract Year. No one (1) Participant would need to meet more than the individual deductible to satisfy that Participant's deductible requirement.
- For coverage with three (3) or more enrolled participants, the Family Annual Deductible requirement is met when the applicable family amount has been met during the Contract Year. No one (1) Participant would need to meet more than the individual deductible to satisfy that Participant's deductible requirement.

PLAN YEAR OUT-OF-POCKET MAXIMUM

To protect you and your covered dependents from the high cost of catastrophic illness, there is a maximum on the total Co-Payment or Co-Insurance amount you must pay in a Plan Year for Covered services. This total amount is referred to as your Out-of-Pocket Maximum. After your Out-of-Pocket maximum is reached, the Plan pays 100% for Covered Services for the remainder of that Plan Year, up to the maximum benefit amounts. Please refer to your Summary of Benefits for your Plan's individual and family out-of-pocket maximum amounts.

Dependent upon the Tier level of coverage you access at the time of service, certain Co-payments and Co-insurance apply to the Out-of-Pocket Maximum. Please refer to the Summary of Benefits to determine which services apply to your Out-of-Pocket Maximum. The Out-of-Pocket Maximum does not include non-covered charges, any amounts over Reasonable and Customary charges, or prescription drug Co-payments. If any one family Participant's out-of-pocket amount equals the individual Out-of-Pocket Maximum, the Out-of-Pocket Maximum for that Participant is met.

Contract Year Family Out-of-Pocket Limit

An entire family meets the applicable out-of-pocket limit when three family Participants each satisfy the individual out-of-pocket limit as indicated on the Summary of Benefits. The Summary of Benefits also illustrates the Two-Party and family out-of-pocket limits.

Note: If a Participant's individual out-of-pocket is met, no more charges incurred by that Participant may be used to satisfy the family out-of-pocket. The Out-of-Pocket Maximum is listed in the Summary of Benefits and includes Co-insurance. The Out-of-Pocket Maximum does not include copayments, deductibles, , non-covered charges, any amounts over Reasonable and Customary charges, or prescription drug Co-payments.

MAXIMUM BENEFITS

In general there is no lifetime maximum payment under the Plan as shown in the Summary of Benefits. However, certain benefits are specifically limited and are described in the Summary of Benefits and Section 6 have maximum limits per Contract Year or lifetime.

BENEFIT CERTIFICATION

Benefit Certification can provide you with assurance that, when you are using the Plan, you are being treated in the most efficient and appropriate health care setting. It will also help manage the rising costs of health care. Your participation is essential. Together, we can make Benefit Certification an effective program.

Benefit Certification is a review process where Lovelace Insurance Company physicians, nurses, and/or clinical staff work with your Provider to determine whether a procedure, treatment or service is a Covered Benefit under your Plan. The UNM Medical Plan does not restrict your Participating Provider from discussing various treatment options with you, even if the treatment is not covered under your Plan. However, please confirm that a treatment, Provider or service will be covered by carefully reviewing this PBB, your Summary of Benefits or by contacting the Lovelace Customer Care Center.

A referral, recommendation or order from your Physician is not a guarantee of Plan coverage. In addition, receiving Benefit Certification is not a guarantee of payment. Coverage includes verification of Benefit Plan Coverage, Limitations and Exclusions and Eligibility Requirements. If Benefit Certification is not obtained when required, services may not be covered under your Plan. To ensure a necessary Benefit Certification has been obtained, contact Lovelace Customer Care Center.

How Does The Process Work?

Your UNM Medical Plan requires Lovelace Insurance Company to verify or require a Benefit Certification be obtained for hospital admissions and selected outpatient services. When a request for Benefit Certification comes into the Lovelace Insurance Company Health Services Department, the staff will ask your PCP, Specialist or other Participating Provider for information about your medical condition, the proposed treatment plan and the estimated length of stay, if hospitalization is required.

The Health Services Department staff member will evaluate the request using nationally recognized guidelines to assist in the review and notify your provider (usually at the time of the call) if the proposed treatment or hospitalization is approved. Standard/Non-urgent service determinations are made within five (5) business days of Lovelace Insurance Company receiving the request. Notice of coverage decisions will be given to you and your Provider in writing.

The guidelines used in the review process are consistent with sound clinical principles and processes and have been developed with involvement from actively practicing health care providers. Lovelace Insurance Company staff members determine what services are covered based on your Plan benefits and using national guidelines. When guidelines do not exist, clinical resource tools based on clinical evidence are used.

Some Benefit Certification requests are referred to one of the Lovelace Insurance Company Medical Directors, a physician who considers each case on an individual basis. The Medical Director may speak with your physician to obtain additional information. You and your physician will be notified in writing if a request for Benefit Certification cannot be approved based on the information Lovelace received and/or on your Plan benefits.

NOTE: The Benefit Certification requirements affect whether the Plan pays for your Covered Services. However, Benefit Certification does not deny your right to be admitted to any Hospital.

When Does The Review Occur?

Participating Providers (those providers contracted with Lovelace Insurance Company) are responsible for contacting Lovelace Insurance Company and obtaining approval before Participants receive services for services requiring Benefit Certification. **You are responsible for obtaining approval for In-patient Admissions to any PHCS/Multiplan facility or Out-of Network Provider/Facility. Failure to obtain Benefit Certification may result in non payment for services.** In addition, you are responsible for contacting Lovelace Insurance Company before receiving services from a non-Participating Provider, except for emergencies. Only in limited circumstances, and with Benefit Certification, are services provided by non-Participating Providers a covered benefit.

Your Provider must submit clinical information specific to your case in order for Lovelace Insurance Company to determine whether the requested service is Medically Necessary and a covered benefit under your Plan. These services may also require oversight by Lovelace Insurance Company or are limited benefits and have specific time frames when services can be provided.

Benefit Certification has been completed when your provider receives confirmation that the proposed services are approved. Payment is made as explained in the Summary of Benefits and in the "Covered Services" section of this PBB.

For services obtained on Tier 3, Out-of-Network, or received by MultiPlan/PHCS providers or facilities, you are responsible to ensure that a Benefit Certification is obtained prior to the services being provided, if not an emergency or an urgent occurrence. **If the Benefit Certification is not obtained by you in these circumstances you may be responsible for the payment of the services.**

Second Opinions

A second opinion may be obtained from a Participating Provider without a Benefit Certification or approval from the Plan. Any request for a second opinion outside the Lovelace Insurance Company network of Participating Providers may require an approval from Lovelace Insurance Company or may result in additional expenses to you.

IMPORTANT: If you have Two-Party or Family Coverage, Benefit Certification requirements apply to your family members who are also covered persons.

WHAT PROCEDURES REQUIRE BENEFIT CERTIFICATION?

Benefit Certification is required for the following services detailed below. If you are being treated/seen by an Out-of-Network Provider or a PHCS/MultiPlan Provider outside the state of New Mexico, it is your responsibility to obtain or verify that a Certification has been obtained. Services of an Out-of-Network Provider will not be covered without a written Benefit Certification

Benefit Certification determines only the Medical Necessity of a procedure or an Admission and an allowable length of stay. Approvals (for example, to receive non-specified services from a particular Provider) do not guarantee payment, and do not validate eligibility. Benefit payments are based on your eligibility and benefits in effect at the time you receive services. Services not listed as covered benefits and services that are not Medically Necessary are not covered.

Benefit Certification – Inpatient

If your Participating Provider in the LoboCare or the Lovelace Expanded Networks (Tiers 1 and 2) recommends you be admitted as an Inpatient to a Hospital or treatment facility, your provider, in conjunction with the Hospital or facility is responsible for any Benefit Certification requirement for Inpatient Admissions. If the admission is in an Out-of-Network or MultiPlan/PHCS facility you are responsible for obtaining the Benefit Certification. If there has been no Benefit Certification, and you are Hospitalized, and Lovelace Insurance Company determines that the Admission was for a covered service but hospitalization was not Medically Necessary, no benefits are paid for Inpatient room and board charges and these expenses do not apply toward the out-of-pocket maximum provision. Covered Services are paid as explained in the Summary of Benefits and Section 5. If the Admission is not for a covered service, no payment is made.

The following Inpatient services require Benefit Certification from the Plan via Lovelace Insurance Company:

- Medical/Surgical/Maternity Inpatient admission
- Behavioral Health Inpatient admission
- Inpatient Rehabilitation Services
- Long-term Acute Hospital Care
- Skilled Nursing Facility Care
- Behavioral Health Partial Hospitalization
- Residential Behavioral Health
- Inpatient Detoxification
- Inpatient Substance Abuse rehabilitation
- Inpatient Hospice Care

Note: For Inpatient Admissions to a Lovelace Insurance Company contracted provider/facility, it is the responsibility of the Participating Provider to obtain Benefit Certification. Services without Benefit Certification will not be covered. For Inpatient Admissions to an Out-of-Network facility or a PHCS/Multiplan facility, it is the responsibility of the Participant to obtain Benefit Certification. For emergencies, Lovelace Insurance Company must be notified by the end of the next business day or benefits may be denied. Benefit Certification procedures also apply in the event you are transferred from one facility to another, or when a newborn child remains Hospitalized after the mother is discharged.

IMPORTANT: If you have Two-Party or Family Coverage, Benefit Certification requirements apply to your family members, too.

Benefit Certification For Other Medical Services

In addition to Benefit Certification for all Inpatient services, Benefit Certification is required for a number of outpatient services. For some services, Benefit Certification may be requested over the telephone. In other cases, a written request for approval must be submitted. Your Primary Care Physician, Specialist or other Participating Provider requests Benefit Certifications.

Please refer to Section 5 & 6 of this PBB to determine the coverage, limitation and exclusions of these services. Additionally, discuss the need for Benefit Certifications with your Participating Provider before obtaining any of the following services:

- Selected Medical & Surgical Procedures, including, but not limited to:
  - Cosmetic or Reconstructive Surgery
  - Cardiology procedures
  - Sleep Studies
  - Pain Management
  - Dental services
- Magnetic Resonance Imaging (MRI), Computed Tomography (CT) and Positron Emission Tomography (PET) Scans;
- Nuclear Medicine
- Genetic Testing And Counseling;
- Treatment Of Genetic Inborn Errors Of Metabolism Disorders (IEM);
- Bone growth stimulators;
- Cancer Clinical Trials (as specified in Section 5);
- Durable Medical Equipment (DME);
- Prosthetic appliances and orthotics;
- Medical Supplies;
- Certain injectables received in the Provider's office (If your PCP requires you to purchase an injectable drug and bring it to the PCP office for injection that drug must be purchased through by Express Scripts);
- Injectable drugs;
- Medical Detoxification;
- Skilled Nursing Facility Care;
- Home health services/home health intravenous drugs;
- Substance Abuse services – inpatient;
- Physical, Occupational and Speech therapy;
- Uterine monitoring, home;
- Transplants.

IMPORTANT: If you have Two-Party or Family Coverage, Benefit Certification requirements apply to your family members who are also covered persons.

MEDICAL NECESSITY

The Plan helps pay health care expenses that are Medically Necessary and for those routine services specifically covered in this PBB. No benefit is available for any expense that is not Medically Necessary, unless it is for a routine service specifically covered in this PBB.

Medical Necessity or Medically Necessary means health care Services determined by a Provider, in consultation with the Plan via Lovelace, to be appropriate or necessary, according to any applicable generally accepted principles of good medical practice and practice guidelines developed by the federal government, national or professional medical societies, boards and associations, and 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/Mental Health or Substance Abuse condition, illness, injury, or disease.

The Plan via Lovelace Insurance Company determines whether a health care service or supply is Medically Necessary, and, therefore, whether the expense is covered. The fact that a Provider has prescribed, ordered, recommended, or approved a service or supply does not make it Medically Necessary or make the expense a covered service, even though it is not specifically listed as an exclusion.

Note: If you disagree with Lovelace Insurance Company's decision regarding the Medical Necessity of any item or service, you may file a Grievance or complaint. Please refer to the "Appeals & Grievance Procedures" in Section 9.

CASE MANAGEMENT PROGRAM

Case Management is a collaborative process which assesses plans, implements, coordinates, monitors and evaluates options and services to meet an individual's health needs through communications and available resources to promote quality, cost-effective outcomes. Lovelace Insurance Company's Case Management Program is a program that, as early as possible, identifies patients who have the potential for having high-cost medical expenses, may require extensive hospitalization, or have complicated discharge planning needs so that cost-effective alternative care arrangements can be made. Special care arrangements are coordinated with the Physician and may include benefits for services that are not ordinarily covered. In addition, the case management program acts to assist the patient and Physician in complex situations and coordinates care across the health care spectrum.

Transition of Care

If you are a new Participant and are in an ongoing course of treatment with an Out-of-Network Provider, you may be allowed to continue receiving care from this Provider for a transitional period of time (usually not to exceed 90 days). Similarly, if you are in an ongoing course of treatment with an In-Network Provider and that Provider becomes an Out-of-Network Provider, you will be allowed to continue care from this Provider for a transitional period of time. Application must be made within 30 days of the event. Please contact the Lovelace Customer Care Center for further information on Transition of Care.

SECTION 4 – PARTICIPANT RIGHTS AND RESPONSIBILITIES

Thank you for choosing the UNM Medical Plan for your choice for health care benefits. The Plan described in this document is administered by Lovelace Insurance Company. Lovelace is committed to providing UNM Participants high-quality health care insurance service. Under this benefit plan 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, (see additional information on pharmacy benefits). In addition, your rights include access to information pertaining to Participating Providers and Participant 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 different benefit tier level and/or a Non-Participating Provider or without the required pre-authorization.
- To be treated in a manner that respects your privacy and dignity as a person.
- To participate with Participating Providers in making decisions about your health care.
- To be informed of your diagnosis, prognosis, and treatment plan. This must be done in terms you understand. If you do not understand the information, you have right to conduct a candid discussion to explain the treatment plan with you or your next of kin or guardian, if available. This information will also be documented in your medical record.
- To be informed by your Participating Plan Provider about your treatment. This pertains to any appropriate or Medically Necessary treatment you may receive. This right exists regardless of cost of benefit coverage. Your treating Participating Provider will request your consent for all treatment. This is required unless there is an emergency and your life and health are in serious danger.
- To voice Complaints, Grievances or Appeals with UNM or UNM's Plan administrator, LINC or the regulatory bodies about UNM or the coverage that is provided under this plan. Participants also have the right to receive an answer to such within a reasonable time and without fear of retaliation.
- To make recommendations regarding our Participant 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 Plan, the Lovelace Insurance Company, and Participating Providers. There are laws and professional medical ethics that call for this. Your written permission will always be required for the release of medical and financial information, except:
- When clinical data is needed by health care Providers for your care.
- When we are bound by law to release information.
- When we prepare and release data but without identifying names of Participants.
- When necessary, to support Plan's or LINC's programs or operations that evaluates quality and service.
- To be promptly informed of termination or changes in benefits, services or Participating Providers.
- To refuse treatment. You also have the right to be advised of the likely results of your decision. We encourage you to discuss your Concerns with your Primary Care Physician (PCP). He or she will discuss alternate treatment plans with you; however, you will make the final decision.
- To a complete explanation of why you were denied a health care service. You will be guided through the Grievance procedure if you are not satisfied with the decision.
- To know, upon request, of any financial arrangements or provisions between the Plan, Lovelace Insurance Company and Participating Providers which may restrict treatment options or limit the services offered to you.

- To adequate access to qualified health care professionals.
- To always have available and accessible urgent and emergency medical services twenty-four (24) hours a day, seven (7) days a week.
- To receive information about how services are authorized or denied. You have the right to know how new technologies for covered services are evaluated. You can also request and receive information about Lovelace Insurance Company's quality assurance plan and utilization review methods.
- To have access to a current list of Participating Providers in the UNM Medical Plan network. You are also entitled to information about a particular provider's education, training and practice.

All Participants are responsible for learning how the Plan works. This is achieved by carefully reading and referring to this PBB and your Summary of Benefits. Contact the Lovelace Customer Care Center when you have questions or concerns about your Plan.

You have a responsibility:

- To provide honest, complete, to the extent possible, information to those providing care.
- To follow your Participating Providers' advice, plans and instructions that you have agreed on with the provider and consider the likely results if you do not.
- To question your Participating Provider so you can fully understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
- To review and understand fully the information you receive about your Plan.
- To know the proper use of the services covered by the Plan.
- To present your Lovelace Insurance Company UNM Medical Plan ID card before you receive care.
- To consult your primary provider before receiving medical care, unless your condition is life threatening.
- If you will be delayed or unable to keep an appointment, you are to notify the Participating Provider's office promptly.
- To pay all charges, deductibles, or Co-Payment/Co-Insurance amounts, including those for missed appointments. This also applies to non-Covered Benefits and Services.
- To obtain Prior Authorization when using a Tier 3 Provider or using the PHCS/MultiPlan Network outside of New Mexico.
- To know what medication you are taking. You should also know why you are taking it and the right way to take it.
- You are to follow instructions if Follow-up Care is needed.
- To express your opinions, Concerns or Complaints in a constructive way to the Lovelace Insurance Company Customer Care Center or your Participating Provider.
- To inform UNM Benefit Office/the Plan of any changes in family size, address, phone number or membership status. This is to be done within thirty (31) calendar days of the change.
- To notify Lovelace Insurance Company of other insurance coverage.
- To follow the Appeal and Grievance process when displeased with actions or decisions made by Lovelace Insurance Company on behalf of the Plan.
- To understand your health problems and participate in developing mutually agreed upon treatment goals to the degree possible.

SECTION 5 – COVERED SERVICES

This section describes the services and supplies covered by the UNM Medical Plan, subject to plan limitations and exclusions. Please refer to Section 6 for details regarding the Limitations and Exclusions applicable to this Plan. Benefits are subject to the Co-payments, Deductibles and Co-insurance listed in the Summary of Benefits.

Only benefits described in this section are covered under the Plan. Please refer to the Summary of Benefits for co-pay and coinsurance information. Any services received must be provided by a Participating Provider and/or Facility (except in cases of an emergency), or as applicable under Tier 3, Out-of-Network Tier, and Medically Necessary to be covered. Benefits are based upon the least costly, medically appropriate procedure or device available. **Because a provider prescribes, orders, recommends, or approves a service does not make it medically necessary or make it a covered service, even if it is not specifically listed as an exclusion.**

Note: If you disagree with Lovelace Insurance Company's decision regarding the Medical Necessity of any item or service, you may file a complaint. You may also request an external review of the Lovelace Insurance Company decision at any time. Please refer to Section 9 "Appeal & Grievance Procedure."

ACCIDENTAL INJURY/MEDICAL EMERGENCY CARE/URGENT CARE

Medical Emergency Care

Treatment performed for a Medical Emergency or Accidental Injury in the emergency room of a Hospital or an Urgent Care facility is a benefit and does not require notification to Lovelace Insurance Company unless after initial treatment you are admitted into the hospital. Please refer to the Summary of Benefits for emergency room or Urgent Care facility Co-payments. Treatment in a Physician's office or Ambulatory Surgical Facility is also a benefit and is paid as any other illness.

Emergency Care means health care procedures, treatments, or services delivered to a covered person after 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 reasonably be expected by a reasonable layperson, to result in (a) serious dysfunction of any bodily organ or part; or (b) disfigurement to the person.

You may receive your emergency care services from your PCP at his/her direction. When your PCP is not available to personally handle your care, he/she will arrange for another Physician to be available. PCPs have a 24 hour telephone number for this purpose.

The Plan will provide coverage when a Participant, acting in good faith, obtains Emergency Medical Care for what reasonably appears to the Participant, acting as a reasonable lay person, to be an acute condition that requires immediate medical attention, even if the patient's condition is subsequently determined to be non-emergent.

If your emergency treatment requires direct Admission to the Hospital, you are responsible for any applicable deductible and the Hospital Admission Co-payment, but you do not have to pay a separate Co-payment for the emergency room visit.

No notification or Benefit Certification is required for Out-of-Network (including out-of-state or out of the country) Hospitals or treatment facilities for Medical Emergency services unless admitted. Coverage for

trauma services and all other emergency services will continue at least until the Participant is medically stable, does not require critical care, and can be safely transferred to another facility based on the judgment of the Attending Physician in consultation with Lovelace Insurance Company. Emergency Services Out-of Network will be covered as in Tier 2.

Lovelace Insurance Company may require that the Participant be transferred to an In-Network Participating Hospital in its Provider network, if the patient is stabilized and the transfer is completed in accordance with federal law. If you are hospitalized in an Out-of-Network facility (Tier III) due to an emergency, services are covered at Tier II In-Network benefit level until you are stabilized and can be transferred to a Tier II facility. If you choose to remain in a Tier III facility once you are stabilized, service will be subject to Tier III coverage level from that point forward.

Care that is received from an Out-of-Network Provider and not specifically for the diagnosis and treatment of a Medical Emergency or Urgent Medical may not be covered under this Plan or may be covered at an additional expense paid by you.

Urgent Care

Urgent Care means Medically Necessary Health care Services provided in non-life threatening situations, or after a Primary Care Physician'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.

You will be reimbursed for all services rendered that satisfy this definition, unless otherwise limited or excluded, if provided by a licensed Provider and/or an appropriate facility for treating urgent medical conditions. Participants are encouraged to contact their PCPs for an appointment, if available, before seeking care from another Provider.

Participants may contact Lovelace Insurance Company Customer Care Department for information regarding the closest In-Network facility that can provide Urgent Care. The amount of the Co-payment for Emergency and Urgent Care is determined by the location where care is received (i.e. Hospital, Emergency Room, Urgent Care facility, Physician's office). For Urgent Care received Out-of-Network, no notification is required unless admitted. You will be responsible for charges not covered by the Plan.

ACUPUNCTURE SERVICES

Acupuncture services are covered when they are diagnostic treatment services utilized in an office setting, medically necessary and are services that are within the scope of the practitioners practice. Treatment included the conservation management of neuromusculoskeletal conditions and ancillary physiological treatments rendered to control of hyperemesis, linked to chemotherapy or pregnancy, restore motion, reduce pain and improve functions. Service must be provided by a medical doctor, licensed physical therapist, doctor of oriental medicine acting within the scope of his/her licensure and according to the standards in New Mexico fo the state in which services are rendered. This benefit excluded services of massage therapist. Maintenance or preventive treatment/therapy is not covered. Treatment must be restorative.

AMBULANCE SERVICES

Benefits are available for Medically Necessary professional Ambulance Services. Ambulance Service means transportation in a specially designed and equipped vehicle used only for transporting the sick and injured.

Air ambulance is a covered benefit when Medically Necessary, when terrain, distance, or your physical condition requires the use of air ambulance services or for such services as a high-risk Maternity or a newborn transport to tertiary care facilities.

The ambulance Co-payment is waived if transportation is Medically Necessary and between medical facilities.

Some non-emergent medically necessary transport requires approval/benefit certification. There are no benefits when the ambulance transportation is primarily for the convenience of the patient, the patient's family, or the health care Provider.

CHIROPRACTIC SERVICES

Services administered by a Chiropractor on an Outpatient basis are a benefit if necessary for treatment of an illness or Accidental Injury. No chiropractic benefits are paid for Maintenance Therapy as determined by Lovelace Insurance Company.

Benefits are subject to a Contract Year limit as shown in the Summary of Benefits. This benefit is combined with Acupuncture and massage therapy. In addition, for ancillary treatment modalities associated with chiropractic services, other Plan limitations may apply. See Acupuncture benefit above.

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:

- The clinical trial is undertaken for the purposes of the prevention, early detection or treatment of cancer for which standard cancer treatment has not been effective;
- The clinical trial is not designed exclusively to test toxicity or disease pathophysiology, and it has a therapeutic intent;
- 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 and in which the scientific study includes all of the following: (a) specific goals; (b) a rationale and background for the study; (c) criteria for patient selection; (d) specific direction for administering the therapy and for monitoring patients; (e) definition of quantitative measures for determining treatment response; (f) methods for documenting and treating adverse reactions; and (g) a reasonable expectation that the treatment will be at least as efficacious as standard cancer treatment;
- The clinical trial is being provided as part of a study 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 Member 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;
  (1) The proposed 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;

(2) 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 and that are not more than the level of reimbursement applicable to other similar services provided by the health care providers within the network.

(3) There is no non-investigational treatment equivalent to the clinical trial; and

(4) The available clinical or pre-clinical data provide a reasonable expectation that the clinical trial will be at least as efficacious as any non-investigational alternative.

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

- **"Cooperative Member"** – means a formal network of facilities that collaborates on research projects and has an established federal national institutes of health approved peer review program operating within the Member.
- **"Institutional Review Board"** – means a board, committee or other Member that is both: (a) formally designated by an institution to approve the initiation and to conduct periodic review of biomedical research involving human subjects and in which the primary purpose of such review is to assure the protection of the rights and welfare of the human subjects and not to review a clinical trial for scientific merit; and (b) approved by the federal national institutes of health for protection of the research risks.
- **"Investigational Drug or Device"** – means a drug or device that has not been approved by the United States Food and Drug Administration.
- **"Multiple Project Assurance Contract"** – means a contract between an institution and the United States Department of Health and Human Services that defines the relationship of the institution to the United States Department of Health and Human Services and that sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects participating in clinical trials.
- **"Routine Patient Care Cost"** – means (1) a medical service or treatment that is a benefit under the Evidence of Coverage 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 Plan if non-investigational treatments were provided; or (5) costs paid or not charged for by the cancer clinical trial providers.

DENTAL CARE AND MEDICAL CONDITIONS OF THE MOUTH & JAW

This Plan covers the following services when Medically Necessary and Authorized by the Plan. The following services are the only dental services covered under this Plan. Benefits are based upon the least costly, medically appropriate procedure or device available:

- 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.
- Cosmetic surgery that is expected to correct functional disorders and where improvement in physiologic functioning can be expected. These disorders result from accidental injury or from congenital defects or disease.

The following are examples of benefits 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.

See your Dental Benefits Booklet for additional benefits that may be available to you.

Accidental Injury

A condition that is not the result of illness but is caused solely by external, traumatic, and unforeseen means. Accidental injury does not include disease or infection. Dental injury caused by chewing, biting, or malocclusion is not considered an accidental injury.

Dental services

Services performed for treatment of conditions related to the teeth or structures supporting the teeth.

Sound natural teeth

Teeth that are whole, without impairment, without periodontal or other conditions, and not in need of treatment for any reason other than the accidental injury. Teeth with crowns or restorations (even if required due to a previous injury) are not sound natural teeth. Therefore, injury to a restored tooth will not be covered as an accident-related expense. (Your provider may need to submit x-rays taken before the dental or surgical procedure in order for Lovelace Insurance Company to determine whether the tooth was "sound.")

Dental and Facial Accidents

Benefits for covered services for the treatment of accidental injuries to the jaw, mouth, face, or sound natural teeth are subject to the same limitations, exclusions, and participant cost-sharing requirements that would apply to similar services when not dental-related (e.g., x-rays, medical supplies, surgical procedures).

Any services required after the initial treatment must be received within twelve (12) months from the date of accident in order to be covered (unless treatment must be delayed due to dental necessity as determined by Lovelace Insurance Company).

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:

- Participant 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;
- Participants 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 (5) are not required to meet any of these criteria);
- Participants 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. Please contact your Dental Carrier for coverage information.

Oral Surgery

Oral dental Surgery benefits are available for cutting procedures for diseases, such as:

- Removal or biopsy of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of mouth when pathological examination is required;
- External or intraoral cutting and draining of cellulitis (inflammation) that extends beyond the dental space;
- Surgical correction of prognathism with handicapping malocclusion, a marked projection of the lower jaw that interferes with chewing;
- Removal of bony growths on the jaws and hard palate, unless done in preparation of the mouth for dentures;
- Incision of accessory sinuses, salivary glands, or ducts; and
- Frenectomy.

Benefits are payable based upon the Coordination of Benefits (COB) requirements set forth in Section 7 of this booklet. Periodontal Surgery and removal of impacted wisdom teeth are not covered benefits.

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

The Plan covers services for CMJ and TMJ when Medically Necessary and authorized by Lovelace Insurance Company. 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 unless these are required because of a trauma to a sound, natural tooth.

DIABETES EDUCATION

Diabetes education is a covered benefit that includes coverage for any Provider rendering education or instructional services for diabetes. Service include, but are not limited to:

- Visits to normalize glucose and maintain control of diabetes;
- Visits for insulin start up and management;
- Hypoglycemia and glucose intolerance;
- Insulin Pump Training
- Additional visits - include following a Physician diagnosis that represents a significant change in the patient's symptoms or condition that warrants changes in the patient's self-management; or visits when re-education or refresher training is prescribed by a health care Provider with prescribing authority.

DIABETES SUPPLIES AND SERVICES

When prescribed by the Participant's Primary Care Physician or a Plan Participating Provider, the following equipment, supplies, appliances, and services are covered. Supplies and equipment will be provided by several different types of providers or vendors. Benefit Certifications are required for Durable Medical Equipment (DME), Prosthetic appliances and orthotics. Discuss the need for Benefit Certifications with your Physician before obtaining services.

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

- Standard blood glucose monitors and specialized blood glucose monitors, when Medically Necessary; are provided by Express Scripts.
- Insulin pump and supplies, when Medically Necessary and prescribed by a participating endocrinologist.
- Medically Necessary podiatric appliances for prevention of foot 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 of diabetic foot disease.

The following supplies and benefit coverage information can be obtained by calling Express Scripts at - 1-800-232-6549:

- Insulin;
- Prescriptive oral agents;
- Topical agents;
- Test strips for blood glucose monitors;
- Visual reading urine and ketone strips;
- Autolet, Lancets and lancet devices;
- Injection aids, including those adaptable to meet the needs of the legally blind;
- Syringes and needles; and
- Glucagon emergency kits.

DIAGNOSTIC SERVICES

Diagnostic Services including laboratory tests and x-rays to detect a known or suspected illness or Accidental Injury are covered if ordered and provided by a Participating Provider. Benefit Certification may be required services listed below. Please refer to Section 3 "How the Plan Works" for more information. Discuss the need for Benefit Certifications with your Participating Provider before obtaining services.

Covered services include:

- Radiology, ultrasound, and nuclear medicine;
- Laboratory and pathology;
- Bone density studies;
- Genetic testing;
- Chromosome analysis, including karyotyping and molecular cytogenetic testing;
- EKG, EEG, and other electronic diagnostic medical procedures;
- Magnetic Resonance Imaging (MRI);
- Positron Emissions Tomography (PET) scans
- Computed Tomography (CT) scans;
- Sleep disorders - sleep lab studies must be performed in a certified sleep lab approved by Lovelace Insurance Company; and
- Allergy testing.

For services received during a covered inpatient admission, see "Hospital/Other Facility Services."

DURABLE MEDICAL EQUIPMENT, ORTHOTICS, PROSTHETIC APPLIANCES AND MEDICAL SUPPLIES

Durable Medical Equipment (DME)

DME is covered only upon Benefit Certification by the Plan. For coverage, DME must be Medically Necessary for a person's case or health status. It must be prescribed, ordered and provided by a Participating Provider. Coverage includes the rental or purchase of DME, at the option of Lovelace Insurance Company the Plan administrator.

Durable Medical Equipment is defined as items that have 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

Examples of covered DME include, but are not limited to:

- Crutches
- Hospital beds
- Oxygen equipment
- Wheelchairs
- Walkers
- Diabetic Insulin Pumps
- Repairs or replacement of Durable Medical Equipment when Medically Necessary due to change in the Participant's condition

Prosthetic Appliances and Orthotics

Prosthetic Appliances and Orthotics are covered only upon Benefit Certification by the Plan. For coverage, services must be Medically Necessary for a person's case or health status. It must be prescribed, ordered and provided by a Participating Provider.

Prosthetic Appliances and Orthotics 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.

Examples of covered services include, but are not limited to:

- Purchase, fitting and necessary adjustments of prosthetic devices and supplies that replace all or part of the function of a permanently inoperative or malfunctioning body extremity;
- Replacement if needed due to normal body growth or changes due to illness or injury;
- Prosthetic eyes and prosthodontic appliances;
- Breast prosthetics, when required as the result of a mastectomy;
- Orthotic (a rigid or semi-rigid supportive device) or Orthopedic Appliance (Prefabricated) that supports or eliminates motion of a weak or diseased body part. This does not include foot orthotics, functional or otherwise;
- Custom-Fabricated knee-ankle-foot Orthoses (AFO and/or KAFO) for Participants up to eight years old;
- Repairs or replacement of prostheses and orthotics when Medically Necessary due to change in the Participant's medical condition
- Contact lenses for aphakia (those with no lens in the eye) or keratoconus;
- Sclera shells (white supporting tissue of eyeball);
- Initially, either one set of prescription eyeglasses or one set of contact lenses (whichever is appropriate for your medical needs) when necessary to replace lenses absent at birth or lost through cataract or other intra-ocular Surgery or ocular injury, or prescribed by a Physician as the only treatment available for keratoconus.
- The following guidelines apply to eyeglasses provided under this benefit:
  - Only standard frames are covered. Deluxe frames are not covered.
  - Ultraviolet (UV) protection is covered.
  - Anti-reflective coating, tints, or oversize lenses are covered only when they are Medically Necessary for the individual patient and Medical Necessity is documented by your treating Physician.
  - Bifocal lenses in frames or lenses in frames for far vision and lenses in frames for near vision are covered only when determined to be Reasonable and Customary.
  - Tinted lenses, including photochromatic lenses, used as sunglasses, which are prescribed in addition to regular prosthetic lenses are not covered.
  - Scratch resistant coating, mirror coating, polarization and progressive lenses are not covered.
  - Lenses made of polycarbonate or other impact-resistant materials are covered for a patient with functional vision in only one eye.
  - Use of polycarbonate or similar material or high index glass or plastic for indications such as light weight or thinness are considered deluxe, and therefore, are not covered.
  - Duplicates are not covered and replacement is covered only if a Physician or optometrist recommends a change in prescription due to the medical condition.
  - Eye glass cases are not covered.

Surgically implantable devices and prostheses are covered as follows:

- Surgically implanted prosthetics or devices, including penile implants required as a result of illness or injury;
- Implantable mechanical devices such as cardiac pacemakers or defibrillators, insulin pumps, epidural pain pumps, and neurostimulators;
- Intra-ocular lenses;
- Cochlear implants (see "Surgery" for additional information about benefits available for cochlear implantation);
- Teflon/dacron surgical grafts and meshes; and
- Artificial or porcine heart valves.

When alternative prosthetic/orthotic devices are available, the allowance for a prosthesis/orthosis will be based upon the least costly item.

EMERGENCY MEDICAL EVACUATION AND REPATRIATION OF REMAINS

Emergency medical evacuation and repatriation of remains are a covered benefit. For coverage details and service exclusions, participants should contact Lovelace Customer Care Center at 505.727.5683 or 1.800.808.7363, TTY at 711 or by calling Assist America toll free inside the U.S.A. 1.800.872.1414; outside the U.S.A. +1.609.986.1234 (precede number by U.S. access code). Reference Number 01-AA-LHP-03093M.

HEARING AIDS FOR DEPENDENT CHILDREN

For dependent children under eighteen (18) years of age or under twenty-one (21) years of age if attending high school, coverage is provided for hearing aids and certain related services. Coverage includes fitting and dispensing service, including providing ear molds as necessary to maintain optimal fit. Services must be provided by a Participating audiologist, hearing aid dispenser or physician. Coverage is for the full cost of one hearing aid per hearing-impaired ear up to two thousand two hundred dollars ($2,200) every thirty –six (36) months. Participants may choose a higher priced hearing aid, however any cost above the $2,200 limit will be the responsibility of the Participant.

CONSUMABLE MEDICAL SUPPLIES

Consumable medical supplies are covered during hospitalization. They are also covered during an office visit or authorized home health visit. This Plan does not cover these supplies when used at other times by the Participant or Participant'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 Participating Provider

The following medical supplies are covered; not to exceed a one-month supply during any 30-day period. Examples include, but are not limited to:

- Bandages and dressing supplies;
- Colostomy bags, catheters;
- Gastrostomy tubes;
- Hollister supplies;
- Tracheostomy kits, masks;
- Compression hose when prescribed by a Physician for the Medically Necessary treatment of varicose veins (Benefits are limited to six pair of hose per Contract Year); and
- Other supplies determined by Lovelace Insurance Company to be Medically Necessary and covered under the Plan.

Benefits are not available for the following items:

- Deluxe equipment, accessories and/or supplies such as motor-driven wheelchairs, chair lifts, or beds, when standard equipment is medically appropriate, available and adequate;
- Rental of Durable Medical Equipment if the patient is in a facility that provides such equipment;
- Replacement of equipment or supplies due to loss, theft or destruction;
- Dental appliances including dentures;
- Equipment that is primarily non-medical such as heating pads, hot water bottles, water beds, jacuzzi units, specialized clothing, hot tubs, or exercise equipment;
- Environmental control equipment such as air conditioners, dehumidifiers, or electronic air filters, regardless of the therapeutic value they may provide;
- Accommodative foot orthotics, which are used to accommodate the structural abnormalities of the foot by providing comfort, but not altering function;
- Functional foot orthotics including those for plantar fasciitis, pes planus (flat feet), heel spurs, and other conditions (as determined by Lovelace Insurance Company), except for Participants with diabetes or other significant neuropathies when Certified/Approved by Lovelace Insurance Company;
- Orthopedic or corrective shoes, arch supports, shoe appliances, foot orthotics, and custom fitted braces or splints, except for Participants with diabetes or other significant neuropathies when Benefit Certification is obtained from Lovelace Insurance Company;
- Custom fabricated foot orthotics/orthosis except for knee-ankle-foot orthosis (AFO and/or KAFO) devices for Participants up to eight years old; and
- Duplicate equipment is not covered under this Plan for participant convenience, comfort or travel purposes.

FAMILY, INFANT AND TODDLER (FIT) PROGRAM

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

FAMILY PLANNING AND RELATED SERVICES

Family planning services, when provided by your Participating PCP or Plan Specialist are covered. Family Planning and related services are not covered Out-of-Network without a prior authorization. Refer to your Summary of Benefits for the applicable Co-Payment and/or Co-Insurance information for the following procedures:

- Injection of Depo-Provera for birth control purposes;
- Diaphragm, including fitting;
- Implantable contraceptive devices, including surgical implantation and removal;
- IUDs or cervical caps, including fitting, insertion, and removal;
- Genetic counseling (may require Benefit Certification);
- Surgical sterilization procedures such as vasectomies and tubal ligations (If the tubal ligation is done during a delivery, only the Maternity Co-payment applies. There will not be an additional Surgery Co-payment.);
- Elective and therapeutic abortions; and
- RU486 administered by a Physician.

Only the following infertility-related treatment and testing services are covered (note that the following procedures only secondarily also treat infertility):

- Surgical treatments such as opening an obstructed fallopian tube, epididymis, or vas when the obstruction is not the result of a surgical sterilization; and
- Replacement of deficient, naturally occurring hormones if there is documented evidence of a deficiency of the hormone being replaced.

The above services are the only infertility-related treatments that will be considered for benefit payment. Infertility testing is covered only to diagnose the cause of infertility. Once the cause has been established and the treatment determined to be non-covered, no further testing is covered.

This Plan will also cover testing related to one of the covered treatments, listed above (such as lab tests to monitor hormone levels). However, daily ultrasounds to monitor ova maturation are not covered since the testing is being used to monitor a non-covered infertility treatment.

This Plan does not cover any services or charges for artificial conception including fertilization and/or growth of a fetus outside the mother's body in an artificial environment, such as artificial insemination, in-vitro ("test tube") or in-vivo fertilization, GIFT, ZIFT, all drugs, hormonal manipulation, or embryo transfer is not a covered benefit. Any artificial conception method not specifically listed is also excluded.

GENETIC INBORN ERRORS OF METABOLISM DISORDERS (IEM)

Coverage is provided for diagnosing, monitoring, and controlling of disorders of Genetic Inborn Errors of Metabolism (IEM) where there are standard methods of treatment, when Medically Necessary and subject to the Limitations and Exclusions, (Section 6) and Benefit Certification (Section 3) requirements listed in the Participant Benefit Booklet. A genetic inborn error of metabolism is a rare, inherited, disorder that is present at birth, can result in death if untreated.

Medical services provided by licensed Health care Professionals, including Physicians, dieticians and nutritionists, with specific training in managing Participants diagnosed with Genetic Inborn Errors of Metabolism (IEM) are Covered.

Covered Services include:

- nutritional and medical assessment;
- clinical services;
- biochemical analysis;
- medical supplies;
- Prescription Drugs;
- corrective lenses for conditions related to Genetic Inborn Errors of Metabolism (IEM);
- nutritional management; and
- Special Medical Foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status when Certified or Preauthorized by Lovelace Insurance Company.

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. These services are available through Express Script through your Pharmacy Benefit provider. 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

Foods obtained from a grocery store or internet provider will not be covered as Special Medical Foods. In addition Special Medical Foods are for the Participant with the medical condition and will not be paid if consumed by other family members. Special Medical foods may require a prescription. Please be sure to check with your pharmacy benefit manager Express Scripts.

Please refer to your Schedule of Benefits for applicable office visit, Inpatient Hospital, Outpatient facility, and other related Co-payments.

HEARING CARE

Hearing exams are covered when they are used to diagnose and treat ear injuries or diseases of the ear. For Participants age seventeen (17) and younger, routine hearing screenings by a physician are covered on your plan.

HOME HEALTH CARE

If a Participant needs health care at home, a benefit of up to 100 combined visits per Plan year are available for services provided by a Participating Home Health Agency. This benefit provides skilled nursing services when ordered by a Physician and administered in the home on an intermittent basis. A visit is one period of home health service of up to four hours.

Before the Participant receives home health care, the treating Physician, Home Health Agency, or Participant must request Benefit Certification from Lovelace Insurance Company. Benefit Certifications are requested by your PCP or Specialist. Discuss the need for Benefit Certifications with your Physician before obtaining services.

The following home health care services are covered:

- Skilled Nursing Care by a Registered Nurse (RN) or Licensed Practical Nurse (LPN);
- Physical, occupational by licensed or certified therapists, and speech therapy provided by an American Speech and Hearing Association certified therapist;
- Respiratory/inhalation therapy;
- Skilled services by a qualified aide (to support Skilled Nursing Care) to do such things as change dressings, check blood pressure, pulse, and temperature;
- Medical supplies, drugs, and laboratory services that would have been provided by a Hospital had the Participant been Hospitalized;
- Physician home visits;
- Home Intravenous services; and
- Enteral tube feeding equipment.

There are no home health care benefits provided for care that:

- Is provided primarily for the convenience of the Participant or the Participant's family;
- Consists mostly of bathing, feeding, exercising, preparing meals, homemaking, moving the patient, giving medications, or acting as a sitter; or
- Is provided by a nurse who ordinarily resides in the Participant's home or is a Participant of the patient's immediate family.

HOSPICE CARE

Hospice benefits are available for Covered Services provided by an approved Participating Hospice agency, or Hospital or other facility by or on behalf of a Hospice agency, and received during a Hospice benefit period. Before the Participant receives Hospice care, the treating Physician or Hospice agency must request Benefit Certification from Lovelace Insurance Company. Benefit Certifications are requested by your PCP or Specialist. Discuss the need for a written Benefit Certifications with your Physician before obtaining services.

The Hospice benefit period must begin while the patient is covered for these benefits, and coverage must be continued throughout the benefit period. The benefit period is defined as beginning on the date the treating Physician certified that the patient is terminally ill with a life expectancy of six months or less, ending six months after it began or upon the death of the patient, if sooner. If the patient requires an extension of the benefit period, the Hospice agency must provide a new treatment plan and the treating Physician must re-certify the patient's condition to Lovelace Insurance Company. No more than one additional Hospice benefit will be approved. Hospice care benefits are limited to a lifetime maximum payment per Participant for covered expenses as shown in the Summary of Benefits.

Benefits are available only for or on behalf of an approved Hospice agency. An approved Hospice agency must be:

- Licensed when required;
- Medicare-certified as a Hospice agency; or
- Accredited by the Joint Commission on Accreditation of Health care Organizations (JCAHO) as a Hospice agency.

The following services are covered under this Hospice benefit:

- Inpatient Hospice care;
- Hospice care Physician benefits;
- Skilled Nursing Care by a Registered Nurse (RN) or Licensed Practical Nurse (LPN);
- Home health care by a home health aide;
- Physical therapy, speech therapy, or occupational therapy;
- Medical supplies; and
- Drugs and medications for the terminally ill patient.

Hospice benefits are not available for the following services:

- Food, housing, or delivered meals;
- Medical transportation;
- Comfort items;
- Homemaker and housekeeping services;
- Private duty nursing;
- Pastoral and spiritual counseling: and
- Services for Respite Care
- Bereavement counseling

The following services are not benefits under Hospice but may be covered elsewhere under this booklet, subject to applicable Co-payment and Co-insurance provisions:

- Acute Inpatient Hospital care for curative services;
- Non-Hospice care Physician visits; and
- Ambulance Services.

HOSPITAL INPATIENT SERVICES

When a Participant receives acute Inpatient medical/surgical or pregnancy related Hospital care, benefits are available for covered room and board and other covered Hospital services.

Benefits are available for a non-private room with two or more beds. Private room charges are a covered benefit only when Medically Necessary and when the private room is ordered by the Participant's PCP or the admitting Physician and Benefit Certification is obtained from Lovelace Insurance Company. If the Participant requests a private room or the private room is not Medically Necessary, the Plan bases payment on the Hospital's average non-private room rate and the Participant is responsible for the balance. The balance you pay does not apply to the Out-of-Pocket Maximum.

Benefits are available for other room accommodations or special care units such as:

- Intensive Care Unit (ICU);
- Cardiac Care Unit (CCU);
- Sub-Intensive Care Unit; and
- Isolation Room.

Blood

Benefits are available for blood transfusions, blood plasma, and blood plasma expanders, and the charges for directed donor or autologous blood storage fees if the blood is to be used during a procedure that has been scheduled for that Participant.

Physical Rehabilitation – Inpatient

Benefits are available for Inpatient rehabilitation services that are Medically Necessary to restore and improve lost functions following illness or Accidental Injury and are provided in Plan authorized facilities.

Hospitalization for rehabilitation must begin within one year after the onset of the condition and while the Participant is covered under this Plan. Inpatient rehabilitation treatment must be Medically Necessary and not for personal convenience.

Benefits are not available for care that is not provided by a Plan authorized/Participating facility. These Inpatient services are not eligible for any additional benefits on an Outpatient basis.

There are no benefits for Maintenance Therapy or care provided after the patient has reached his/her rehabilitative potential. In the case of a dispute about whether the patient's rehabilitative potential has been reached, the patient is responsible for furnishing documentation from the treating Physician supporting that the patient's rehabilitative potential has not been reached.

MATERNITY AND NEWBORN CARE

Your UNM Medical Plan offers you a unique Maternity/Prenatal care benefit at your Tier 1 and Tier 2 level. After your initial visit to your Participating Provider to establish your pregnancy, all prenatal visits up to delivery will be covered with no additional co-payment or co-insurance due. Please note: While Pre-natal care is covered on all three tiers of your Plan, the special co-payment arrangement is not available on the 3rd Tier.

- 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 and her newly born child shall be available for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a Cesarean section. Any decision to shorten the period of inpatient care for the mother or the newborn must be made by the attending Physician in consultation with the mother. Please refer to the "Newborn and Adopted Children Coverage" section for information regarding newborn coverage.
- If the hospitalization period is shortened to less than 48 hours for vaginal delivery or less than 96 hours for Cesarean, at least (3) three home care visits will be provided to you on Tier 1 and Tier 2, unless the attending Physician or home care provider and you agree that (1) one or (2) two 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 contracted tertiary 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 contracted tertiary care facility, is covered.

Newborn and Adopted* Children Coverage

Newly born and adopted children of a Participant will be covered from the moment of birth/adoption given the newborn/adopted child is enrolled in the plan within 31 calendar days from date of 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

Coverage of a Participant's newly born natural and adopted* children includes coverage of injury or sickness. 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 flight) to the nearest available contracted tertiary care facility is covered. Coverage is provided for circumcision for newborn males.

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

Benefits include complete prenatal care, pregnancy related diagnostic tests, visits to an obstetrician, Nurse-Midwife, or licensed midwife, and childbirth in a Hospital or in a licensed Birthing Center staffed by a Certified Nurse Midwife or Physician. Home births are not a covered benefit. Lay midwife deliveries are not a covered benefit. Deliveries by cesarean section, ectopic pregnancies, other pregnancy complications, such as miscarriage, and therapeutic or elective abortions are also covered. Third trimester elective abortions are excluded. If Maternity benefits change during a pregnancy, the Participant receives the benefits in effect on the day the service is received. Under Two-Party or Family Coverage, an unmarried Dependent daughter is eligible for Maternity benefits. Coverage for the baby is available only if covered as an eligible Dependent.

Note: To add coverage for your newborn child, you must submit an Application for your child as a Dependent before or within 31 calendar days of birth. If enrolled within 31 calendar days of birth, the baby is then covered from the moment of birth. No pre-existing condition limitation applies. If you have Employee coverage, you must change to Two-Party coverage; if you have Two-Party coverage, you must change to Family Coverage; if you already have Family Coverage; you must submit an Application to add your newborn as a Dependent.

If the baby is enrolled within 31 calendar days, newborn visits in the Hospital by the baby's Physician, circumcision, incubator, and routine Hospital nursery charges are covered. If your baby needs special care including diagnostic tests and Surgery, the Plan pays benefits for that care too.

A separate Inpatient Co-payment for your newborn applies only when the infant's inpatient stay exceeds the mother's date of discharge. Additional services above and beyond routine newborn care are not subject to an additional Co-payment if the infant is discharged on the same day or before the mother is discharged from the Hospital.

If your newborn stays in the Hospital longer than the mother, you must notify Lovelace Insurance Company by calling the Lovelace Customer Care Center before the mother's discharge from the Hospital, to coordinate the baby's care.

Newborns' and Mothers' Health Protection Act 0f 1996

NMHPA Notice:
Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending physician (e.g., your physician, nurse, or midwife, or a physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and insurers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a Plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your Plan Administrator.

BEHAVIORAL/MENTAL HEALTH AND/OR SUBSTANCE ABUSE

To obtain information on Behavioral/Mental Health and/or Substance Abuse benefits, Participants should call Lovelace Insurance Company Customer Care Center.

Admissions to inpatient or partial hospitalization for Behavioral/Mental Health or to inpatient or detoxification for Substance Abuse requires Benefit Certification by the Lovelace Insurance Company Behavioral Health Department, with the exception of life-threatening emergencies. Benefit Certification is based on Medical Necessity and are requested by the provider of the services. Services will not be covered if Benefit Certification is not obtained prior to services being rendered.

Applicable co-payment information is listed in the Summary of Benefits. Day/visit limitations listed in the Summary of Benefits apply to Substance Abuse services only.

Outpatient services are available from the following credentialed Providers:

- Doctors of Medicine (MD) or Osteopathy (DO);
- Board Eligible or Board Certified in Psychiatry;
- Licensed Psychologists (L.P.);
- Licensed Prescribing Psychologists (L.P.);
- Licensed Independent Social Workers (L.I.S.W.);
- Licensed Clinical Behavioral/Mental Health Counselors (L.P.C.C.);
- Licensed Marriage and Family Therapists (L.M.F.T.);
- Clinical Nurse Specialists (C.N.S.); and
- Licensed Alcohol & Drug Abuse Counselors (L.A.D.A.C.) with Master's degree in counseling or social work.

Behavioral/Mental Health Services

Inpatient and partial hospitalization Behavioral/Mental Health services will be covered in an In-Network facility when performed by a licensed participating Provider. These levels of care require Benefit Certification from Lovelace Insurance Company. Failure to obtain Benefit Certification for services will result in no benefit coverage.

Outpatient Behavioral/Mental Health treatment does not require certification. Outpatient services must be Medically Necessary.

Outpatient services include individual, group, family and marital/relationship counseling, medication management and psychological and neuropsychological testing for Behavioral/Mental Health disorders.

Substance Abuse Services

Benefits for alcoholism and/or drug abuse are limited to those limitation set on medical surgical benefits. Inpatient services require Benefit Certification from Lovelace Insurance Company. Failure to do so will result in benefits being denied.

Inpatient treatment in a Hospital or Substance Abuse treatment center requires Benefit Certification from Lovelace Insurance Company prior to Admission. Failure to obtain Benefit Certification for services will result in denial of coverage Partial hospitalization can be substituted for Inpatient Substance Abuse services. Inpatient treatment is limited to 30 days per contract year

Partial hospitalization is a non-residential day program, attended by the Participant for fewer than 24 hours a day, based in a Hospital or treatment center that includes various daily and weekly therapies. Two partial hospitalization days are equivalent to one day of inpatient care. Partial hospitalization services require Benefit Certification from Lovelace Insurance Company. Failure to obtain Benefit Certification for services will result in no benefit coverage.

Outpatient, non-Hospital based Intensive and standard Outpatient evaluative and therapeutic services for Admission and/or Substance Abuse do not require Benefit Certification. Outpatient services are limited to 60 visits per Contract Year.

Intensive Outpatient Program (IOP) services for Substance Abuse disorders is treatment provided in a group setting, two to four times a week for two to three hours at a time for a specific number of weeks. Standard Outpatient therapy visits are defined as Outpatient visits lasting between 15 and 110 minutes.

Coverage includes all services provided by the IOP Program. Outpatient Substance Abuse services include individual, family, couple/relationship or group therapy, and medication management.

PHYSICIAN SERVICES

Please refer to the Summary of Benefits for applicable Co-payments for the following services:

Allergy Services

Benefits are available for direct skin (percutaneous and intradermal) and patch allergy tests and radioallergosorbent testing (RAST).

Contraceptive Devices

Benefits are available for contraceptive devices that require a prescription by a Physician including:

- IUDs;
- Diaphragms; and
- Implantable devices.

If you must obtain the IUD, diaphragm, or Norplant from a pharmacy, you will have to pay for the item and then file a claim through your pharmacy benefit administrator. All other contraceptive devices that do not require a prescription are not a benefit. For oral contraceptive prescription drug benefits, see the Express Scripts benefits booklet.

Injectable Drugs

FDA-approved therapeutic injections administered in a Participating Provider's office are covered. For those services covered under this plan, such as allergy injections, please refer to the Summary of Benefits.

However, certain injectable drugs are covered only when provided by your pharmacy provider Express Scripts. Injectable and other pharmaceutical benefit information can be obtained by calling Express Scripts at 1-800-232-6549.

Inpatient Physician Visits and Consultations

Attending Physician visits and consultations in the Hospital are benefits during a covered Admission.

Obstetrics/Gynecological Visits

Women can obtain gynecological care for routine exams and other obstetrical and/or gynecological care from participating OB/GYN providers.

Office Visits

Benefits are available as outlined in the Summary of Benefits.

Weight Management and Nutritional Counseling

Weight loss management, obesity treatment, and nutritional counseling are not a benefit unless dietary advice and exercise are provided by a Physician, licensed nutritionist, or registered dietician.

Weight loss management, obesity treatment, and nutritional counseling must be prescribed by a Participating Provider and are a benefit only when Medically Necessary. Exercise therapy or movement therapy is not part of a covered service. Weight loss medications require Pre-Approval by Express Scripts, your prescription drug plan for University of New Mexico employees. Express Scripts can be reached at 1-800-232-6549. Also see Morbid Obesity.

Note: If you disagree with Lovelace Insurance Company's decision regarding the Medical Necessity of any item or service, you may file a complaint. You may also request an external review of the Lovelace Insurance Company decision at any time. See "Appeal and Grievance Procedure" in Section 9.

PREVENTIVE CARE

Preventive care services are those Professional services rendered for the early detection of asymptomatic illnesses or abnormalities and to prevent illness or other conditions. Benefit payments for services listed in this section may be subject to Co-payments. Preventative Health Services are NOT covered at the Out-of-Network benefit level.

Cytologic Screening (Pap smear screening)

Benefits are available to determine the presence of pre-cancerous or cancerous conditions and other health problems in accordance with the national medical standards for women who are at risk of cancer or at risk of other health conditions that can be identified through a cytology screening.

Health Education and Counseling

Health education and counseling services will be provided if recommended by your treating Physician and if consistent with Plan policy, including:

If you are 20 years of age or older, you may receive an consultation to discuss lifestyle behaviors that promote health and well being. Included in the consultation may be, but not limited to:

- smoking control;
- nutrition and diet recommendations;
- exercise plans;
- lower back protection;
- immunization practices;
- breast self-examination;
- testicular self-examination;
- use of seat-belts in motor vehicles; and
- other preventive health care practices.

If you are under age 20, educational materials or consultation to discuss lifestyle behaviors that promote health and well being including, but not limited to:

- the consequences of tobacco use;
- nutrition and diet recommendations;
- exercise plans; and
- as deemed appropriate by the treating Physician or as requested by the parents or legal guardian for children under 18, educational information on alcohol and substance abuse, sexually transmitted diseases and contraception.

Diabetes self-management education programs are also covered when Medically Necessary.

The Lovelace HEALTHY Steps program offers no-cost educational presentations on a variety of health topics, including, but not limited to:

- Fitness and Exercise
- Children's Health
- Optimum Health for Men and Women
- Well-Being: Healthy Stress

Additionally, the Lovelace program under the Plan offers community education classes available to help keep you on a healthy path in life. For dates, times and locations, please call the Lovelace Customer Care Center.

Mammography Coverage

Benefits are available for low-dose screening mammograms for determining the presence of breast cancer. Guidelines for a routine mammography are:

- A baseline before age 40;
- One every year; and
- As otherwise medically indicated.

Prostate Exams

Benefits are available for certain prostate tests. Guidelines for prostate exams are:

- One screening every year for men 40 to 50 years of age who are at increased risk of developing prostate cancer; and
- One screening every year for men 50 years of age or older.

Routine Eye Screening

Routine eye screenings performed by a PCP to determine the need for vision correction are a benefit and are limited to screening for Participants age 17 and under only. This does not include routine eye exams or refractions performed by eye care Specialists. Please see Vision Benefit Plan.

Routine Hearing Screening

Routine hearing screenings performed only by a PCP to determine the need for hearing correction are a benefit and are limited to screening for Participants age 25 and under only.

Routine Immunizations

Routine immunizations such as flu shots and other covered adult immunizations including pneumococcal vaccine, diptheria/tetanus, meningitis, and hepatitis when clinically appropriate as determined by Lovelace Insurance Company are covered. Immunizations for employment and travel are not a covered benefit.

Routine Physical Examinations

This benefit provides routine physical, breast, gynecological and pelvic examinations. In addition, periodic tests to determine blood hemoglobin, blood pressure and blood glucose level are also covered.

The following is a suggested schedule for routine physical examinations, after an initial examination:

- Ages 8-19, see Well Child Care (next page);
- Ages 20-39, an exam every 5 years;
- Ages 40-49, an exam every 3 years; and
- Ages 50 and over, an exam every 2 years.

Additional services as recommended by the U.S. Preventive Services Task Force:

- Periodic blood cholesterol, or periodic fractionated cholesterol level including a low-density lipoprotein (LDL) and a high-density lipoprotein (HDL) level;
- Periodic stool examination for the presence of blood for Participants age 40 or older;
- Periodic left-sided colon examination of 35 to 60 centimeters for Participants age 45 or older;
- Periodic glaucoma eye tests for Participants age 35 or older.

Employment (or return to work) physicals, insurance examinations, examinations at the request of a third party for premarital, sports, camp, school physicals, international travel and/or other non-preventive services are not covered.

Well-Child Care

Coverage is provided in accordance with the schedule of well-child exams suggested by the American Academy of Pediatrics as follows:

- During 1st year of age at 1, 2, 4, 6, 9, and 12 months;
- During 2nd year of age at 15, 18, and 24 months;
- Yearly check-ups for ages 3 and 4; and
- Every year for ages 3 through 18.

SKILLED NURSING FACILITY

A skilled nursing facility provides room and board and skilled nursing services for Medical Care and has one or more licensed nurses on duty at all times supervised on a 24 hour basis by a Registered Nurse (RN) or a Physician, and the services of the Physician are available at all times by an established agreement. The facility must also comply with the legal requirements that apply to its operation, and keep daily medical records on all patients. A skilled nursing facility is not an institution used mainly for rest care, care of the aged, care of substance abuse treatment, Custodial Care, or educational care.

Note: Benefit Certification is required for Skilled Nursing Facility benefits. This benefit is limited as shown in the Summary of Benefits. The Inpatient Co-payment is waived if confinement in the Skilled Nursing Facility is within 15 days after release from the Hospital and the stay is subject to continued stay review for Medical Necessity. Your Participating Provider requests your Benefit Certification for you. Discuss the need for Benefit Certifications with your Provider before obtaining services.

SMOKING CESSATION

Benefits are available for smoking cessation expenses. This benefit includes Acupuncture, hypnotherapy and other recognized smoking cessation programs that are covered through the medical portion of the Plan.

In addition, benefits can be accessed through Express Scripts, your prescription drug Provider to include Nicorette or any other drug containing nicotine or other smoking deterrent medications.

In order to use this benefit, Participants may secure medical services and/or purchase the smoking deterrent and pay for the services and drugs in full. All claims for medical services must then be filed through the medical portion of the Plan using a Participant Claim Form.
All prescription and non-prescription drug claims must be sent as separate claims to Express Scripts, your prescription drug Plan.

SURGERY

Benefits are available for the following surgical services:

- Necessary anesthesia services by a qualified Provider;
- Sterilization, but not procedures to reverse voluntary sterilization;

- Services of a Physician who actively assists the operating surgeon in the performance of a covered Surgery when the procedure requires an assistant, but not services of a Physician who is on standby, or available should services be needed; and
- Second or third opinion consultants. The second opinion must be received within six months of when the procedure was recommended. The third opinion must be received within six months of the date the second opinion was given. They Physician giving the second or third opinion must not be the Physician who recommends or performs the Surgery, and must practice in a different office than the Physician who recommends or performs the Surgery.

Cosmetic or plastic Surgery or reconstruction procedures, such as breast augmentations, rhinoplasties, surgical alteration of the eye, and surgical correction of prognathism, that Plan administrator determines are not required to materially improve the physiological function of an organ or body part are not Covered Services.

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- *All stages of reconstruction of the breast on which the mastectomy was performed;*
- *Surgery and reconstruction of the other breast to produce a symmetrical appearance;*
- *Prostheses; and*
- *Treatment of physical complications of the mastectomy, including lymphedemas.*

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Cardiac Surgery

Benefits are available for cardiac Surgery such as those for valve replacements or pacemakers.

Cataract Surgery

Benefits are available for cataract Surgery. The initial placement of either one set of prescription eyeglasses or one set of contact lenses (whichever is appropriate for your medical needs) will be a covered service. Contact lenses are also available when necessary to replace lenses absent at birth or lost through cataract or other intraocular Surgery or ocular injury, or prescribed by a Physician as the only treatment available for keratoconus. Services must be Medically Necessary and further replacement is covered only if a Physician or optometrist recommends a change in prescription.

Cochlear Implants

Cochlear implantation of a hearing device (such as an electromagnetic bone conductor) to facilitate communication for the profoundly hearing impaired, including training to use the device, is covered.

Congenital Anomalies

Benefits are available for the surgical correction of functional anomalies present from birth. There are no benefits for Cosmetic procedures or procedures that are not Medically Necessary.

Morbid Obesity
Benefits do not include treatment of morbid obesity (bariatric surgery or related surgeries).

Oral Surgery
See "Dental Care and Medical Condition of the Mouth and Jaw" in this Section.

Outpatient Surgery
Benefits are available for Medically Necessary surgical procedures performed in an Outpatient setting (there is no Hospital Admission).

Reconstructive Surgery
Benefits are available for certain types of reconstructive Surgery needed to restore or correct the function of a body part damaged by illness or Accidental Injury.

Reconstructive Surgery that is required as a consequence of an Accidental Injury, or breast reconstruction subsequent to a mastectomy (breast removal) required as a consequence of disease, is a benefit. The Participant or Provider must obtain prior written Benefit Certification from the Plan administrator before the service is provided. Reconstructive surgeries provided without prior written Benefit Certification are not eligible for benefits under this Plan.

Mastectomy Services – Medically Necessary hospitalization related to a covered mastectomy including at least 48 hours of Inpatient care following a mastectomy and 24 hours following a lymph node dissection is covered.

When breast reconstruction is chosen, Covered Services include:
- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications in all stages of mastectomy, including lymphedemas as determined by the Attending Physician and the patient.

Breast reconstruction Surgery is limited to a surgical procedure or procedures performed following a mastectomy on one or both breasts to re-establish symmetry between the two breasts. Benefits are also available for procedures related to nipple reconstruction following a mastectomy.

Removal of a breast Prosthesis is a covered benefit when deemed Medically Necessary. Replacement of the Prosthesis is not a covered benefit if original placement was due to a cosmetic procedure. Reduction mammoplasty Surgery is covered if the patient meets all the criteria to establish Medical Necessity.

Note: If you disagree with Lovelace Insurance Company's decision regarding the Medical Necessity of any item or service, you may file a complaint. You may also request an external review of the Lovelace Insurance Company decision at any time. See "Appeal and Grievance Procedure" in Section 9.

THERAPY

Cardiac and/or Pulmonary Rehabilitation

Coverage is provided for 36 visits per Participant per Annual Plan Year. Please remember, Long Term rehabilitation is not covered.

Pulmonary Rehabilitation Services are provided for 24 sessions of progressive exercises and monitoring of pulmonary functions per Participant per Annual Plan Year.

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Chemotherapy/Dialysis/Radiation Therapy

Benefits are available for the following Inpatient or Outpatient therapeutic services:

- Treatment of malignant disease by standard chemotherapy;
- Treatment for removal of waste materials from the body; including renal dialysis, hemodialysis, or peritoneal dialysis, and the cost of equipment rentals and supplies; and
- Treatment of disease by x-ray, radium, or radioactive isotopes.

Physical, Occupational and Speech Therapy

Benefits are limited (as shown in the Summary of Benefits) for Outpatient rehabilitation services including physical therapy from a Licensed Physical Therapist, and occupational or speech therapy from a licensed or certified therapist. Benefits are not available for speech therapy in connection with learning disabilities. Benefit Certification is required based upon Medically Necessity as determined by the plan. Discuss the need for Benefit Certifications with your PCP or Specialist before obtaining services. These services may also include treatment using cold, heat, or similar modalities to relieve pain, restore maximum function, and prevent disability following illness, Accidental Injury, or loss of a body part.

Benefits are not available for Maintenance Therapy or any diagnostic, therapeutic, rehabilitative, or health maintenance service provided at or by a health spa or fitness center, even if the service is provided by a licensed or registered Provider.

Note: If you disagree with Lovelace Insurance Company's decision regarding the Medical Necessity of any item or service, you may file a complaint. You may also request an external review of the Lovelace Insurance Company decision at any time. See "Appeal and Grievance Procedure" in Section 9.

Restorative Speech Therapy

Restorative speech therapy, in conjunction with a covered illness or injury, includes an additional benefit through the Plan to restore speech. Benefits are limited as shown in the Summary of Benefits and subject to Benefit Certification from Lovelace Insurance Company. Your PCP or Specialist for you requests Benefit Certifications for you. Discuss the need for Benefit Certifications with your Physician before obtaining services.

To be eligible for this additional coverage, the Participant must have a documented potential for improvement. This therapy excludes coverage for Participants with normal physical development but having speech intelligibility limitations. Also excluded is Maintenance Therapy.

Note: If you disagree with Lovelace Insurance Company's decision regarding the Medical Necessity of any item or service, you may file a complaint. You may also request an external review of the Lovelace Insurance Company decision at any time. See "Appeal and Grievance Procedure" in Section 9.

TRANSPLANT SERVICES

This Plan covers human organ and tissue transplant services. Transplant services include a surgical process that involves the removal of an organ from one person and placement of the organ into another. Transplant can also mean removal of organs or tissue from a person for the purpose of treatment and re-implanting the removed organ or tissue into the same person.

These services require Benefit Certification by Lovelace Insurance Company and are only covered at certain Lovelace Insurance Company-approved facilities within the United States. The recipient of an organ transplant must be a Participant at the time of services. Benefits are not available when the Participant is a donor. The term recipient is defined to include a participant 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 below:

Out-of-Network (Tier 3) benefits are not covered.

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: allogenic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas, or small bowel/liver.

Covered cardiac surgeries, such as valve replacements and pacemaker insertions, are covered under "Surgery."

Coverage is subject to the following conditions and limitations outlined below.

Benefit Certification

Benefit Certification must be obtained from Lovelace Insurance Company before a pre-transplant evaluation is scheduled. A pre-transplant evaluation is not covered if Benefit Certification is not obtained from Lovelace Insurance Company. Certification is based on an evaluation conducted by a Lovelace Insurance Company-approved transplant facility and on the relevant evidence-based medical guidelines.

A Lovelace Insurance Company case manager will be assigned to you (the transplant recipient candidate) and must later be contacted with the results of the evaluation. Benefit Certifications are requested by your PCP or Specialist. Discuss the need for Benefit Certifications with your Physician before obtaining services.

If you are approved as a transplant recipient candidate, you must ensure that Benefit Certification for the actual transplant is also received. None of the benefits described here are available unless you have this Benefit Certification. In addition, benefits are available only when the transplant is performed at a facility with a transplant program approved by Lovelace Insurance Company. Call the Lovelace Insurance Company Customer Care center for more information.

Effect of Medicare Eligibility on Coverage

If you are now eligible for or are anticipating receiving eligibility for Medicare benefits, you are solely responsible for contacting Medicare to ensure that the transplant will be eligible for Medicare benefits.

Organ Procurement or Donor Expenses

If a transplant is covered, the surgical removal, storage, and transportation of an organ acquired from a cadaver are also covered. If there is a living donor that requires Surgery to make an organ available for a covered transplant (e.g., kidney or liver), coverage is available for expenses incurred by the donor for travel (if required, covered under the "Transplant" provision, and approved by the Lovelace Insurance Company case manager), Surgery, organ storage expenses, and Inpatient follow-up care only. This Plan does not cover donor expenses after the donor has been discharged from the transplant facility.

Coverage for compatibility testing prior to organ procurement is limited to the testing of cadavers and, in the case of a live donor, to testing of the donor selected.

Covered Services related to the transplants are subject to usual cost sharing features and benefit limitations of this Plan (e.g. Co-payments and out-of-pocket limits; annual home health care maximums).

Reminder: Benefits are available only when the transplant is performed at a facility with a transplant program approved by Lovelace Insurance Company.

Transplant Travel

Travel expenses incurred by you 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 you only if you are the recipient of a pre-approved organ/tissue transplant from a Lovelace Insurance Company approved Organ Transplant facility.

Travel expenses for the Participant receiving the transplant will include charges for:

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

In addition to you being covered for the charges associated with the item above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a Participant of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver.

By way of example, but not of limitation, the following are specifically excluded travel expenses:

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

Travel benefits are available for an adult transplant recipient and one other person or for a transplant recipient who is a minor, benefits are available for two adults. Transportation costs will be covered only if travel beyond 60 miles of your home is required.

Reasonable expenses for lodging and meals will be covered, up to a maximum of $150 per day for each person, the transplant recipient and companion(s). All benefits for transportation, lodging, and meals are limited to a maximum payment of $10,000.

Benefits are not available for implantation of artificial organs, mechanical devices or for non-human organ transplants and those services otherwise listed as covered elsewhere in this booklet. Follow-up care and complications of non-covered transplants are not a covered benefit.

Benefits are subject to the same Co-payment, Co-insurance and Out-of-Pocket Maximum provisions as other benefits. The cost-sharing provisions of the coverage in effect on the date services are rendered apply to the transplant benefits.

Note: If you disagree with Lovelace Insurance Company's decision regarding the Medical Necessity of any item or service, you may file a complaint. You may also request an external review of the Lovelace Insurance Company decision at any time. See "Appeal and Grievance Procedure" in Section 9.

SECTION 6 – LIMITATIONS AND EXCLUSIONS

Please read this section carefully. It identifies the limitations that apply to certain Covered Services and specifies the Health care Services and supplies that are not covered under this Plan.

Note: If you disagree with Lovelace Insurance Company's decision regarding the Medical Necessity of any item or service, you may file a complaint. You may also request an external review of the Lovelace Insurance Company decision at any time. See "Appeal and Grievance Procedure" in Section 9.

LIMITATIONS

The following benefits have limits applied:

Acupuncture treatment benefits are limited to a Contract Year maximum of 20 visits per contract year per Participant for covered expenses, in combination with services provided for chiropractic and massage therapy.

Air ambulance charges for non-emergencies will be covered only if Medically Necessary.

Chiropractic (manipulation) services are limited to 20 visits each therapy combined visits per Contract Year.

Cochlear implants and related care are limited to implantation of a hearing device to facilitate communication for the profoundly hearing impaired, including any necessary training required to use the device.

Consumable medical supplies are covered during hospitalization. They are also covered during an office visit or authorized home health visit Lovelace Insurance Company does not cover supplies used at other times by the Participant or Participant's family. Consumable medical supplies are (1) usually disposable, (2) cannot be used repeatedly by more than one individual, (3) are primarily used for a medical purpose, (4) generally are useful only to a person who is ill or injured and (5) are ordered or prescribed by a licensed Provider.

Contact lenses or eyeglasses are limited to services necessary to replace lenses absent at birth or lost through cataract or other intraocular Surgery or prescribed by a Physician as the only treatment available for keratoconus. Duplicate lenses are not covered; replacement is covered only if a Physician or optometrist recommends a change in prescription due to the medical condition.

Dental Services - This Plan covers only those procedures listed as covered benefits as indicated in the Dental Service section of this PBB.

Diagnostic testing for infertility is limited to testing needed to diagnose the cause of infertility. Once the cause has been established and the recommended treatment is not covered by this Plan, no further testing will be covered under this Plan.

Durable Medical Equipment, orthotic and prosthetic devices and external prostheses require Benefit Certification. Discuss the need for Benefit Certification with your Physician.

Family planning coverage is limited to Depo-Provera injections, diaphragms, implantable contraception devices (insertion and removal), intrauterine devices (IUDs), genetic testing, and sterilization procedures.

Home health care services require Benefit Certification. Discuss the need for Benefit Certification with your Physician.

Hospice care benefits are limited to patients terminally ill as described in Section 5. Benefit Certification is required from the Plan. Discuss the need for Benefit Certification with your Physician.

Infertility testing is limited to testing needed to diagnose the cause of infertility. Once the cause has been established and the treatment is determined not covered by this Plan, no further testing will be covered under this Plan.

Infertility treatment is limited to Surgery to open obstructed tubes, epididymis or vas when not the result of sterilization and replacement of deficient hormones if there is documented evidence of a deficiency.

Physical, occupational and speech therapies are limited to 20 visits per Participant per Contract Year for all therapies and services require Benefit Certification.

Reconstructive Surgery requires Benefit Certification or no benefits are payable through the Plan.

Repair or replacement of non-rental Durable Medical Equipment, orthotic appliances and prosthetic devices due to normal wear and damage requires Benefit Certification or no benefits are payable under this Plan.

Routine eye screenings are limited to Dependents through age 17.

Routine hearing screenings are limited to Dependents through age 21 if still attending high school.

Skilled Nursing Care is limited to 60 days per Contract Year and is subject to Benefit Certification by Lovelace Insurance Company. Discuss the need for Benefit Certification with your Physician.

Substance Abuse Limitations - Limited to 30 days combined benefit for inpatient and 60 days combined benefit for outpatient per contract year.

Transplants and related services, and supplies provided after the transplant are limited per benefit description in Section 5. Benefits for travel, lodging, and meals are limited to the adult transplant recipient and one other person. For minor children, benefits are payable for two other persons. Lodging and meals are limited to $150 per day per person including the transplant patient, to a maximum lifetime benefit payment of $10,000, to include transportation. Donor organ procurement costs for the surgical removal, storage, and transportation of the donated organ are covered for Reasonable and Customary Charge.

EXCLUSIONS

Any service, supply, item or treatment not listed as a covered service in Sections 5 "Covered Services" is not covered under this Plan.

Benefits are not available for any of the following services, supplies, items, situations, or related expenses for the items listed below. In addition any services provided to treat what is an uncovered or excluded benefit is also not covered under this plan.

SECTION 6 – LIMITATIONS AND EXCLUSIONS

Acts of War – treatment for injuries received due to acts of war are not a covered benefit.

Activities of daily living are not a covered benefit, to include assistance in bathing, dressing, feeding, exercising, preparing meals, homemaking, moving the patient, giving medications, or acting as a sitter.

Adoption/Surrogate expenses are not a covered benefit.

Ambulance (including air ambulance) charges which are not medically necessary.

Amniocentesis and/or ultrasound to determine the gender of a fetus are not covered benefits under this Plan.

Assistance with activities of daily living are excluded.

Artificial conception including fertilization and/or growth of a fetus outside the mother's body in an artificial environment, such as artificial insemination, in-vitro ("test tube") or in-vivo fertilization, GIFT, ZIFT, all drugs, hormonal manipulation, donor sperm or embryo transfer are not covered services. Any artificial conception method not specifically listed is also excluded.

Autopsies are not a covered benefit under this Plan.

Before effective date benefits are not available for any treatment that began before the Participant's effective date or for any service or supply received before the Participant's effective date under this Plan.

Behavioral disorders are not a covered benefit under this unless associated with a manifested behavioral/mental health disorder.

Bereavement counseling is excluded from Hospice Care.

Biofeedback treatment is excluded.

Blood charges if the blood has been replaced and blood donor storage fees if there is not a scheduled procedure.

Charges:

- In excess of Plan limits.
- In excess of Reasonable and Customary amounts when services are secured from an out-of-network Provider in an emergency or urgent need or for transplant services.
- Made by a family Participant (spouse, parent, grandparent, sibling or child) or someone who lives with you.

Clinic or other facility services that the Participant is eligible to have provided without charge.

Complications of non-benefit services, supplies and treatment received including, but not limited to, complications for non-covered transplants, cosmetic, Experimental, or Investigational procedures, sterilization reversal, infertility treatment, or gender changes are not Covered Services, unless authorized by the Plan.

SECTION 6 – LIMITATIONS AND EXCLUSIONS

Contact lenses or eyeglasses unless specifically listed as a covered benefit under this Plan.

Convalescent care or rest cures.

Cosmetic and/or plastic Surgery or services, unless specifically covered in this booklet. Cosmetic Surgery is beautification or aesthetic Surgery to improve an individual's appearance by surgical alteration of a physical characteristic. The Plan does not cover Cosmetic Surgery, services or procedures for psychiatric or psychological reasons, or to change family characteristics or conditions caused by aging. This Plan does not cover services related to a cosmetic service, procedure, or Surgery, or required as a result of a non-covered cosmetic service, procedure, or Surgery.

Counseling services are not a covered benefit under this Plan unless listed as a covered service.

Court ordered services are not a covered benefit under this Plan.

Custodial Care such as sitters, homemaker's services, or care in a place that serves the patient primarily as a residence when the Participant does not require Skilled Nursing Care.

Dental services to include periodontal Surgery except if the services required are due to Accidental Injury of sound natural teeth or as otherwise listed as a covered benefit under this Plan.

Dependent of a Dependent (grandchild) expenses are not a covered benefit unless the Dependent is otherwise eligible for coverage under this Plan.

Diagnostic testing for infertility is limited to testing needed to diagnose the cause of infertility. Once the cause has been established and the treatment is determined to be not covered by this Plan, no further testing will be covered under this Plan.

Diagnostic, therapeutic, rehabilitative, or health maintenance services provided at or by a health spa or fitness center, even if the service is provided by a licensed or registered Provider.

Domiciliary care or care provided in a residential institution, treatment center, halfway house, or school because a Participant's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Donor expenses incurred by a Participant are not a covered benefit under this Plan, except as specified in this PBB.

Duplicate coverage including, but not limited to:

- Services already covered by other valid coverage;
- Services already paid under Medicare;
- If your prior coverage has an extension of benefits provision, this Plan will not cover charges incurred after your effective date under this Plan that are covered under the prior plan's extension of benefits provision.

Duplicate diagnostic testing or over reads of laboratory, pathology, or radiology tests are not covered.

Duplicate equipment is not covered under this Plan.

Durable Medical Equipment, orthotic and Prosthetic Devices and external prostheses repairs for items not owned by the Participant, or which exceed the purchase price.

Educational or institutional services except for diabetes education and preventive care as described in the PBB.

Environmental control expenses are not a covered benefit under this Plan.

Exercise equipment is not a covered benefit under this Plan. Neither is exercise therapy or movement therapy.

Experimental or Investigational services/treatment are not covered benefits. Experimental/ Investigational means any treatment, procedure, facility, equipment, drug, device, or supply not accepted as standard medical practice in the state services are provided. In addition, if a federal or other governmental agency approval is required for use of any items and such approval was not granted at the time services were administered, the service is Experimental.

To be considered standard medical practice and not Experimental or Investigational, treatment must meet all five of the following criteria:

- A technology must have final approval from the appropriate regulatory government bodies;
- The scientific evidence as published in peer-reviewed literature must permit conclusions concerning the effect of the technology on health outcomes;
- The technology must improve the net health outcome;
- The technology must be as beneficial as any established alternatives; and
- The improvement must be attainable outside the Investigational settings.

Eye exercises and refractions are not a covered benefit under this Plan.

Food and lodging expenses are not covered except for those that are eligible for per diem coverage under the "Transplant Services" provision in Section 5.

Foot care, including all routine services such as the treatment of flat foot conditions, supportive devices, accommodative orthotics, orthopedic shoes unless jointed to braces, partial dislocations, bunions except capsular or bone Surgery, fallen arches, weak feet, chronic foot strain, symptomatic complaints of the feet, and the trimming of corns, calluses, or toenails, unless medical conditions such as diabetes exist.

Hair loss and/or replacement, including wigs, artificial hairpieces, hair transplants, or implants, even if there is a medical reason for hair loss.

Health care for injuries that that are sustained in the commission of a crime.

Hearing Aids are excluded other than Hearing Aids for Children.

Home health care benefits for care that:

- Is provided primarily for the convenience of the Participant or the Participant's family;
- Consists mostly of bathing, feeding, exercising, preparing meals, homemaking, moving the patient, giving medications, or acting as a sitter; or
- Is provided by a nurse who ordinarily resides in the Participant's home or is a Participant of the patient's immediate family.

Hospice benefits are not available for the following services:

- Food, housing, or delivered meals;
- Medical transportation;
- Comfort items;
- Homemaker and housekeeping services;
- Private duty nursing ;
- Pastoral and spiritual counseling;
- Respite care;
- Volunteer services; and
- Support services provided to the family when the patient is not a Participant of this Plan.

Additionally, the following services are not benefits under Hospice but may be covered elsewhere under this booklet:

- Acute Inpatient Hospital care for curative services;
- Non-Hospice care Physician visits; and
- Ambulance Services.
- Bereavement counseling

Human Chorionic Gonadotrophin (HCG) injections are not a covered benefit under this Plan.

Hypnotherapy or services related to hypnosis, whether for medical or anesthetic purposes, except as covered under "Smoking Cessation Treatment" provision.

Infertility testing and treatment not listed as a covered benefit under this Plan. Also see the exclusion under Artificial Conception.

Implantation of artificial organs or mechanical devices except as specified in this booklet are not a covered benefit under this Plan, unless as a result of illness or injury and the services have been Prior Authorized by the Plan.

Late claims filing: This plan does not cover services submitted for benefit determination if Lovelace Insurance Company receives the claim more than 12 months after the date of service.
Note: If there is a change in the Claims Administrator, the length of this timely filing period may also change.

Learning disabilities and behavioral problems: This plan does not cover vocational, special education, educational rehabilitations services, job counseling, or behavioral therapy, psychological counseling, therapy or education for learning disabilities, developmental disabilities or mental impairments.

Legal payment obligations: services for which the Participant has no legal obligation to pay or that are free, charges made only because benefits are available under this Plan, services for which the Participant has

received a professional or courtesy discount, services provided by the Participant upon oneself or a covered family Participant, or by one ordinarily residing in the Participant's household, or by a family Participant, or Physician charges exceeding the amount specified by the Health and Human Services Department when benefits are payable under Medicare.

Local anesthesia charges that have been included in the cost of the surgical procedure are not covered.

Long term rehabilitation services are not covered. Long term therapy includes treatment for chronic or incurable conditions for which rehabilitation produces minimal or temporary change or relief. Treatment of chronic conditions is not covered.

Maintenance or long-term therapy or care or any treatment (Inpatient or Outpatient) that does not significantly improve your function or productivity, or care provided after you have reached your rehabilitative potential (unless therapy is covered during an approved Hospice benefit period) is not covered under this Plan. In a dispute about whether your rehabilitative potential has been reached, you are responsible for furnishing documentation from your Physician supporting his/her opinion that your rehabilitative potential has not been reached. Note: Even if your rehabilitative potential has not yet been reached, this Plan does not cover services that are in excess of maximum benefit limitations.

Massage therapy is not covered under this Plan.

Medical equipment to include, but not be limited to, stethoscopes and blood pressure monitors unless listed as a covered item under this Plan.

Medically unnecessary services: This plan does not cover services that are not Medically Necessary as defined in the beginning of Section 3, unless such services are specifically listed as covered (e.g., see "Preventive Services" in Section 5).

Membership fees are not a covered benefit under this Plan.

Behavioral/Mental Health and/or Substance Abuse treatment for the following are not covered:

- Any care which is patient elected and is not considered Medically Necessary;
- Care which is mandated by court order or as a legal alternative, and lacks clinical necessity as diagnosed by a licensed Provider;
- Workers' Compensation or disability claims are not covered as part of treatment;
- Long term Custodial Care of children and adolescents;
- Special education, school testing and evaluations, counseling, therapy or care for learning deficiencies or education and developmental disorders;
- Behavioral problems unless manifested with a behavioral/mental health diagnosis; and
- Non-national standard therapies, including Experimental, which are evaluated by the Lovelace Technology Assessment Committee.

Non-covered Providers: Participants of your immediate family or one normally residing in your home, health spas or health fitness centers, school infirmaries (except for Student Health Centers at institutions of higher education), private sanitariums, nursing homes, rest homes, mutual benefit association, labor union, trustee, or any similar person or group.

SECTION 6 – LIMITATIONS AND EXCLUSIONS

Non-human organ transplants, except for porcine (pig) heart valve, are not covered under this Plan.

Non-medical equipment is not a covered benefit under this Plan.

Non-medical expenses: This Plan does not cover non-medical expenses (even if medically recommended and regardless of therapeutic value), including charges for services such as, but not limited to: missed appointments, "get-acquainted" visits without physical assessment or Medical Care, provision of medical information to perform pre-Admission or concurrent review, filling out of claim forms, mailing and/or shipping and handling charges, interest expenses, copies of medical records, modifications to home, vehicle, or workplace to accommodate medical conditions, voice synthesizers, other communication devices, Membership fees at spas, health clubs, or other such facilities even if medically recommended.

Nonprescription and over the counter drugs are excluded. See Express Scripts benefit.

Nonstandard or deluxe equipment is not a covered benefit under this Plan.

Nutritional supplements are not a covered benefit under this Plan unless the supplement is the sole source of nutrition. Infant formulas are not a covered benefit.

Orthodontic appliances and treatment, crowns, bridges, or dentures for the treatment of craniomandibular joint (CMJ) or temporomandibular joint (TMJ) disorders unless the disorder is trauma related. Also, nonstandard diagnostic, therapeutic and surgical treatments of TMJ are not benefits under any circumstances.

Orthopedic shoes are not a covered benefit under this Plan unless the shoes are attached to a brace, or for treatment of diabetes.

Orthoptics are not a covered benefit under this Plan.

Personal convenience items such as air conditioners, humidifiers, or physical fitness exercise equipment, or personal services such as haircuts, shampoos and sets, guest meals, and radio ortelevision rentals are not covered.

Personal trainers are not covered under the provisions of this Plan.

Physical examinations and/or immunizations for purposes of employment, insurance, premarital or international travel tests, sports, school, camp, other non-preventive tests, and those requested by a third party, are not covered under this Plan unless considered Medically Necessary by the Plan.

Post-termination care: This Plan does not cover services received after your coverage is terminated, even if Benefit Certification for such services were needed because of an event that occurred while you were covered.

Prescription drugs obtained on an Outpatient basis are not covered under the medical portion of this Plan. If you have questions about your other Outpatient prescription drug benefits contact Express Scripts at 1-800-232-6549.

Private room expenses are not a covered benefit under this Plan unless there is documented Medical Necessity.

SECTION 6 – LIMITATIONS AND EXCLUSIONS

Private duty nursing charges are not covered under this Plan unless services are considered Medically Necessary.

Protective clothing or devices are not covered under this Plan.

Radial keratotomy, LASIK and other eye refractive Surgery are not covered benefits under this Plan.

Repair or replacement of Durable Medical Equipment, orthotic appliances and prosthetic devices due to loss, neglect, theft, misuse, abuse, to improve appearance or for convenience.

Residential Treatment Center Services is excluded.

Respite Care is excluded.

Restorative speech therapy is excluded.

Reversals of surgical procedures are not a covered benefit under this Plan.

Self-help programs and therapies not specifically covered in this booklet, such as behavior modification, peer support groups, half-way houses, massage therapy (except when performed by a Licensed Physical Therapist, a Licensed Massage Therapist, a Medical Doctor, Doctor of Osteopathy, Doctor of Oriental Medicine or Chiropractor.)

Services not specifically identified as a benefit in this booklet, or services not listed as a covered benefit in this booklet.

Services for treatment from injuries sustained in the commission of a crime. Services rendered to a participant for injuries as a result of commission of a crime are not covered.

Sex-change operations and reversals of such procedures are not covered benefits.

Sexual dysfunction testing and treatment, unless related to organic disease or Accidental Injury.

Speech therapy charges not otherwise listed as a covered benefit under this Plan.

Sperm storage is not a covered benefit under this Plan.

Standby professional services are not covered under this Plan.

Surgical sterilization reversal of voluntary infertility procedures is not covered.

Thermography (a technique that photographically represents the surface temperatures of the body) is not covered under this Plan.

Transplants not specifically listed as a covered benefit under this Plan are not covered.

Travel and other transportation expenses, except as covered under "Ambulance Services" and "Transplants" are not covered. Emergency Medical Evacuation transportation expenses are covered with no lifetime maximums. See Emergency Medical Evacuation And Repatriation Of Remains section of this document.

Treatment for injuries sustained by a Participant in the course of committing a felony, if the Participant is subsequently convicted of the felony is not covered.

Unreasonable charges will not be covered by this Plan.

Untimely filing: Claims filed more than 12 months after the date of service are not covered.

Veterans Administration facility services or supplies furnished by a Veterans Administration facility for a service-connected disability, or while a Participant is in active military service are not covered.

Vision care: The Plan does not cover eyeglasses, contact lenses, and routine eye refractions unless listed as covered in this booklet.

Vision therapy or any surgical or medical service or supply provided in connection with refractive keratoplasty (Surgery to correct nearsightedness) or any complication related to keratoplasty, including radial keratotomy or any procedure designed to correct myopia, or any procedure to correct refractive defects such as farsightedness, presbyopia, or astigmatism are not covered.

Vitamins, dietary supplements, special foods, formulas, or diets Nutritional supplements are not a covered benefit under this Plan unless the supplement is the sole source of nutrition. Infant formulas are not a covered benefit.

Vocational rehabilitation services are not a covered benefit under this Plan.

Weight loss programs, obesity treatment, and nutritional counseling, except as outlined in Section 5.

Work-related conditions: This Plan does not cover services resulting from work-related illness or injury, or charges resulting from occupational accidents or sickness covered under:

- Occupational disease laws,
- Employer's liability,
- Municipal, state, or federal law (except Medicaid); or
- Workers' Compensation Act.

To recover benefits for a work-related illness or injury, you must pursue your rights under the Workers' Compensation Act or any of the above provisions that apply, including filing an appeal. (Lovelace Insurance Company may pay claims during the appeal process on the condition that you sign a reimbursement agreement.)

This Plan does not cover a work-related illness or injury, even if:

- You fail to file a claim within the filing period allowed by the applicable law;
- You obtain care not authorized by Workers' Compensation insurance;
- Your employer fails to carry the required Workers' Compensation insurance. (The employer may be liable for an employee's work-related illness or injury expenses.);or
- You fail to comply with any other provisions of the law.

Weight loss treatment for obesity or bariatric surgery is not a benefit.

SECTION 7 – COORDINATION OF BENEFITS

This Plan contains a coordination of benefits (COB) provision that prevents duplication of payments. Under this provision, if a Participant is eligible for benefits under any other valid coverage, the combined benefit payments from all coverage cannot exceed 100% of the covered expenses. Other valid coverage means all other insurance policies, which may include Medicare, that provide payments for medical expenses.

If a Participant is covered by both Medicare and this Plan and is not a retiree, special COB rules may apply. Contact a Lovelace Insurance Company Customer Care Representative for more information.

If a Participant is currently covered under COBRA provisions, coverage ceases at the beginning of the month in which the Participant either becomes enrolled for any other valid coverage unless a preexisting condition limitation applies, or until the COBRA period expires, whichever occurs first.

The following rules determine order of benefit determination between this Plan and any other plan covering a Participant not on COBRA continuation on whose behalf a claim is made:

1. No COB Provision - If the other valid coverage does not include a COB provision, that coverage pays first and this Plan pays secondary benefits.

2. Employee/Dependent. If the Participant who received care is covered as the employee under one coverage and as a Dependent under another, the employee's coverage pays first. If the Participant is also a Medicare beneficiary, and Medicare is secondary to the plan covering the person as a Dependent of an active employee, then the order of benefit determination is:

a. Benefits of the plan of an active worker covering the Medicare beneficiary as a Dependent;
b. Medicare;
c. Benefits of the plan covering the Medicare beneficiary as the policyholder or as an active or retired employee.

If the Participant has other valid coverage, please contact the other carrier's Customer Care/Service Department to determine if that coverage is primary or secondary to Medicare. There are many federal regulations regarding Medicare Secondary Payer provisions, and other coverage may or may not be subject to those provisions.

3. Dependent Child/Parents Not Separated or Divorced. If the Participant who receives care is a Dependent child, the coverage of the parent whose birthday falls earlier in the Calendar Year pays first. If the other valid coverage does not follow the birthday rule, then the gender rule applies (that is, the male parent's coverage comes first.

4. Child/Parents Separated or Divorced. If two or more plans cover a Participant as a Dependent child of divorced or separated parents, benefits for the child follow these rules:

a. Court-Decreed Obligations. Regardless of which parent has custody; if a court decree specifies which parent is financially responsible for the child's health care expenses, the coverage of that parent pays first.
b. Custodial/Non Custodial. The plan of the parent with custody of the child pays first. The plan of the spouse of the parent with custody of the child pays second. The plan of the parent not having custody of the child pays last.

c. Joint Custody. When a court decree specifies that the parents share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child follow the order of benefit determination rules applicable to children whose parents are not separated or divorced.

5. Active/Inactive Employee. If the Participant who received care is covered as an active employee under one coverage and as an inactive employee under another, the coverage through active employment pays first. Likewise, if a Participant is covered as the Dependent of an active employee under one coverage and as the Dependent of the same but inactive employee under another, the coverage through active employment pays first. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, the next rule applies.

6. Longer/Shorter Length of Coverage. When none of the above applies, the coverage in effect for the longest continuous period of time pays first. The start of a new plan does not include a change in the amount or scope of a plan's benefits, a change in the entity that pays, provides, or administers the plan's benefits or a change from one type of plan to another.

If you receive more than you should have when benefits are coordinated, you are required to repay any overpayment.

Your other valid coverage may be with a Health Maintenance Organization (HMO), a Preferred Provider Organization (PPO), or another program that limits or excludes benefits if you do not meet the obligations for obtaining Benefit Certification of care, for obtaining the proper level of care for the condition treated or for obtaining services from Providers authorized or recognized by your primary carrier. If you do not meet these obligations and your primary benefits are reduced as a result, UNM Custom Care Plan limits its secondary benefit payment to the difference between the Lovelace Insurance Company Negotiated Fee-for-Service for the service received and the amount that would have been paid if you had met the obligations recognized by your primary carrier. If you do not meet these obligations and your primary benefits are reduced as a result, Lovelace Insurance Company limits its secondary benefit payment to the difference between the Lovelace Insurance Company Negotiated Fee-for-Service for the service received and the amount that would have been paid if you had met the obligations.

EFFECT OF MEDICARE ON BENEFITS

Shortly before you or your spouse become age 65, or if you or any other family Participant becomes qualified for Medicare benefits, contact your local Social Security office to establish Medicare eligibility. Then, contact your agency group representative to discuss coverage options.

If you are a working employee age 65 or over or your spouse is age 65 or over, you are eligible to continue the University of New Mexico coverage on the same basis as Participants under age 65.

When a retiree becomes eligible for Medicare, Medicare is primary and benefits are paid according to the Coordination of Benefits provisions of this Plan.

If Medicare coverage coexists with this Plan, Medicare will be secondary until the Plan pays primary for at least 30 months from the date the Participant became eligible for or entitled to Medicare on the basis of end-

stage renal disease. A person Eligible under Medicare is defined as an employee or Dependent who is enrolled and covered under the voluntary portion (Part B) of Medicare, or who has been eligible to enroll under such part.

EFFECT OF MEDICAID ON BENEFITS

Benefits payable on behalf of a Participant who is qualified for Medicaid will be paid to the Plan when:

- The Plan has paid or is paying benefits on behalf of the Participant under the Group's Medicaid program pursuant to Title XIX of the Federal Social Security Act; and
- The payment for the services in question has been made by the Plan to the Medicaid Provider.

Benefits payable on behalf of a Participant who is qualified for Medicaid is made to the New Mexico Human Services Department or to the Medicaid Provider when required by law.

SUBROGATION

When this Plan pays for your care and you have the right to recover those expenses from the person or organization causing your illness or Accidental Injury, the Plan has the right of subrogation to recover the amount it has paid. This right of subrogation against the third party may be exercised even if you do not file a legal action. The right of subrogation applies whether you recover directly from the wrongdoer or from the wrongdoer's insurer, or from your uninsured motorist insurance coverage. This applies to any and all moneys a Participant may receive from any third party or insurer, or from any uninsured or underinsured motorist insurance benefits, as well as from any other person, organization or entity.

You have the legal obligation to help recover the amounts paid, and you must do nothing that would prejudice the Plan's subrogation right. You must notify Lovelace Insurance Company if you file a claim, consult an attorney, or bring action against a third party.

If you are in an accident and another person or entity may be legally liable to you, please notify our Subrogation Services department right away at:

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

We will work with you or your lawyer to protect the Plan's right of subrogation.
If contacted by Lovelace Insurance Company or its representative, you must provide all requested information. Settlement of a controversy without prior notice to Lovelace Insurance Company's is a breach of this agreement. In the event that you fail to cooperate with the Plan or take any action, through agents or otherwise, to interfere with the exercise of a subrogation right of the Plan's, the Plan may recover its benefit payments from you.

SECTION 7 – COORDINATION OF BENEFITS

ASSIGNMENT OF BENEFITS

Your benefits under the Plan generally cannot be transferred or assigned in any way, except as required under a Qualified Medical Child Support Order (QMCSO). A qualified child support order is a court order, which may be granted in the case of a divorce.

FRAUDULENT APPLICATION OR CLAIM

If you knowingly make a false statement on your enrollment Application or file a false claim, such Application or claim will be revoked retroactively back to the date of the Application or claim. Any premiums collected from the Participant for coverage that is later revoked due to a fraudulent Application will be refunded to the Participant by the Plan. If a claim is paid by the Plan and it is later determined that the claim should not have been paid due to a fraudulent Application or claim, the Participant shall be responsible for full reimbursement of the claim amount to UNM.

SECTION 8– CLAIMS FILING

Claims Payment Process

This is a Managed Care Preferred Provider Plan with multiple tier or Networks wherein the contracted Participating Providers have agreed to file your claims directly to Lovelace Insurance Company and payment is made directly to the Provider for the LoboCare and the Lovelace Expanded Provider Networks (Tiers 1 and 2). A Participant should not be required to pay additional amounts to any Participating Provider except for required Co-payments and Co-insurance amounts, or to meet a Deductible, as indicated on your Summary of Benefits. In addition to these networks you have a choice to choose any additional Provider when you choose the Out-of Network Tier or Tier 3. In this case you may have to pay for your services up front and then submit the bill to Lovelace Insurance Company for reimbursement of the covered amount or Co-insurance payment payable by Lovelace once your Deductible has been met.

If you believe you are being asked to pay an amount to a Participating Provider (the LoboCare and the Lovelace Expanded Provider Networks (Tiers 1 and 2) that you do not agree with, you may contact the Lovelace Customer Care Center for assistance. Participants are not liable to a Participating Provider on these Tiers for any amounts owed to the Provider by Lovelace Insurance Company, once Deductible amounts have been reached on Tier 2. To help ensure claims are paid in a timely and appropriate manner, Participants must present their UNM Medical Plan ID card to Providers at the time of service.

Claims for Emergency Services

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

Services Provided by Non-Participating/Non-Contracted Providers

Participants who receive Covered Benefits or Services from an approved Non-Participating Provider may be required to make full payment to that Provider at the time services are rendered. In order for the Participant to be reimbursed, the Participant must submit satisfactory evidence to the Plan via Lovelace Insurance Company that indicates such payment was made to the Non-Participating Provider. For non-emergent or non-urgent services provided by non-Participating Providers, Benefit Certification for those services is also required.

Participants will need to submit itemized bills and receipts to Lovelace Insurance Company. The submission must contain an itemized statement of treatment, expenses, and diagnosis, including an explanation for the services and the identification information from your UNM Medical Plan ID card. Medical records of treatment/service may also be required. Once reviewed and approved, the Plan will reimburse the Participant for Covered Services, less any required Co-payment or Deductable and Co-Insurance amount the Participant would have been required to pay if the services had been obtained from a Participating Provider. The Participant will be responsible for charges not specifically covered by the Plan.

Note: When the Out-of-Network, Non-Participating Provider does not bill for you, you will be required to pay that Provider.

SECTION 8– CLAIMS FILING

Participant Claim Forms are available from your UNM Employee Benefit representative, the Lovelace Insurance Company Web site at www.lovelacehealthplan.com or from a Lovelace Customer Care Representative. Claims must be submitted no later than 12 months after the date a service or supply was received. If your Provider does not file a claim for you, you are responsible for filing the claim within the 12-month deadline. Claims submitted after the 12-month deadline are not eligible for benefit payments. If a claim is returned for further information, you must resubmit it within 90 days.

Please mail the claim forms and itemized bills to:

Lovelace Claims Department
Attention: UNM - Participant Submitted Claims Team
4101 Indian School Rd, NE
Albuquerque, New Mexico 87110

If payment is denied, you will receive notice of the decision, including the reasons for the denial and your Appeal rights. For additional information or if you have questions regarding this process, please refer to Section 9 - Appeals and Grievance Procedures or contact the Lovelace Customer Care Center.

CLAIMS FOR SERVICES RECEIVED OUTSIDE THE UNITED STATES

Even overseas, this Plan's coverage travels with you. If you need Urgent or Emergent Hospital or Physician care, claims should be handled the same way as described above. Participants 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. If you need assistance with getting the services you need while more than 100 miles away from home you may contact Assist America toll free inside the U.S.A. 1.800.872.1414; outside the U.S.A. +1.609.986.1234 (precede number by U.S. access code). Reference Number 01-AA-LHP-03093M.

ITEMIZED BILLS

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.

The only acceptable bills are those from health care Providers. 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.

PRESCRIPTION DRUG CLAIMS

Claims for Prescription Drugs must be sent to the Prescription Drug Plan Administrator, not to Lovelace Insurance Company. Please refer to the Express Scripts Participant Benefit Booklet or call them at 1-800-232-6549 for the claims filing procedures for Prescription Drugs.

HOW PAYMENTS ARE MADE

Payments for Covered Services usually are sent directly to PCPs and Participating Providers, including in-network Hospitals/treatment facilities.

Provider payments are based upon PCP and In-Network Provider agreements and the Negotiated Fee Schedule as determined by Lovelace Insurance Company. You are responsible for paying all applicable Co-payments, Deductibles and Co-insurance, and non-Covered Services.

If you obtain services from an Out-of-Network Provider, you are responsible for paying all, Co-payments, Deductibles and Co-insurance, and non-Covered Services. The Plan only covers reasonable and customary charges out-of-network for the benefits covered by the Plan. The participant could be balanced billed for charges above reasonable and customary.

Payment of benefits for Participants eligible for Medicaid is made to the New Mexico Human Services Department or to the Medicaid Provider when required by law. Additional information may be requested to process your claim, coordinate benefits, or protect the subrogation interest. You must supply the information or agree to have the information released by another person to Lovelace Insurance Company.

You may be requested to have another Physician examine you if there are questions about a Benefit Certification review or about a particular service or supply for which you are claiming benefits. In this event, the Plan will cover the requested examination.

OVERPAYMENTS

If payments made by Lovelace Insurance Company are greater than the benefits you have under this Plan, you are required to refund the excess. In the event that you do not, future benefits may be withheld and applied to the amount that you owe to the Plan.

FRAUD AND ABUSE

The UNM Medical Plan administrators have enlisted the support of the Lovelace Insurance Company's Fraud and Abuse Program to ensure that the Plan is not paying for services that are not required under the Plan and that the Plan is compliant with state and federal regulations in this area. The Lovelace Insurance Company Fraud & Abuse Program is dedicated to detecting, investigating, and preventing all forms of suspicious activity related to possible health insurance fraud or abuse, including any reasonable belief that insurance fraud has or may be committed. Lovelace is required to cooperate with regulatory and law enforcement agencies in reporting any activity that appears to be suspicious in nature. According to the law, any information that Lovelace has concerning such matters must be turned over to the appropriate governmental agencies.

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 Participant practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to UNM Medical Plan, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to UNM Medical Plan.

Examples of Provider Fraud:

- Billing for services not rendered
- Altering medical records
- Use of unlicensed staff
- Drug diversion
- Kickbacks and bribery

Examples of Participant Fraud:

- Falsification of information
- Forging or selling Prescription Drugs
- Adding an ineligible Dependent to the plan
- Loaning/using another's insurance card.
- Using transportation benefit for non-medical related business.

Examples of Employer Group Fraud:

- Providing false employer or group membership information to secure health care coverage
- Falsification of information
- Misrepresenting who is actually eligible for coverage by representing them as an employee of the group

How to Report Potential Fraud, Abuse, or Suspicious Activity

If you suspect insurance fraud, abuse, or suspicious activity has or may occur please report it immediately. You can contact the Lovelace Fraud & Abuse Department 24 hours a day by leaving a telephone message on the confidential hotline. Lovelace Insurance Company will treat any information that you provide with strict confidentiality.

When reporting suspected health insurance fraud, you may remain anonymous:

- Call the Lovelace Insurance Company Fraud & Abuse Telephone Hotline at (505) 727.5384
- Fax information to the Fraud & Abuse Department: (505) 727.5510
- Mail to:
  Lovelace Insurance Company
  Attn: Fraud & Abuse Department
  4101 Indian School Rd
  Albuquerque, NM 87110

SECTION 8– CLAIMS FILING

When reporting suspected fraud, please include as much detail as possible to ensure Lovelace's ability to fully investigate each issue. Please remember to include the names of all applicable parties involved. Specify which person you believe is committing the fraud, identify the dates of service or issues in question and describe in detail why you believe a fraudulent act may have occurred.

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. However if possible, please include your name and telephone number so Lovelace may contact you if they have any questions during their investigation.

Do I run a risk reporting fraud?

No. Any person reporting insurance fraud in good faith is immune from civil liability. That means that no one can take any adverse action against you for reporting what you reasonably believe to be insurance fraud. A court must award attorney's fees and costs to any person winning a lawsuit arising out of such a report.

Anti-Fraud Contacts

Lovelace Insurance Company provides the following information because it may be of interest or useful to you. Lovelace Insurance Company does not own, control, or influence these sites, and are not responsible for their content.

NM Public Regulation Commission

Insurance Fraud Bureau (IFB) P. O. Box 1269 Santa Fe, NM 87504-1269
(505) 476-0560 Main Number
(505) 476-0479 Fax Number
(877) 807-4010 Toll-free Number
You may email the Bureau at: stopfraud@state.nm.us

New Mexico Medical Assistance Division for Medicaid Fraud

Telephone: toll-free 1-888-997-2583

Centers for Medicare and Medicaid Services (CMS)

Office of the Inspector General (OIG)
National Fraud HotlineTelephone: 1-800-447-8477

The United States Office of Personnel Management (OPM)

Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400 Washington, DC 20415-0001
Telephone: 202-418-3300

SECTION 9 – APPEAL AND GRIEVANCE PROCEDURE

The UNM Medical Plan Appeal and Grievance process is overseen by the Lovelace Insurance Company Appeals and Grievance Department. Its purpose is to resolve issues from Participants who disagree with Plan decisions to deny a service for coverage or lack of Medical Necessity, called an Adverse Determination. You may disagree with the Plan administrative practices, called an administrative grievance. That is, those decisions that appear to affect the availability, delivery or quality of health care services, including but not limited to claims payment, termination of coverage, and quality of care or service. Lovelace will provide you a written copy of the Plan's appeal and grievance process upon request. Lovelace or the Plan will never retaliate against a Participant in any way for filing a Grievance or Appeal. For the purposes of this section, any reference to "you", "your", or "Participant" also refers to a representative or Provider designated by you to act on your behalf, unless otherwise noted.

The UNM Medical Plan requires Participants to exhaust all administrative remedies before seeking other relief.

When You Have a Concern or Complaint

The Plan has established a process for working to research and resolve your Concern or Complaint.

Start with the Lovelace Customer Care Center

Lovelace is there to listen and help. If you have a Concern regarding a person, a service, the quality of care, or contractual benefits, you can contact the Lovelace Customer Care Center in Albuquerque at 505.727.5381 or toll-free outside of Albuquerque at 800.808.7363 (TTY Services provided by Relay New Mexico 711). One of the Lovelace Customer Care Center representatives can assist you and address your Concern.

A Lovelace Customer Care Center representative will make every effort to resolve the Concern or Complaint to a Participant's satisfaction the first time it is brought to their 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 the Lovelace Customer Care Representatives by phone, you can also express your Concerns by walk-in interview or arranged appointment at the following address:

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

Or you may submit your Concerns in writing to:

Lovelace Health Plan
P.O. Box 27107
Attn: Appeals and Grievance Department
Albuquerque, NM 87125-7107
Fax: 505.727.5307

SECTION 9 – APPEAL AND GRIEVANCE PROCEDURE

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.

Processing Your Complaint

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

Appeals

Lovelace will administer Level I and Level II appeals on behalf of UNM according to the procedures set forth below. Lovelace is administering such appeals process on behalf of UNM, and in all cases the final authority to make decisions regarding appeals and grievances rests solely with UNM.

1. Level I Appeals

To initiate a Level I appeal, a Plan Participant must submit a request for an appeal to Lovelace within one hundred eighty (180) days of receipt of a notice of denial of items or services under the Plan. The Participant must tell Lovelace the reason why the denial should be overturned and include any information supporting the appeal. Lovelace will acknowledge to the Participant in writing within one (1) working day that it has received a request for an Appeal. The acknowledgement letter will contain the name, address, and direct telephone number of an individual at Lovelace who may be contacted regarding the appeal.

a. Timeframes for Processing Appeals of Adverse Determinations

Level I 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 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 Lovelace can: 1) show reasonable cause beyond Lovelace's control for the delay; 2) can show that the delay will not result in increased medical risk to the Participant; and 3) provide a written progress report to the Participant and the related provider within the thirty (30) or sixty (60) days review period. Participants must agree, in writing, to a request to extend a deadline.

Some appeals of pre-service denials are processed on an expedited basis. Expedited decisions are made when a Participant's life or health, or ability to regain maximum function, would be jeopardized by following the standard appeal process and time frames. In cases that require an expedited decision of a pre-service request, based at the request of a participating provider, a decision will be made within seventy-two (72) hours of the request. Lovelace will not conduct expedited appeals for services already provided ("post service") to a Participant. If a Participant requests an expedited decision, a Lovelace 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, the applicable provider and the Participant by the quickest means possible. If the medical director determines that a request for an expedited appeal is not medically necessary, Lovelace will notify the applicable Participant and then process the appeal within the standard (20) working days.

b. Internal Review of Appeal of Adverse Determination by Medical Director Level I

The appeal will be reviewed by a Lovelace medical director not involved in the initial determination. The medical director will re-review the request to make a determination regarding whether the requested health care services are medically necessary and covered under the Plan.

c. Notice of Decision on Appeal of Adverse Determination by Medical Director

If the medical director decides to reverse an initial adverse determination, Lovelace will approve coverage of the services. The applicable Participant and the applicable provider will be notified by mail or electronic means (fax, e-mail, etc.) within two (2) working days of such decision.

If the medical director decides to uphold an initial adverse determination, the applicable Participant and the applicable 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. The Participant will be given the choice of whether or not to pursue a Level II appeal. If the Participant does not wish to pursue the appeal, Lovelace will mail to the Participant written notification of the decision and confirmation of the Participant's decision not to pursue the appeal within three (3) working days of the medical director's decision.

If Lovelace is unable to contact the Participant by telephone within seventy-two (72) hours after making the decision to uphold the initial adverse determination, then Lovelace will notify the Participant by mail of the decision. Included in the notification will be a self-addressed stamped response letter which asks whether the Participant wants to pursue the Level II appeal by asking the Participant to check "yes" or "no" on the letter. If the Participant does not return the letter within ten (10) working days, Lovelace will again try to contact the Participant by telephone. If the Participant does not respond to Lovelace's telephone calls and does not return the response letter within twenty (20) working days of the written notification to uphold the initial decision, Lovelace will close the file, documenting that the Participant has not responded.

If the appeal was processed on an expedited basis, then a Level II appeal will automatically proceed. This review will be completed within seventy-two (72) hours. If an expedited review is conducted during a Participant's stay or course of treatment, coverage for health care services will be continued subject to applicable co-payments and deductibles until Lovelace makes a decision and notifies the Participant. If the Participant does not make an immediate decision to pursue a Level II appeal, or if the Participant requests additional time to supply supporting documents or information, the timeframes described above for completing an appeal will be extended to include the additional time the Participant needs.

2. Internal Panel Review of Adverse Determination - Level II

If the Participant requests a Level II appeal, then Lovelace will conduct the appeal on behalf of Employer according the process set forth below.

a. Internal Panel Review Committee

An internal panel review committee will consider the appeal. The internal panel review committee will consist of Lovelace staff and one (1) or more health care or other professionals. At least one (1) of the health care professionals will practice in a specialty that would typically manage the case that is the subject under appeal or be mutually agreed upon by the Participant and Lovelace. 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.

b. Notice of Internal Panel Review Hearing

Lovelace will notify the Participant in writing of the date, time, and place of the internal panel review hearing. The notice will also advise the Participant of the Participant's appeal rights. Such rights include: attending and participating in the internal panel review; presenting a 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; asking questions of the health care professionals on the internal panel review committee; and being assisted or represented by a person of the Participant's choice, including legal representation. A Participant may hire a specialist to participate in the internal panel review at the Participant's own expense. This specialist may not participate in making the decision.

If the Participant chooses to have legal representation at the hearing, the Participant must notify Lovelace prior to the hearing. Failure to notify may require rescheduling of the hearing within the timeframe allowed to complete the appeal. If Lovelace or UNM has an attorney present to protect its interests, a notice will advise the Participant of that and advising that the Participant may wish to obtain legal representation of his or her own. Lovelace will notify the Participant of this at least three (3) working days before the hearing.

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

c. Timeframes for Internal Panel Review Committee

No fewer than three (3) working days prior to the internal panel review, Lovelace will provide the Participant with: pertinent records; treating provider's recommendation; the PBB; a copy of the notice of the adverse determination; uniform standards relevant to the Participant's medical condition used by the internal panel in reviewing the adverse determinations; information provided to or received by any medical consultants retained by Lovelace; all other evidence or documentation relevant to reviewing the adverse determination. The internal panel review committee will complete its review for expedited cases within seventy-two (72) hours of receipt of the request if the Participant's life or

health would be jeopardized or the Participant's ability to retain maximum function would be jeopardized by a delay. The internal panel review committee will complete its review of a standard appeal within timeframes previously noted days. Lovelace will notify the Participant and the treating provider of UNM'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.

d. 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; an explanation of the clinical or other rationale for the 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 decision regarding coverage of the requested service. For medical necessity determinations, it will include the uniform standards relevant to the Participant's medical condition and an explanation whether each supported or did not support the 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 the Participant's right to request an external review by UNM. 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.

3. Level III – Binding Arbitration

Any controversy or claim made on or after July 1, 2009 arising from or relating to a claim for benefits payable by this plan, or any administrative grievance, which is not resolved after Level II internal review shall be settled by arbitration administered by the American Arbitration Association under its Employee Benefit Plan Claims Arbitration Rules, incorporated by reference herein. The decision of the arbitrator shall be final and binding and judgment on the award may be entered in any court having jurisdiction.

An administrative grievance is any grievance asserting dissatisfaction with any aspect of the health benefit plan, other than a request for health care services, including but not limited to: administrative practices that affect the availability, delivery or quality of health care services, claims payment, handling or reimbursement for health care services; and, termination of coverage.

Notwithstanding anything set forth in the American Arbitration Association's Employee Benefit Plan Claims Arbitration Rules the dispute shall be heard and determined by one neutral arbitrator; and, the arbitrator shall not reallocate the filing fee or award attorney fees in favor of the Plan.

A copy of the American Arbitration Association's Employee Benefit Plan Claims Arbitration Rules may be found at: http://www.adr.org/sp.asp?id=22076

Grievances

Participants may file a grievance they are dissatisfied with any aspect of their health benefits plan, other than a request for health care services, including, but not limited to: administrative practices that affect the availability, delivery or quality of health care services; claims payment, handling or reimbursement for health care services; and terminations of coverage. If the Participant is unable to

resolve the grievance with a customer service representative, the Participant may file a formal grievance by notifying a customer service representative.

1. Initial Internal Review - Level I

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

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

Lovelace's response letter to the Participant 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 grievance and pertinent facts; a clear and complete explanation of the reason for the response/decision; the Plan provisions relied on in reaching the response; a statement that the initial decision will be binding unless the Participant submits 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.

2. Reconsideration of Internal Review – Level II

If the Participant is not satisfied with the outcome of the initial review, Lovelace will appoint a reconsideration committee consisting of Lovelace representatives who have not participated in the initial internal review, to review the grievance. The Participant must request this committee hearing within twenty (20) days after receiving the response letter, or the initial review decision will be final.

a. Reconsideration Committee

Upon receipt of a request for a reconsideration committee hearing, Lovelace will schedule and hold a hearing within fifteen (15) working days. The hearing will be held during regular business hours at a location reasonably accessible to the Participant. The Participant will have the opportunity to participate at the committee meeting in person, by conference call, video conferencing or other technology, at Lovelace's expense. Lovelace will not unreasonably deny a request for postponement of the hearing. Postponement requests must be made in writing.

b. Reconsideration Committee Hearing

Lovelace will notify the Participant 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 the Participant of his or her rights: to attend the hearing; to present a case to the committee; to submit supporting material both before and at the hearing; to ask question of any representative of

Lovelace; and be assisted or represented by a person of the Participant's choice that may or may not be a legal representation. If Lovelace will have an attorney to represent its interests; the notice will advise the Participant of this and that the Participant may wish to obtain legal representation of his or her own. If the Participant chooses to have legal representation at the hearing, the Participant must notify the grievance department representative prior to the hearing. Failure to notify may require rescheduling of the hearing within the timeframe allowed for administrative grievances. No fewer than three (3) working days prior to the hearing, Lovelace will provide the Participant with all the documents and information that the reconsideration committee will rely on in reviewing the grievance.

c. Decision of Reconsideration Committee

Lovelace will mail a written decision to the Participant 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 decision; the 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 Participant submits a request for external review by UNM; and a description of the procedures and deadlines for requesting external review by UNM, including any necessary forms.

3. Level III – Binding Arbitration

Any controversy or claim made on or after July 1, 2009 arising from or relating to a claim for benefits payable by this plan, or any administrative grievance, which is not resolved after Level II internal review shall be settled by arbitration administered by the American Arbitration Association under its Employee Benefit Plan Claims Arbitration Rules, incorporated by reference herein. The decision of the arbitrator shall be final and binding and judgment on the award may be entered in any court having jurisdiction.

An administrative grievance is any grievance asserting dissatisfaction with any aspect of the health benefit plan, other than a request for health care services, including but not limited to: administrative practices that affect the availability, delivery or quality of health care services, claims payment, handling or reimbursement for health care services; and, termination of coverage.

Notwithstanding anything set forth in the American Arbitration Association's Employee Benefit Plan Claims Arbitration Rules the dispute shall be heard and determined by one neutral arbitrator; and, the arbitrator shall not reallocate the filing fee or award attorney fees in favor of the Plan.
A copy of the American Arbitration Association's Employee Benefit Plan Claims Arbitration Rules may be found at: http://www.adr.org/sp.asp?id=22076

Retaliatory Action

Neither Lovelace Insurance Company nor the University of New Mexico shall take any retaliatory action against you for filing a Grievance under this health benefits plan.

SECTION 10 – TERMINATION

Termination guidelines for this Plan are determined by the University of New Mexico Human Resources Department. Lovelace Insurance Company administers termination activities based upon the guidelines and requirements provided. Contact your University of New Mexico Benefits Office for details about termination guidelines.

HOW COVERAGE STOPS

Coverage under this Plan terminates on the last day of the earliest of:

- The period for which premiums are paid;
- On the date when eligibility ceases; or
- When this Plan ends.

HOW TO DISENROLL DEPENDENTS

When you lose a Dependent through marriage, death, divorce, annulment, or legal separation, or a Dependent is ineligible due to age, please submit an Application to dis-enroll the Dependent from your coverage. Contact your UNM Human Resources representative for the necessary forms.

CERTIFICATE OF COVERAGE

If your coverage is terminated, the Claim Administrator provides evidence of your prior health coverage by supplying you with a Certificate of Coverage. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for a preexisting condition or if you want to buy, for you or your family, an individual insurance policy.

SECTION 11 – PROTECTING YOUR CONFIDENTIALITY

The UNM Regents, as the sponsor of the Plan, and Lovelace Insurance Company, as the Plan Administrator of that Plan are committed to maintaining the confidentiality of your personal and sensitive information. You and your family members trust the Plan to collect and maintain the information it needs to administer your benefits in a way that protects your privacy. In addition, Lovelace and the Plan are subject to state and federal laws regarding confidentiality. That's why Lovelace and the Plan have policies and safeguards in place to protect the confidentiality and security of your personal information.

To help you better understand how the UNM Regents, the Plan, and Lovelace protect your confidentiality when administering your UNM Medical Plan, we're providing you with answers to some common questions about Lovelace's confidentiality policies.

What Types of Information do the UNM Regents and Lovelace receive?

Lovelace, acting on behalf of the UNM Regents, receives information needed to administer your Plan, including information from Participants who apply for coverage or who submit a claim, and information from medical providers and your employer, UNM.

How does Lovelace Protect Confidential Information?

Lovelace Insurance Company's employees and organizations that act on behalf of Lovelace Insurance Company, and as a business associate of UNM, are required to keep Plan Participants' personal information confidential. Here's what Lovelace is doing to help ensure the policy is followed:

- Lovelace has established a HIPAA Privacy Office, which is responsible for monitoring Lovelace's compliance with the UNM Regents' confidentiality and HIPAA compliance policies with respect to the UNM Medical Plan, and for educating the organization on this important topic.
- Whenever possible, Lovelace provides only aggregate information that doesn't identify any individual. If Lovelace needs to share individually identifiable information, they have policies that protect confidentiality.
- The Lovelace employees may not disclose information to other employees except when it is needed to conduct UNM Medical Plan business.
- The UNM Regents and the UNM Medical Plan require a written agreement from companies and organizations, including Lovelace Insurance Company, who receive confidential information from them. These companies and organizations agree that they will use any individually identifiable information only to administer the benefits Plan in accordance with applicable laws.
- Consistent with the UNM Regents' Notice of Privacy Practices for the UNM Medical Plan as described in Section 12 of this Booklet, sometimes Lovelace requires a Participant's written authorization before Lovelace discloses confidential information. For example, a request from a research organization or from a Participant's attorney would require an authorization signed by the Participant. 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 Participant's parent or legal guardian.
- Lovelace protects the confidentiality of information for former Participants, just as they do for current Participants.

SECTION 11 – PROTECTING YOUR CONFIDENTIALITY

Lovelace Insurance Company has also taken the following steps to make sure Lovelace facilities have policies to protect confidential information:

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

What Types of Information Does Lovelace Insurance Company Disclose And To Whom?

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

- Medical Providers; Plan sponsors and insurers that provide reinsurance or excess (stop loss) insurance to UNM;
- Lovelace Insurance Company affiliated companies such as contracted entities providing medical services for Lovelace Insurance Company Participants;
- 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 the Plan with a subpoena;
- New insurers or claim administrators who assume responsibility for administering the benefit Plan;
- Companies that assist Lovelace Insurance Company in recovering overpayments;
- Companies that pay claims or perform Utilization Review services for Lovelace Insurance Company;
- Companies that assist Lovelace Insurance Company in recovering benefits that were paid for claims incurred as a result of third-party negligence, and companies not affiliated with Lovelace Insurance Company that perform other services for Lovelace Insurance Company.

How Can Participants Access Their Confidential Information?

All Participants 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. Consistent with the UNM Regents' Notice of Privacy Practices with respect to the UNM Medical Plan described in Section 12 of this Booklet, Lovelace Insurance Company strives to make sure that information is accurate and complete. If a Participant finds an error and wishes to correct it, he or she should contact the Provider who created the record, Lovelace Insurance Company will correct any mistakes if either the UNM Regents or Lovelace Insurance Company created the information or if the person or entity that originally created the information is no longer available to make the amendment.

You may request amendments of your PHI by completing the appropriate form available from the University's Privacy Officer and sending it to the University's Privacy Officer at the address shown in Section 12 of this Booklet. Be sure to include evidence to support your request because we cannot amend PHI that we believe to be accurate and complete.

How Does Lovelace Let Participants Know About the UNM Regents' and Lovelace's Respective Confidentiality Policies?

Often, Participants are informed about the UNM Regents' and Lovelace's respective confidentiality policies and practices for the UNM Medical Plan during enrollment.

Conditions of Disclosure for Plan Administration Purposes

The UNM Regents agree that with respect to any Protected Health Information (PHI) (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Plan, Designated UNM Representatives (as described below) shall:

a. Not use or further disclose PHI other than as permitted or required by the Plan or as Required by Law;

b. Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to UNM with respect to PHI;

c. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of UNM, except pursuant to an authorization which meets the requirements of the Privacy Standards;

d. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

e. Make available PHI to comply with HIPAA's right to access in accordance with 45 CFR § 164.524;

f. Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526;

g. Make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;

h. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services (DHHS) for purposes of determining compliance by the Plan with HIPAA's privacy requirements;

i. If feasible, return or destroy all PHI received from the Plan that Designated UNM Representatives still maintain in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

j. Ensure that the adequate separation between Plan and Designated UNM Representatives (i.e., the firewall), required in 45 CFR § 164.504(f)(2)(iii), is satisfied.

UNM further agrees that if it creates, receives, maintains, or transmits any electronic PHI (ePHI) (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the UNM Medical Plan, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI,

and it will ensure that any agents (including subcontractors) to whom it provides such ePHI agree to implement reasonable and appropriate security measures to protect the information. UNM will report to the Plan any security incident of which it becomes aware.

Adequate Separation Between the UNM Medical Plan and UNM

Designated UNM Representatives in the following employee classifications will be allowed access to PHI:

- Plan Administrator, the University's Vice President of Human Resources,
- Benefits Office employees,
- Privacy Officer and/or any Privacy Officer designee,
- ITS Department employees that provide technical support for the UNM Medical Plan participant database and networks, and
- Office of University Counsel employees for the provision of legal advice and representation as to any matter or issue regarding the UNM Medical Plan or participant in the UNM Medical Plan.

No other persons shall have access to PHI. These Designated UNM Representatives shall only have access to and use PHI to the extent necessary to perform the plan administration functions.

UNM will ensure that the provisions of this paragraph are supported by reasonable and appropriate security measures to the extent that the designees have access to ePHI.

Certification of UNM

The UNM Medical Plan (or health insurance issuer with respect to the Plan) shall disclose PHI to Designated UNM Representatives only upon receipt of a certification by UNM that the UNM Medical Plan has been amended to incorporate the provisions of 45 CFR 164.504(f)(2)(ii), and that UNM agrees to the conditions of disclosure set forth above.

SECTION 12 – NOTICE OF PRIVACY PRACTICES

The following is UNM's Notice of Privacy Practices.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
Effective Date: July 1, 2009
UNIVERSITY OF NEW MEXICO HEALTH PLANS

NOTICE OF PRIVACY PRACTICES

General Information About This Notice

The University of New Mexico ("UNM") continues its commitment to maintaining the confidentiality of your private medical information. This Notice describes our efforts to safeguard your health information from improper or unnecessary use or disclosure. This Notice only applies to health-related information received by or on behalf of the Health Plans listed below. A federal law, known as HIPAA, requires us to provide you with a summary of the Health Plans' privacy practices and related legal duties, and your rights in connection with the use and disclosure of your Health Plan information.

This Notice applies to UNM employees, former employees, and dependents (but does not apply to UNM Hospital employees) who may participate in any of the following benefit programs offered by UNM (collectively referred to in this Notice as the "Health Plans"):

- **Medical benefits** under the UNM Medical Plan (administered by Presbyterian Health Plan or Lovelace Health Plan depending on your election)
- **Dental benefits** under the Delta Dental Plan
- **Prescription drug benefits** under the Express Scripts Pharmacy Benefit Management Program
- **Healthcare FSA benefits** under the UNM Flexible Spending Account program (administered by Stanley, Hunt, Dupree & Rhine)

In this Notice, the terms "we," "us," and "our" refer to the Health Plans, all UNM employees involved in the administration of the Health Plans, and all third parties who perform services for the Health Plans. Actions by or obligations of the Health Plans include these UNM employees and third parties. However, UNM employees perform only limited Health Plan functions – most Health Plan administrative functions are performed by third party service providers.

CONTACT INFORMATION

If you have any questions regarding this Notice, please contact:

Benefits and Employee Services
University of New Mexico
1 University of New Mexico
MSC01 1220
Albuquerque, NM 87131
(505) 277-MYHR (6947)

Privacy Officer
University of New Mexico
1 University of New Mexico
MSC08 4760
Albuquerque, NM 87131
(505) 272-1493

What is Protected?

Federal law requires the Health Plans to have a special policy for safeguarding a category of medical information called "protected health information," or "PHI," received or created in the course of administering the Health Plans. PHI is health information that can be used to identify you and that relates to:

- your physical or mental health condition,
- health care services provided to you, or
- payment for your health care.

Your medical and dental records, your claims for medical and dental benefits, and the explanation of benefits ("EOBs") sent in connection with payment of your claims are all examples of PHI.

If UNM obtains your health information in another way – for example, if you are hurt in a work accident or if you provide medical records with your request for leave under the Family and Medical Leave Act ("FMLA") – then UNM will safeguard that information in accordance with other applicable laws and UNM policies. Similarly, health information obtained by a non-health-related benefits program, such as the long-term disability program is not protected under this Notice. This Notice does not apply in those types of situations because the health information is not received or created in connection with a Health Plan.

The remainder of this Notice generally describes our rules with respect to your PHI received or created by the Health Plans.

Uses and Disclosures of Your PHI

To protect the privacy of your PHI, the Health Plans not only guard the physical security of your PHI, but also limit the way your PHI is used or disclosed to others. We may use or disclose your PHI in certain permissible ways described below. To the extent required under federal health information privacy law, we use the minimum amount of your PHI necessary to perform these tasks.

- To determine proper payment of your Health Plan benefit claims. The Health Plans use and disclose your PHI to reimburse you or your doctors or health care providers for covered treatments and services. For example, your diagnosis information may be used to determine whether a specific procedure is medically necessary or to reimburse your doctor for your medical care.

- For the administration and operation of the Health Plans. We use and disclose your PHI for numerous administrative and quality control functions necessary for the Health Plans' proper operation. For example, we may use your claims information for fraud and abuse detection activities or to conduct data analyses for benefit utilization.

- To inform you or your health care provider about treatment alternatives or other health-related benefits that may be offered under a Health Plan. For example, we may use your claims data to alert you to an available case management program if you become pregnant or are diagnosed with diabetes or liver failure.

- To a health care provider if needed for your treatment. For example, we may disclose your prescription information to a pharmacist regarding a drug interaction concern.

- To a non-UNM health plan to determine proper payment of your claim under the other plan. For example, we may exchange your PHI with your spouse's health plan for coordination of benefits purposes.

- To a health care provider or to a non-UNM health plan for certain administration and operations purposes. We may share your PHI with another health plan or health care provider who has a relationship with you for quality assessment and improvement activities, to review the qualifications of health care professionals who provide care to you, or for fraud and abuse detection and prevention purposes.

- To a family member, friend, or other person involved in your health care if you do not object, or it can reasonably be inferred that you do not object, to the sharing of your PHI, or, in the event of an emergency.

- To comply with an applicable federal, state, or local law, including workers' compensation or similar programs.

- For public health reasons, including (1) to a public health authority for the prevention or control of disease, injury or disability; (2) to a proper government or health authority to report child abuse or neglect; (3) to report reactions to medications or problems with products regulated by the Food and Drug Administration; (4) to notify individuals of recalls of medication or products they may be using; or (5) to notify a person who may have been exposed to a communicable disease or who may be at risk for contracting or spreading a disease or condition.

- To report a suspected case of abuse, neglect or domestic violence, as permitted or required by applicable law.

- To comply with health oversight activities, such as audits, investigations, inspections, licensure actions, and other government monitoring and activities related to health care provision or public benefits or services.

- To the U.S. Department of Health and Human Services to demonstrate our compliance with federal health information privacy law.

- To respond to an order of a court or administrative tribunal.

- To respond to a subpoena, warrant, summons or other legal request if sufficient safeguards, such as a protective order, are in place to maintain your PHI privacy.

- To a law enforcement official for a law enforcement purpose.

- For purposes of public safety or national security.

- To allow a coroner or medical examiner to identify you or determine your cause of death.

- To allow a funeral director to carry out his or her duties.

- To respond to a request by military command authorities if you are or were a member of the armed forces.

Certain UNM employees may access your PHI to perform administrative functions on behalf of the Health Plans. Absent your written permission, however, UNM employees will only use or disclose your PHI as described above. UNM employees will not access your PHI for reasons unrelated to Health Plan administration. UNM will not use your PHI for any employment-related reason without your express written authorization.

State law may further limit the permissible ways the Health Plans use or disclose your PHI. If an applicable state law imposes stricter restrictions on the Health Plans, we will comply with that state law.

Other Uses and Disclosures of Your PHI

Before we use or disclose your PHI for any other purpose, we must obtain your written authorization. You may revoke your authorization, in writing, at any time. If you revoke your authorization, the Health Plans will no longer use or disclose your PHI except as described above (or as permitted by any other authorizations that have not been revoked). However, please understand that we cannot retrieve any PHI disclosed to a third party in reliance on your prior authorization.

Your Rights

Federal law provides you with certain rights regarding your PHI. Parents of minor children and other individuals with legal authority to make health decisions for a Health Plan participant may exercise these rights on behalf of the participant, consistent with state law.

Right to request restrictions: You have the right to request a restriction or limitation on the Health Plans' use or disclosure of your PHI. For example, you may ask us to limit the scope of your PHI disclosures to a case manager who is assigned to you for monitoring a chronic condition. Because we use your PHI only as necessary to pay Health Plan benefits, to administer the Health Plans, and to comply with the law, it may not be possible to agree to your request. The law does not require the Health Plans to agree to your request for restriction. However, if we do agree to your requested restriction or limitation, we will honor the restriction until you agree to terminate the restriction or until we notify you that we are terminating the restriction on a going-forward basis.

Restriction request forms are available from the University's Privacy Officer. You may make a request for restriction on the use and disclosure of your PHI to the University's Privacy Officer. Contact information for the University's Privacy Officer is listed on the front of this Notice. When making such a request, you must specify: (1) the PHI you want to limit; (2) how you want the Health Plans to limit the use and/or disclosure of that PHI; and (3) to whom you want the restrictions to apply.

Right to receive confidential communications: You have the right to request that the Health Plans communicate with you about your PHI at an alternative address or by alternative means if you believe that communication through normal business practices could endanger you. For example, you may request that the Health Plans contact you only at work and not at home.
You may request confidential communication of your PHI by completing an appropriate form available from the University's Benefits & Employee Services Department, UNM Human Resources Division (the "Benefits Department"). You should send your written request for confidential communication to the Benefits Department at the address listed on the front of this Notice. We will honor all reasonable requests. You must make sure your request specifies how or where you wish to be contacted.

Right to inspect and copy your PHI: You have the right to inspect and copy your PHI contained in records that the Health Plans maintain for enrollment, payment, claims determination, or case or medical management activities, or that we use to make enrollment, coverage, or payment decisions about you.

However, we will not give you access to PHI records created in anticipation of a civil, criminal, or administrative action or proceeding. We will also deny your request to inspect and copy your PHI if a licensed health care professional hired by the Health Plans has determined that giving you the requested access is reasonably likely to endanger the life or physical safety of you or another individual or to cause substantial harm to you or another individual, or that the record makes references to another person (other than a health care provider), and that the requested access would likely cause substantial harm to the other person.

In the unlikely event that your request to inspect or copy your PHI is denied, you may have that decision reviewed. A different licensed health care professional chosen by the Health Plans will review the request and denial, and we will comply with the health care professional's decision.

You may make a request to inspect or copy your PHI by completing the appropriate form available from the Benefits Department and sending it to the Benefits Department at the address listed on the front of this Notice. We may charge you a fee to cover the costs of copying, mailing or other supplies directly associated with your request. You will be notified of any costs before you incur any expenses.

Right to amend your PHI: You have the right to request an amendment of your PHI if you believe the information the Health Plans have about you is incorrect or incomplete. You have this right as long as your PHI is maintained by the Health Plans. We have contracted with third party administrators for the health benefits identified on Page 1 of this Notice. These third party administrators will correct any mistakes if either we or they created the PHI or if the person or entity that originally created the PHI is no longer available to make the amendment.

You may request amendments of your PHI by completing the appropriate form available from the University's Privacy Officer and sending it to the University's Privacy Officer at the address listed on the front of this Notice. Be sure to include evidence to support your request because we cannot amend PHI that we believe to be accurate and complete.

Right to receive an accounting of disclosures of PHI: You have the right to request a list of certain disclosures of your PHI by the Health Plans. The accounting will not include (1) disclosures necessary to determine proper payment of benefits or to operate the Health Plans, (2) disclosures we make to you, (3) disclosures permitted by your authorization, (4) disclosures to friends or family members made in your presence or because of an emergency, or (5) disclosures for national security purposes. Your first request for an accounting within a 12-month period will be free. We may charge you for costs associated with providing you additional accountings. We will notify you of the costs involved, and you may choose to withdraw or modify your request before you incur any expenses.

Accounting request forms are available from the University's Privacy Officer and you may request such an accounting of disclosures from the University's Privacy Officer at the address listed on the front of this Notice. When making your request, you must specify the time period for the accounting, which may not be longer than six years and may not include dates prior to April 14, 2003, and the form (e.g., electronic, paper) in which you would like the accounting.

Right to file a complaint: If you believe your rights have been violated, you should let us know immediately. We will take steps to remedy any violations of the Health Plans' privacy policy or of this Notice.

SECTION 12 – NOTICE OF PRIVACY PRACTICES

You may file a formal complaint with our Privacy Officer and/or with the United States Department of Health and Human Services at the addresses below. You should attach any documents or evidence that supports your belief that your privacy rights have been violated. We take your complaints very seriously. **UNM prohibits retaliation against any person for filing such a complaint.**

Complaints should be sent to:

University of New Mexico
Privacy Officer
1 University of New Mexico
MSC 08 4760
Albuquerque, New Mexico 87131-0001
Phone: (505) 272- 1493
Fax: (505) 272-2461
TDD: (505) 272-2111

Region VI (New Mexico), Office for Civil Rights, U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, Texas 75202
Phone: (214) 767-4056
Fax: (214) 767-0432
TDD: (214) 767-8940
www.hhs.gov/ocr/hipaa/

Additional Information About This Notice

Changes to this Notice: We reserve the right to change the Health Plans' privacy practices as described in this Notice. Any change may affect the use and disclosure of your PHI already maintained by the Health Plans, as well as any of your PHI that the Health Plans may receive or create in the future. If there is a material change to the terms of this Notice, you will receive a revised Notice.

How to obtain a copy of this Notice: You can obtain a copy of the current Notice by writing to the Benefits Department at the address listed on the front of this Notice.

No guarantee of employment: This Notice does not create any right to employment for any individual, nor does it change UNM's right to discharge any of its employees at any time, with or without cause, or as provided by the terms of any applicable collective bargaining agreement.

No change to Health Plan benefits: This Notice explains your privacy rights as a current, former, or potential participant in the UNM Health Plans. The Health Plans are bound by the terms of this Notice as they relate to the privacy of your protected health information. However, this Notice does not change any other rights or obligations you may have under the Health Plans. You should refer to the Health Plan documents for additional information regarding your Health Plan benefits.

NOTICE OF CONFIDENTIALITY OF DOMESTIC ABUSE INFORMATION

There is a state confidentiality statue that protects UNM Custom Care participant's confidential abuse information. State statute NMSA 59A-16B-1, ET. SEQ. and state regulation 13.7.5 NMAC protects participant's confidential information should they have been involved in domestic abuse.

In processing your application for insurance or a claim for insurance benefits, UNM Custom Care Plan or Lovelace Insurance Company/Lovelace may receive confidential domestic abuse information from sources other than you. If this were the case UNM Custom Care Plan and Lovelace is 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 participant you have a right to access and correct all confidential domestic abuse information that Lovelace may have about you. A full or more comprehensive notice and explanation of confidential domestic abuse information practices as required by the NMAC 13. 7.5.8 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 contract Lovelace Customer Care Center, 727-5381 or 1-800- 808-7363.

SECTION 13 – GLOSSARY OF TERMS

ACCIDENTAL INJURY means a bodily injury caused solely by external, traumatic, and unforeseen means. Accidental Injury does not include disease or infection, hernia, or cerebral vascular accident. Dental injury caused by chewing, biting, or malocclusion is not considered an Accidental Injury.

ACUPUNCTURE means the use of needles inserted into and removed from the body and the use of other devices, modalities and procedures at specific locations on the body for the prevention, cure or correction of any disease, illness, injury, pain or other condition by controlling and regulating the flow and balance of energy and functioning of the person to restore and maintain health.

ADMISSION means the period of time between the date a patient enters a Hospital or other facility as an Inpatient and the date he/she is discharged as an Inpatient. The date of Admission is the date of service for the hospitalization and all related services.

ALCOHOLISM means alcohol dependence or alcohol abuse meeting the criteria as stated in the Diagnostic and Statistical Manual IV for these disorders.

AMBULANCE SERVICE means a duly licensed transportation service, capable of providing Medically Necessary life support care in the event of a life-threatening situation.

AMBULATORY SURGICAL FACILITY means an appropriately licensed Provider, with an organized staff of Physicians that meets all of the following criteria: Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis; Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility; Does not provide Inpatient accommodations; and Is not a facility used primarily as an office or clinic for the private practice of a Physician or other professional Provider.

APPLICATION means the form that an employee is required to complete when enrolling for Lovelace Insurance Company coverage.

ATTENDING PHYSICIAN means the doctor who is responsible for the patient's Hospital treatment or who is charged with the patient's overall care and who is responsible for directing the treatment program. A consulting Physician is not the Attending Physician. A Physician employed by the Hospital is not ordinarily the Attending Physician.

BEHAVIORAL HEALTH DISORDER means any disorder, other than a disorder induced by alcohol or drug use that impairs the behavior, emotional reaction, or thought process of a person, regardless of medical origin.

BEHAVIORAL HEALTH SERVICES means the services that are required to treat a disorder that impairs the behavior, emotional reaction, or thought process of a person, regardless of medical origin. In determining benefits payable, charges made for the physiological symptoms related to Behavioral Health Disorder are not considered to be charges made for the treatments of a Behavioral Health Disorder.

BENEFIT CERTIFICATION means the process whereby Lovelace Insurance Company or Lovelace Insurance Company's delegated Provider contractor reviews and approves, in advance, the provision of certain Covered Services to Participants before those services are rendered. If a required Benefit Certification is not obtained for services rendered by an Out-of-Network Provider, the Participant may be responsible for the resulting charges. Benefit Certification is used in the management of health care needs; Services rendered beyond the scope of the Benefit Certification may not be covered.

SECTION 13 – GLOSSARY OF TERMS

BIRTHING CENTER means an alternative birthing facility licensed under state law, with care primarily provided by a Certified Nurse Midwife.

CALENDAR YEAR means the period beginning January 1 and ending December 31 of the s same year.

CERTIFIED NURSE MIDWIFE means a licensed Registered Nurse, certified by the American College of Nurse Midwives to administer Maternity care within the scope of the license.

CHIROPRACTOR means a person who is a Doctor of Chiropractic licensed by the appropriate governmental agency to practice chiropractic medicine.

CO-INSURANCE means the amount, expressed as a percentage, of a covered health care expense that is partially paid by the Plan and partially the Participant's responsibility to pay. The cost-sharing responsibility ends for most Covered Services in a particular Contract Year when the Out-of-Pocket Maximum has been reached.

CONGENITAL ANOMALY means any condition from birth significantly different from the common form, for example, a cleft palate or certain heart defects.

CONTRACT YEAR means the period beginning July 1 and ending June 30 of the following year.

CONTRACT YEAR OUT-OF-POCKET MAXIMUM means a specified dollar amount of Covered Services received during a Contract Year that is the Participant's responsibility. This amount includes Co-payments, (except Pharmacy Co-payments), Co-insurance and Deductible.

CO-PAY/CO-PAYMENT means the amount, expressed as a fixed-dollar figure required to be paid by a Participant in connection with Health care Services. Benefits payable by the Plan are reduced by the amount of the required Co-payment for the covered service.

COSMETIC SURGERY means Surgery that is performed to reshape normal structures of the body in order to improve appearance and self-esteem.

COVERED SERVICES means services or supplies specified in this PBB, including any supplements, endorsements, addenda, or riders, for which benefits are provided, subject to the terms, conditions, limitations, and exclusions of this PBB.

CUSTODIAL CARE means care provided primarily for maintenance of the patient and designed essentially to assist in meeting the patient's daily activities. It is not provided for its therapeutic value in the treatment of an illness, disease, Accidental Injury, or condition. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, eating, preparation of special diets, and supervision over self-administration of medication not requiring the constant attention of trained medical personnel.

CUSTOM-FABRICATED ORTHOSIS means an Orthosis which is individually made for a specific patient starting with the basic materials including, but not limited to, plastic, metal, leather, or cloth in the form of sheets, bars, etc. It involves substantial work such as cutting, bending, molding, sewing, etc. it may involve the incorporation of some prefabricated components. It involves more than trimming, bending, or making other modifications to a substantially prefabricated item.

SECTION 13 – GLOSSARY OF TERMS

DENTIST means a Doctor of Dental Surgery (DDS) or Doctor of Medical Dentistry (DMA) who is licensed to practice prevention, diagnosis, and treatment of diseases, Accidental Injuries, and malformation of the teeth, mouth, and jaws.

DEPENDENT means any Participant of a covered employee's family who meets the requirements of Section 2 of this PBB and is actually enrolled in the Plan.

DIAGNOSTIC SERVICES means procedures ordered by a Physician or other professional Provider to determine a definite condition or disease.

DURABLE MEDICAL EQUIPMENT means equipment prescribed by a Physician that is Medically Necessary for the treatment of an illness or Accidental Injury, or to prevent the patient's further deterioration. This equipment is designed for repeated use, generally not useful in the absence of illness or Accidental Injury, and includes items such as oxygen equipment, wheelchairs, Hospital beds, crutches, and other medical equipment.

EMERGENCY MEDICAL CONDITION means 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 your health, if pregnant the health of you or your unborn child; 2) Serious impairment to the bodily functions; or 3) Serious dysfunction of any bodily organ or part.

EXPERIMENTAL/INVESTIGATIONAL means any treatment, procedure, facility, equipment, drug, device, or supply not accepted as standard medical practice in the state services are provided. In addition, if a federal or other governmental agency approval is required for use of any items and such approval was not granted at the time services were administered, the service is Experimental. To be considered standard medical practice and not Experimental or Investigational, treatment must meet all five of the following criteria: A technology must have final approval from the appropriate regulatory government bodies; The scientific evidence as published in peer-reviewed literature must permit conclusions concerning the effect of the technology on health outcomes; The technology must improve the net health outcome; The technology must be as beneficial as any established alternatives; and The improvement must be attainable outside the Investigational settings.

FAMILY COVERAGE means coverage for the employee, the employee's spouse, and/or the employee's Dependent children.

FREESTANDING DIALYSIS FACILITY means a Provider primarily engaged in providing dialysis treatment, maintenance, or training to patients on an Outpatient or home basis.

GENETIC INBORN ERRORS OF METABOLISM (IEM) means a rare, inherited disorder that is present at birth and results in death or behavioral/mental retardation if untreated and requires consumption of Special Medical Foods. Categories of IEMs are as follows: disorders of protein metabolism (i.e. amino acidopathies such as PKU, organic acidopathies, and urea cycle defects); disorders of carbohydrate metabolism (i.e. carbohydrate intolerance disorders, glycogen storage disorders, disorders of gluconeogenesis and glycogenolysis); or disorders of fat metabolism.

SECTION 13 – GLOSSARY OF TERMS

GRIEVANCE means an oral or written complaint submitted by or on behalf of a covered person regarding the: availability, delivery or quality of Health care Services; administrative practices of the health care insurer that affect the availability, delivery or quality of Health care Services; claims payment, handling or reimbursement for health care Services; or matters pertaining to any aspect of the health benefits Plan.

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.

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 behavioral health, including community-based behavioral health.

HIPAA means Health Insurance Portability and Accountability Act.

HOME HEALTH AGENCY means an appropriately licensed Provider that both: Brings skilled nursing and other services on an intermittent, visiting basis into the Participant's home in accordance with the licensing regulations for home health agencies in New Mexico or in the locality where the services are administered; and Is responsible for supervising the delivery of these services under a plan prescribed and approved in writing by the Attending Physician.

HOSPICE means a duly licensed program or facility providing care and support to terminally ill patients and their families.

HOSPITAL means a duly licensed Provider that is a short-term, acute, general Hospital that meets all of the following criteria: Is a duly licensed institution; For compensation from its patients, is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians; Has organized departments of medicine and major Surgery; Provides 24-hour nursing service by or under the supervision of Registered Nurses; Is not, other than incidentally, a skilled nursing facility, nursing home, Custodial Care home, health resort, spa, or sanitarium; and Is not a place for rest, for the aged, for the treatment of behavioral/mental illness, Admission, drug abuse, or pulmonary tuberculosis, and ordinarily does not provide Hospice or rehabilitation care, and is not a residential treatment facility.

IDENTIFICATION CARD or ID CARD means the card issued to the covered employee/participant enrolled under this Plan.

IMMUNOSUPPRESSIVE DRUGS (Inpatient only) means drugs used to inhibit the human immune system. Some of the reasons for using Immunosuppressive Drugs include but are not limited to: (1) preventing transplant rejection; (2) supplementing chemotherapy; (3) treating certain diseases of the immune system (i.e. "auto-immune" diseases); (4) reducing inflammation; (5) relieving certain symptoms; and (6) other times when it may be helpful to suppress the human immune response.

INDEPENDENT CLINICAL LABORATORY means a laboratory that performs clinical procedures under the supervision of a Physician and that is not affiliated or associated with a Hospital, Physician, or Other Provider.

IN-NETWORK PROVIDER means Physicians, Hospitals, and other Health care Professionals, facilities, and suppliers that have contracted with Lovelace Insurance Company as In-Network Providers.

SECTION 13 – GLOSSARY OF TERMS

INPATIENT means a Participant who has been admitted by a health care practitioner to a Hospital for occupancy for the purposes of receiving Hospital services. Eligible Inpatient Hospital services shall be those acute care services rendered to Participants who are registered bed patients, for which there is a room and board charge, and which are covered as defined in this Plan. Admissions are considered Inpatient based on Medical Necessity as identified in the Lovelace Insurance Company designated level of care criteria, regardless of the length of time spent in the Hospital.

INTENSIVE OUTPATIENT PROGRAM (IOP) means a level of care for the treatment of either a Substance Abuse or a Behavioral Health Disorder. The treatment is provided in a group setting, two to four times a week for two to three hours at a time for a specific number of weeks.

LICENSED ACUPUNCTURIST means an Acupuncture practitioner who is licensed by the appropriate state authority. Certification alone does not meet the licensure requirement.

LICENSED NAPRAPATHIC means a naprapathy practitioner who is licensed by the appropriate state authority. Certification alone does not meet the licensure requirement.

LICENSED PRACTICAL NURSE (LPN) means a nurse who has graduated from a formal practical nursing education program and is licensed by the appropriate state authority.

MAINTENANCE THERAPY means treatment that does not significantly enhance or increase the patient's function or productivity.

MATERNITY means any condition that is pregnancy related. Maternity care includes prenatal and postnatal care, and care for the complications of pregnancy, such as ectopic pregnancy, spontaneous abortion (miscarriage), elective abortion, or cesarean section.

MEDICAID means Title XIX of the Social Security Act and all amendments thereto.

MEDICAL CARE means professional services administered by a Physician or another professional Provider for the treatment of an illness or Accidental Injury.

MEDICAL EMERGENCY means an Accidental Injury or a condition that occurs suddenly and unexpectedly and is life threatening or could result in permanent damage if not treated immediately. To be eligible for possible emergency benefits, the Participant must seek treatment within 48 hours of the Accidental Injury or onset of the condition.

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 of good medical practice and practice guidelines developed by the federal government, national or professional medical societies, boards and associations, and 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 or Behavioral/Mental Health condition, illness, injury, or disease.

MEDICARE means the program of health care for the aged, end-stage renal disease (ESRD) beneficiaries, and disabilities established by Title XVIII of the Social Security Act of 1965, as amended.

MEDICARE SUPPLEMENTAL COVERAGE means health care coverage that provides supplemental benefits to Medicare coverage.

SECTION 13 – GLOSSARY OF TERMS

NEGOTIATED FEE SCHEDULE means the contracted amount that Lovelace Insurance Company agrees to pay to PCPs and In-Network Providers for Hospital, professional services, and other charges, and for which PCPs and In-Network Providers agree to accept as payment for services rendered to Participants.

OBSERVATION means those furnished by a Hospital and practitioner on the Hospital's premises, which may include the use of a bed and periodic monitoring by a Hospital's nursing staff, which are reasonable and necessary to evaluate an Outpatient's condition or determine the need for a possible Admission to the Hospital as an Inpatient, or where rapid improvement of the patient's condition is anticipated or occurs. When a Hospital places a patient under Outpatient Observation stay, it is on the practitioner's written order. If not formally admitted as an Inpatient, the patient initially is treated as an Outpatient. The Participant does not meet Inpatient Admission criteria as identified in the Lovelace Insurance Company designated level of care criteria regardless of the length of time spent in the Hospital.

OCCUPATIONAL THERAPIST means a person registered to practice occupational therapy. An occupational therapist treats neuromuscular and psychological dysfunction, caused by disease, trauma, Congenital Anomaly, or prior therapeutic process, through the use of specific tasks or goals directed activities designed to improve functional performance of the patient.

ORTHOPEDIC APPLIANCES/ORTHOTIC DEVICE/ORTHOSIS means an individualized rigid or semi-rigid supportive device constructed and fitted by a licensed orthopedic technician which supports a or eliminates motion of a weak or diseased body part. Examples of Orthopedic Appliances are functional hand or leg brace, Milwaukee Brace, or fracture brace.

OTHER PROVIDER means a person or facility other than a Hospital that is licensed in the state where services are rendered, to administer Covered Services. Other Providers include: An institution or entity only listed as: Ambulance Provider, Ambulatory Surgical Facility, Birthing Center, Durable Medical Equipment Supplier, Freestanding Dialysis Facility, Home Health Agency, Hospice Agency, Independent Clinical Laboratory, Pharmacy, Rehabilitation Hospital, and Urgent Care Facility. A person or practitioner only listed as: Certified Nurse Midwife, Certified Registered Nurse Anesthetist, Chiropractor, Dentist, Licensed Acupuncturist, Licensed Practical Nurse, Occupational Therapist, Physical Therapist, Podiatrist, Licensed Lay Midwife, Registered Nurse, Respiratory Therapist and Speech Therapist

OUT-OF-NETWORK PROVIDER means a duly licensed health care Provider, including medical facilities which has no agreement with Lovelace Insurance Company for reimbursement of services to Participants.

OUTPATIENT means care received in a Hospital department, Ambulatory Surgical Facility, Urgent Care facility, or Physician's office where the patient leaves the same day.

PARTICIPANT means the eligible employee or Dependent that is enrolled under this Plan.

PARTICIPANT BENEFIT BOOKLET (PBB) means this booklet.

PHYSICAL THERAPIST means a Licensed Physical Therapist. Where there is no licensure law, the physical therapist must be certified by the appropriate professional body. A physical therapist treats disease or Accidental Injury by physical and mechanical means.

PHYSICIAN means a duly licensed practitioner of the healing arts acting within the scope of his/her license.

PLAN YEAR is July 1, 2009 through June 30, 2010.

PODIATRIST means a licensed Doctor of Podiatric Medicine (DPM). A podiatrist treats conditions of the feet.

SECTION 13 – GLOSSARY OF TERMS

PREFABRICATED Orthosis means an Orthosis which is manufactured in quantity without a specific patient in mind. Prefabricated Orthosis may be trimmed, bent, molded (with or without heat), or otherwise modified for use by a specific patient (i.e., custom fitted.) An Orthosis that is assembled from Prefabricated components is considered Prefabricated. Any Orthosis that does not meet the definition of a Custom-Fabricated Orthosis is considered Prefabricated.

PRESCRIPTION DRUGS means those drugs that, by Federal law, require a Physician's prescription for purchase. This drug benefit is Administered by Express Scripts

PRIMARY CARE PHYSICIAN (PCP) means a duly licensed Doctor of Medicine or Osteopathy, formally selected by the Participant to assume primary responsibility for his/her care.

PROSTHESIS, PROSTHETIC DEVICE means an externally attached or surgically implanted artificial substitute for an absent body part, for example, an artificial eye or limb.

PROVIDER means a duly licensed Hospital, Physician, or Other Provider performing within the scope of the appropriate licensure.

REASONABLE CHARGE OR REASONABLE AND CUSTOMARY (R&C) CHARGE means the amount determined to be payable by Lovelace Insurance Company for services rendered to Participants by Out-of-Network Providers, based upon the following criteria: Fees that a professional Provider usually charges for a given service; Fees which fall within the range of usual charges for a given service filed by most professional Providers in the same locality who have similar training and experience; and Fees which are usual and customary or which could not be considered excessive in particular case because of unusual circumstances.

REGISTERED LAY MIDWIFE means a person licensed by the state to provide Health care Services in pregnancy and childbirth within the scope of New Mexico lay midwifery regulations.

REGISTERED NURSE (RN) means a nurse who has graduated from a formal program of nursing education diploma school, associated degree, or baccalaureate program and is licensed by appropriate state authority.

REHABILITATION HOSPITAL means an appropriately licensed facility that, for compensation from its patients, provides rehabilitation care services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by illness or Accidental Injury to achieve the highest possible functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

RESIDENTIAL TREATMENT CENTER means a non-hospital facility based level of care for the treatment of severe Behavioral Health Disorders. This service is provided to patients who do not require care in an acute Hospital facility but do require 24-hour a day, 7 days per week treatment and supervision.

RESPIRATORY THERAPIST means a person qualified for employment in the field of respiratory therapy. A respiratory therapist assists patients with breathing problems.

SEMI-PRIVATE means a two or more bed Hospital room, skilled nursing facility or other health care facility or program.

SECTION 13 – GLOSSARY OF TERMS

SERVICE AREA means the entire state of New Mexico.

SKILLED NURSING CARE means services that can be provided only by someone with at least the qualifications of a Licensed Practical Nurse or Registered Nurse.

SKILLED NURSING FACILITY means an institution that is licensed under state law to provide Skilled Nursing Care services.

SPECIAL CARE UNIT means a designated unit that has concentrated all facilities, equipment, and supportive devices for the provision of an intensive level of care for critically ill patients.

SPECIALIST means a practitioner who practices in a single area. A Doctor of Medicine (MD) or Doctor of Osteopathy (DO) specialist is a physician who practices in an area other than general practice.

SPECIAL MEDICAL FOODS means nutritional substances in any form that are: formulated to be consumed or administered internally under the supervision of a Physician and prescribed by a Physician; specifically processed or formulated to be distinct in one or more nutrients present in natural food; intended for the medical and nutritional management of Participants with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation; and essential to optimize growth, health and metabolic homeostasis.

SPEECH THERAPIST means a speech pathologist certified by the American Speech and Hearing Association. A Speech Therapist assists patients in overcoming speech disorders.

SURGERY means the performance of generally accepted operative and cutting procedures, including: Specialized instrumentation, endoscopic examinations, and other invasive procedures; Correction of fractures and dislocations; and Usual and related preoperative and postoperative care.

TEFRA means Federal law regarding the working aged.

TERMINALLY ILL PATIENT means a Participant with a life expectancy of six months or less as certified in writing by the Attending Physician.

TWO-PARTY COVERAGE means coverage for the employee and his/her spouse, or for coverage for the employee and dependent child(ren).

URGENT CARE means Medically Necessary healthcare services received for an unforeseen condition that is not life-threatening. This condition does, however, require prompt medical attention to prevent a serious deterioration in your health (e.g., high fever, cuts requiring stitches).

URGENT ILLNESS means an unexpected illness that is non-life-threatening that requires prompt medical attention. Some examples of urgent situations are: sprains, strains, vomiting, cramps, diarrhea, bumps, bruises, fever, small lacerations, minor burns, severe stomach pain, swollen glands, rashes, poisoning and back pain.

WELL CHILD CARE means routine pediatric care through the age of 72 months, and includes a history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory tests in accordance with prevailing medical standards as published by the American Academy of Pediatrics.

ACCEPTANCE PAGE

The University of New Mexico agrees that the provisions contained in this Plan Document are acceptable and will be the basis for the administration of the University of New Mexico Medical Plan.

By:

_____ _____
{UNM Representative} Date
Benefits Administration