

Lovelace Health Plan

<http://www.lovelacehealthplan.com>

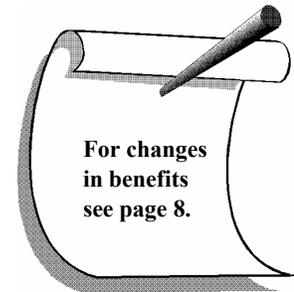


2006

A Health Maintenance Organization

Serving: *The State of New Mexico*

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 7 for requirements.



This Plan has commendable accreditation from the NCQA. See the 2006 Guide for more information on accreditation.

Enrollment codes for this Plan:

- Q11 – Self-Only
- Q12 – Self and Family



Federal Employees
Health Benefits Program

Authorized for distribution by the:



**United States
Office of Personnel Management**

Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>

RI 73-079

Notice of the United States Office of Personnel Management's 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.

By law, the United States Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out (“disclose”) your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the Government Accountability Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government health care oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an “authorization”) to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back (“revoke”) your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.
- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the Web. You may also call 202-606-0745 and ask for OPM’s FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
United States Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the United States Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice are effective April 14, 2003.

Important Notice from Lovelace Health Plan About Our Prescription Drug Coverage and Medicare

OPM has determined that Lovelace Health Plan prescription drug coverage is, on average, comparable to Medicare Part D prescription drug coverage; thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefits. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and Lovelace Health Plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you terminate your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

- If you lose or drop your FEHB coverage, you will have to pay a higher Part D premium if you go without equivalent prescription drug coverage for a period of 63 days or longer. If you enroll in Medicare Part D at a later date, your premium will increase 1 percent per month for each month you did not have equivalent prescription drug coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what most other people pay. You may also have to wait until the next open enrollment period to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help,

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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Introduction

This brochure describes the benefits of Lovelace Health Systems under our contract (CS 1911) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for Lovelace Health Plan's administrative offices is:

Lovelace Health Plan
Altura Office Complex
4101 Indian School Road, NE
Albuquerque, NM 87110

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2006 and changes are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member, “we” means Lovelace Health Plan.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's “Rate Us” feedback area at www.opm.gov/insure or e-mail OPM at fehbwcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.

- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

Call the provider and ask for an explanation. There may be an error.

If the provider does not resolve the matter, call us at (505)262-7363 Albuquerque Area or (800)808-7363 statewide and explain the situation.

If we do not resolve the issue:

**CALL — THE HEALTH CARE FRAUD HOTLINE
202-418-3300**

OR WRITE TO:

**United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100**

- Do not maintain as a family member on your policy:
 - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
 - Your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.

- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
 - Exactly what will you be doing?
 - About how long will it take?
 - What will happen after surgery?
 - How can I expect to feel during recovery?
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

- ▶ www.ahrq.gov/consumer/pathqpack.html. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- ▶ www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- ▶ www.talkaboutrx.org/consumer.html. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- ▶ www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- ▶ www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- ▶ www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1 Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance. We compensate our participating providers in ways that are intended to emphasize preventive care, promote quality of care, and assure the most appropriate use of medical services. You can discuss with your provider how he is compensated by us. The methods we use to compensate participating providers are:

Discounted fee for service - payment for service is based on an agreed upon discounted amount for the services provided.

Capitation - Physicians, provider groups and physician/hospital organizations are paid a fixed amount at regular intervals for each Member assigned to the physician, provider group or physician/hospital organization, whether or not services are provided. This payment covers the physician and/or, where applicable, hospital or other services covered under the benefit plan. Medical groups and physician/hospital organizations may in turn compensate providers using a variety of methods.

Capitation offers health care providers a predictable income, encourages Physicians to keep people well through preventive care, eliminates the financial incentive to provide services that will not benefit the patient, and reduces paperwork.

Providers paid on a "capitated" basis may participate with us in a risk sharing arrangement. They agree upon a target amount for the cost of certain health care services, and they share all or some of the amount by which actual costs are over target. Provider services are monitored for appropriate utilization, accessibility, quality and Member satisfaction.

We may also work with third parties who administer payments to Participating Providers. Under these arrangements, we pay the third party a fixed monthly amount for these services. Providers are compensated by the third party for services provided to Healthplan participants from the fixed amount. The compensation varies based on overall utilization.

Salary - Physicians and other providers who are employed to work in our medical facilities are paid a salary. The compensation is based on a dollar amount, decided in advance each year, that is guaranteed regardless of the services provided. Physicians are eligible for any annual bonus based on quality of care, quality of service and appropriate use of Medical Services.

Bonuses and Incentives - Eligible Physicians may receive additional payments based on their performance. To determine who qualifies, we evaluate Physician performance using criteria that may include quality of care, quality of service, accountability and appropriate use of Medical Services.

Per Diem - A specific amount is paid to a hospital per day for all health care received. The payment may vary by type of service and length of stay.

Case Rate - A specific amount is paid for all the care received in the hospital for each standard service category as specified in our contract with the provider (e.g., for a normal maternity delivery).

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB Web site (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Years in existence
- Profit status

If you want more information about us, call (505)262-7363 Albuquerque area or (800)808-7363 statewide, or write to Lovelace Health Plan, Altura Office Complex, 4101 Indian School Road, NE, Albuquerque, NM 87110. You may also contact us by fax at (505)262-7719 or visit our Web site at www.lovelacehealthplan.com.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area is: The State of New Mexico.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2 How we change for 2006

Do not rely on these change descriptions; this page is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Changes to this Plan

Your share of the non-Postal premium will increase by 4% for Self Only or 4% for Self and Family.

- Under Educational classes and programs, we cover Diabetic education. You pay nothing.
- Under Educational classes we added a Disease Management program.
- We cover one complete eye exam every calendar year subject to a \$5 copayment per visit. Previously, we covered the exam every 24 months subject to a copayment of \$15 for Primary Care doctor visit and \$25 per Specialist visit.
- We limit our coverage period for contacts lenses, frames, and lenses to once every calendar year instead of every 24 months.
- If you request a name brand drug and a federally- approved generic drug is available, you must pay the highest non-formulary copayment at \$35 per prescription or refill.
- We cover surgery for the treatment for modid obesity (Bariatric Surgery) in full. You pay nothing. Previously, you paid 50% of covered charges.
- We now waive copayments, coinsurance and deductibles when a member enrolls in our Medicare Advantage plan and also remains enrolled in FEHB plan.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at (505) 262-7363 Albuquerque area or (800)808-7363 statewide or write to us at Lovelace Health Plan, Altura Office Complex, 4101 Indian School Road, NE, Albuquerque, NM 87110. You may also request replacement cards through our Web site: www.lovelacehealthplan.com.

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, deductibles, and/or coinsurance.

• Plan providers

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site.

• Plan facilities

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our Web site.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care.

• Primary care

Your primary care physician can be a general practitioner, family practitioner, internist or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

• Specialty care

Lovelace Health Plan offers choice and convenience through our Open Access feature. This means you do not need a referral from your Primary Care Physician to see some network specialists.

Your first contact for advice and direction should be your primary care physician. Your PCP's role is to coordinate your overall healthcare. Your PCP should still be your contact for routine and preventive care, recommending specialist and coordinating hospitalizations and follow-up care.

Here are some other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician or specialist will work with the Plan to develop a treatment plan. Your primary care physician or specialist will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will determine if you need to continue care with a specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does

not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist.
- If you have a chronic and disabling condition and lose access to your specialist because we:
 - Terminate our contract with your specialist for other than cause; or
 - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
 - Reduce our service area and you enroll in another FEHB Plan,

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

● Hospital care

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at (505) 262-7363 Albuquerque area or (800)808-7363 statewide. If you are new to the FEHB Program, we will arrange for you to receive care.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

Services requiring our prior approval

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

A Prior Authorization must be obtained prior to receiving services performed by any health care provider EXCEPT:

For services provided by

- Your Primary Care Physician;
- OB/GYN Services; and
- Emergency Services or Urgently Needed Care.

Prior Authorization must always be obtained through your Plan Provider. If Prior Authorization is required from us, your Primary Care Physician or Specialty Care Physician will make arrangements with our Medical Director. Prior Authorization is required for the following types of benefits and services such as: Inpatient and Outpatient Hospital Services, MRI, CT Scan & PET, Rehabilitative Therapy, Skilled Nursing Facility Services, Home Health Services, Second Surgical Opinions, Services provided by a Non-Plan Provider, Durable Medical Equipment and Prosthetic Devices.

If you receive services which require a Prior Authorization without an approved Prior Authorization, you will be obligated to pay for the unauthorized services. We will not pay for unauthorized services.

If your coverage is terminated prior to the date of service, the service will not be covered, regardless of any Prior Authorization given by us or your Primary or Specialty Care Physician.

Section 4 Your costs for covered services

This is what you will pay out-of-pocket for covered care.

Copayments

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services.

Example: When you see your primary care physician you pay a copayment of \$15 per office visit and when you go in the hospital, you pay \$250 per admission.

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible.

- We have no deductible, except for \$200 under the External Prosthetic Appliance benefit.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care.

Example: In our Plan, you pay 50% of our allowance for infertility services.

Your catastrophic protection out-of-pocket maximum

After your total \$2,500 per person or \$5,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments for these services:

- Prescription drugs
- Dental Services
- Mental Health/Substance Abuse
- External prosthetic appliances
- Infertility services

Be sure to keep accurate records of your copayments since you are responsible for informing us when you reach the maximum.

Section 5 Benefits Overview

Note: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at (505)262-7363 Albuquerque area or (800)808-7363 statewide, or at our Web site at www.lovelacehealthplan.com.

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**Section 5(a) Medical services and supplies
provided by physicians and other health care professionals**

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- We have no calendar year deductible except for \$200 under the External Prosthetic Appliance benefit.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians <ul style="list-style-type: none"> ● In physician's office 	\$15 per visit to your primary care physician \$25 per visit to a specialist
Professional services of physicians <ul style="list-style-type: none"> ● In an urgent care center ● During a hospital stay ● In a skilled nursing facility ● Office medical consultations ● Second surgical opinion <p>Note: You pay nothing for these routine screenings, tests and mammograms, however a provider or facility copayment may apply depending on where you receive the service. Refer to the physician's services in this section and facility charges in Section 5(c).</p>	\$15 per visit to your primary care physician \$25 per visit to a specialist
At home	Nothing

Lab, X-ray and other diagnostic tests	You pay
<p>Tests, such as:</p> <ul style="list-style-type: none"> ● Blood tests ● Urinalysis ● Non-routine Pap tests ● Pathology ● X-rays ● Non-routine mammograms ● Ultrasound ● Electrocardiogram and EEG <p>Note: You pay nothing for Lab, X-Rays and other diagnostic tests, however a provider or facility copayment may apply depending on where you receive the service. Refer to the physician's services in this section and facility charges in Section 5(c).</p>	Nothing
<ul style="list-style-type: none"> ● CAT Scans, MRI and PET Scans 	\$75 per test
Preventive care, adult	
<p>Routine screenings, such as:</p> <ul style="list-style-type: none"> ● Total Blood Cholesterol – once every three years ● Colorectal Cancer Screening, including <ul style="list-style-type: none"> - Fecal occult blood test - Sigmoidoscopy, screening – every five years starting at age 50 - Double contrast barium enema – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50 <p>Note: You pay nothing for these routine screenings, tests and mammograms, however a provider or facility copayment may apply depending on where you receive the service. Refer to the physician's services in this section and facility charges in Section 5(c).</p>	Nothing

Preventive care, adult – continued on next page

Preventive care, adult <i>(continued)</i>	You pay
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing
Routine Pap test Note: You do not pay a separate copay for a Pap test performed during your routine annual physical; see <i>Diagnostic and treatment services</i> .	Nothing
Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> ● From age 35 through 39, one during this five year period ● From age 40 through 64, one every calendar year ● At age 65 and older, one every two consecutive calendar years 	Nothing
Routine immunizations, limited to: <ul style="list-style-type: none"> ● Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) ● Influenza vaccine, annually ● Pneumococcal vaccine, age 65 and older 	Nothing
<i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges</i>

Preventive care, children	You pay
<ul style="list-style-type: none"> Childhood immunizations recommended by the American Academy of Pediatrics <p>Note: You pay nothing for childhood immunizations, however a provider or facility copayment may apply depending on where you receive the service. Refer to the physician's services in this section and facility charges in Section 5(c).</p>	Nothing
<ul style="list-style-type: none"> Well-child care charges for routine examinations, immunizations and care (up to age 22) Examinations, such as: <ul style="list-style-type: none"> Eye exams through age 17 to determine the need for vision correction Ear exams through age 17 to determine the need for hearing correction Examinations done on the day of immunizations (up to age 22) 	\$15 per office visit
Maternity care	
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> Prenatal care Delivery Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> You do not need to precertify your normal delivery; see page 10 for other circumstances, such as extended stays for you or your baby. You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). 	\$15 per visit to your primary care physician/\$25 per visit to a specialist for the first office visit to confirm pregnancy; no copay for all pre-/post-delivery visits thereafter.
<i>Not covered: Routine sonograms to determine fetal age, size or sex</i>	<i>All charges</i>

Family planning	You pay
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures Section 5 (b)) <p>Note: You pay nothing for Voluntary sterilization, however a provider or facility copayment may apply depending on where you receive the service. Refer to the physician's services in this section and facility charges in Section 5(c).</p>	Nothing
<ul style="list-style-type: none"> • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	\$15 per visit to your primary care physician \$25 per visit to a specialist
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic counseling.</i> 	<i>All charges</i>
Infertility services	
<p>Diagnosis of infertility</p>	\$15 per visit to your primary care physician \$25 per visit to a specialist
<p>Treatment of infertility, such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI) • Oral fertility drugs <p>Note: Oral fertility drugs are covered under the prescription drug benefit. We do not cover injectable fertility drugs.</p>	50% per treatment/surgical procedure
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> - <i>in vitro fertilization</i> - <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> • <i>Services and supplies related to ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg.</i> 	<i>All charges</i>

Allergy care	You pay
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	\$15 per visit to your primary care physician \$25 per visit to a specialist
Allergy serum	Nothing
<i>Not covered:</i> <ul style="list-style-type: none"> • Provocative food testing and sublingual allergy desensitization • Self-administered allergy injections 	<i>All charges</i>
Treatment therapies	
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 26.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: – We only cover GHT when your Primary Care Physician (PCP) has received our prior authorization – Prior approval must be received before you begin treatment; otherwise, we will only cover GHT services from the date your PCP receives prior authorization. If prior authorization is not received or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p>	Nothing
Physical and occupational therapies	
60 visits for the services of each of the following: <ul style="list-style-type: none"> • qualified physical therapists • occupational therapists • chiropractors and • cardiac and pulmonary rehabilitation programs <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p>	\$25 per office visit Nothing per visit during covered inpatient admission
<i>Not covered:</i> <i>Long-term rehabilitative therapy</i> <i>Exercise programs.</i>	<i>All charges</i>

Speech therapy	You pay
60 visits per condition	\$25 per office visit Nothing per visit during covered inpatient admission.
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17 (see <i>Preventive care, children</i>) 	\$15 per visit to your primary care physician \$25 per visit to a specialist
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • All other hearing testing • Hearing aids, testing and examinations for them, except as shown above. 	<i>All charges</i>
Vision services	
<ul style="list-style-type: none"> • One pair of eyeglasses or contact lenses for treatment of keratoconus or post-cataract surgery 	\$15 per visit to your primary care physician \$25 per visit to a specialist
<ul style="list-style-type: none"> • One pair of eyeglasses or contact lenses is covered once every calendar year limited to the maximum plan payment shown: <p>We pay:</p> <ul style="list-style-type: none"> - Single lenses \$20 - Bifocal lenses \$30 - Trifocal lenses \$40 - Contact lenses \$75 - Frames \$30 	All charges above the maximum plan payment amount shown for lenses and frames.
<ul style="list-style-type: none"> • One complete eye exam, including eye refractions (to determine the need for vision correction) is covered once every calendar year through participating providers. <p>Note: See <i>Preventive care, children</i> for eye exams for children.</p> <ul style="list-style-type: none"> • Medically necessary service – disease or injury to the eye 	\$5 per visit to a specialist \$15 per visit to your primary care physician \$25 per visit to a specialist
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Eye exercises and orthoptics • Radial keratotomy and other refractive surgery • Contact lens fitting exam 	<i>All charges</i>

Foot care	You pay
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	<p>\$15 per visit to your primary care physician \$25 per visit to a specialist</p>
Foot care (continued)	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> ● <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> ● <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery).</i> 	<p><i>All charges</i></p>
Orthopedic and prosthetic devices	
<ul style="list-style-type: none"> ● We limit coverage to \$1,000 per calendar year. Artificial limbs and eyes; stump hose. 	<p>You pay the first \$200 per calendar year.</p>
<ul style="list-style-type: none"> ● Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy ● Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. ● Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. 	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> ● <i>Orthopedic and corrective shoes</i> ● <i>Arch supports</i> ● <i>Foot orthotics</i> ● <i>Heel pads and heel cups</i> ● <i>Lumbosacral supports</i> ● <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> ● <i>Prosthetic replacements due to wear and tear, loss, theft or destruction.</i> ● <i>Biomechanical devices</i> ● <i>Penile prosthetics</i> 	<p><i>All charges</i></p>

Durable medical equipment	You pay
<p>We limit coverage to \$3,500 per member per calendar year.</p> <p>Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, and received by a vendor approved by the Plan, such as oxygen tents and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> ● Hospital beds; ● Wheelchairs (limited to the lowest cost alternative to satisfy medical necessity); ● Crutches; ● Walkers; ● Blood glucose monitors and blood glucose monitors for the legally blind; ● Insulin pumps and infusion devices; ● Respirators; and ● Oxygen tents. <p>Note: Your PCP will prescribe and arrange for a participating health care provider to rent or sell you the durable medical equipment. We will not cover equipment received from a non-participating health care provider unless your PCP has received our prior authorization.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> ● <i>Hygienic or self-help items or equipment, or item or equipment that are primarily for comfort or convenience, such as bathtub chairs, safety grab bars, stair gliders or elevators, over-the-bed tables, saunas or exercise equipment;</i> ● <i>Environmental control equipment, such as air purifiers, humidifiers, and electrostatic machines;</i> ● <i>Institutional equipment such as air fluidized beds and diathermy machines;</i> ● <i>Consumable medical supplies including, but not limited to, bandages and other disposable supplies, skin preparations, test strips, ostomy supplies, surgical leggings, elastic stockings and wigs.</i> 	<i>All charges</i>
Home health services	
<ul style="list-style-type: none"> ● Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. ● Services include oxygen therapy, intravenous therapy and medications. 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> ● <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i> ● <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative;</i> ● <i>Services primarily for rest, domiciliary or convalescent care.</i> 	<i>All charges</i>

Chiropractic	You pay
<ul style="list-style-type: none"> • See Physical and occupational therapies under this Section, Chiropractic is part of Physical and occupational therapies. 	Same as Physical and occupational therapies.
Alternative treatments	
Acupuncture – limited to authorized referrals for the treatment of chronic musculoskeletal or neurogenic pain. The maximum benefit of two months of treatment per condition per lifetime is contingent on documented progress.	\$15 per visit to your primary care physician \$25 per visit to a specialist
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Naturopathic services</i> • <i>Hypnotherapy</i> • <i>Biofeedback</i> • <i>Massage services</i> 	<i>All charges</i>
Educational classes and programs	
<ul style="list-style-type: none"> • Smoking cessation benefit <ul style="list-style-type: none"> - Phone counseling – coverage is limited to 8 sessions for a two-month period per calendar year. - Group counseling – coverage is limited to 8 sessions per calendar year. - Prescription drugs – coverage period is limited to 3 consecutive months twice per calendar year. Prescription drug coverage is up to a 30-day supply with two refills. Each 30-day supply requires applicable prescription drug copayment. 	<p>Nothing</p> <p>\$20 for course materials</p> <p>Applicable prescription drug copayment</p>
<p>Coverage for other educational classes and programs is limited to:</p> <ul style="list-style-type: none"> • Nutrition • Care giving: Families coping with chronic illness • Parenting Children with attention deficit hyperactivity disorder • It's up to You to Bring it Down: A class for people managing hypertension • Breast Health Program • Disease Management Programs 	Costs varies by class and/or program. Call Plan for details.
<ul style="list-style-type: none"> • Diabetes self management, with a referral from your primary care provider 	Nothing

**Section 5(b) Surgical and anesthesia services
provided by physicians and other health care professionals**

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible except for \$200 under the External Prosthetic Appliance benefit.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRIOR AUTHORIZATION OF SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay
Surgical procedures	
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> ● Operative procedures ● Treatment of fractures, including casting ● Normal pre- and post-operative care by the surgeon ● Correction of amblyopia and strabismus ● Endoscopy procedures ● Biopsy procedures ● Removal of tumors and cysts ● Correction of congenital anomalies (see <i>Reconstructive surgery</i>) 	Nothing

Surgical procedures - continued on next page

Surgical procedures (continued)	You pay
<ul style="list-style-type: none"> ● Insertion of internal prosthetic devices. See 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information ● Voluntary sterilization (e.g., tubal ligation, vasectomy) ● Treatment of burns <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	Nothing
<ul style="list-style-type: none"> ● Surgical treatment of morbid obesity (Bariatric Surgery) <ul style="list-style-type: none"> - A condition in which an individual weighs 200% of his or her normal weight according to current underwriting standards; eligible members must be age 18 or over - The patient must first meet the medical guidelines of Lovelace Health Plan AND also meet the guidelines established by the Bariatric surgical facility where the surgery would be performed. These guidelines may include physical and psychological testing. If the patient does not meet the guidelines of the Bariatric surgical facility, the facility may elect not to proceed with the surgery. - Generally, patients must be at least 100 pounds over their ideal weight, and have a body mass index (BMI) exceeding 40. - Patients with a BMI over 35, accompanied by another clinically serious condition (e.g., diabetes, hypertension, etc) may also be considered for this procedure. 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> ● <i>Reversal of voluntary sterilization</i> ● <i>Routine treatment of conditions of the foot; see Foot care.</i> 	<i>All charges</i>

Reconstructive surgery	You pay
<ul style="list-style-type: none"> ● Surgery to correct a functional defect ● Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - the condition produced a major effect on the member’s appearance and - the condition can reasonably be expected to be corrected by such surgery ● Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. ● All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see Prosthetic devices) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> ● <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> ● <i>Surgeries related to sex transformation.</i> 	<i>All charges</i>

Oral and maxillofacial surgery	You pay
<p>Oral surgical procedures, with the prior approval of Plan Medical Director, limited to:</p> <ul style="list-style-type: none"> ● Reduction of fractures of the jaws or facial bones; ● Surgical correction of cleft lip, cleft palate or severe functional malocclusion; ● Removal of stones from salivary ducts; ● Excision of leukoplakia or malignancies; ● Excision of cysts and incision of abscesses when done as independent procedures; ● TMJ treatment and services (non-dental); and ● Other surgical procedures that do not involve the teeth or their supporting structures. 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> ● <i>Oral implants and transplants</i> ● <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone).</i> 	<i>All charges</i>
Organ/tissue transplants	
<p>Limited to:</p> <ul style="list-style-type: none"> ● Cornea ● Heart ● Heart/lung ● Kidney ● Kidney/Pancreas ● Liver ● Lung: Single – Double ● Pancreas ● Allogeneic (donor) bone marrow transplants ● Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin’s lymphoma; advanced non-Hodgkin’s lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors 	Nothing

Organ/tissue transplants – continued on next page

Organ/tissue transplants <i>(continued)</i>	You pay
<ul style="list-style-type: none"> ● Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas ● Autologous tandem transplants for testicular tumors and other germ cell tumors ● National Transplant Program (NTP) – please see Section 5(g) <p>Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute – or National Institutes of Health-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> ● <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> ● <i>Implants of artificial organs</i> ● <i>Transplants not listed as covered.</i> 	<i>All charges</i>
Anesthesia	
<p>Professional services provided in –</p> <ul style="list-style-type: none"> ● Hospital (inpatient) 	Nothing
<p>Professional services provided in –</p> <ul style="list-style-type: none"> ● Hospital outpatient department ● Skilled nursing facility ● Ambulatory surgical center ● Office 	Nothing

Section 5(c) Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We have no calendar year deductible except for \$200 under the External Prosthetic Appliance benefit.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST OBTAIN OUR PRIOR AUTHORIZATION FOR HOSPITAL STAYS, EXCEPT FOR EMERGENCIES.** Please refer to Section 3 to be sure which services require Prior Authorization.

Benefit Description	You pay
Inpatient hospital	
Room and board, such as <ul style="list-style-type: none"> ● Ward, semiprivate, or intensive care accommodations; ● General nursing care; and ● Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	\$250 per admission
Other hospital services and supplies, such as: <ul style="list-style-type: none"> ● Operating, recovery, maternity, and other treatment rooms ● Prescribed drugs and medicines ● Diagnostic laboratory tests and X-rays ● Blood or blood plasma, if not donated or replaced ● Dressings, splints, casts, and sterile tray services ● Medical supplies and equipment, including oxygen ● Anesthetics, including nurse anesthetist services 	Nothing

Inpatient hospital - continued on next page

Inpatient hospital (continued)	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> ● Custodial care ● Non-covered facilities, such as nursing homes, schools ● Personal comfort items, such as telephone, television, barber services, guest meals and beds ● Private nursing care 	<p><i>All charges</i></p>
Outpatient hospital or ambulatory surgical center	
<ul style="list-style-type: none"> ● Operating, recovery, and other treatment rooms ● Prescribed drugs and medicines ● Diagnostic laboratory tests, X-rays, and pathology services ● Administration of blood, blood plasma, and other biologicals ● Blood and blood plasma, if not donated or replaced ● Pre-surgical testing ● Dressings, casts, and sterile tray services ● Medical supplies, including oxygen ● Anesthetics and anesthesia service <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	<p>\$150 per facility use</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> ● Blood and blood derivatives not replaced by the member 	<p><i>All charges</i></p>
Extended care benefits/Skilled nursing care facility benefits	You pay
<p>Covered for up to 60 days per calendar year when full-time skilled nursing care is necessary, and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan.</p> <ul style="list-style-type: none"> ● Skilled and general nursing services ● Physicians visits ● Physiotherapy ● X-rays ● Administration of drugs, medications and fluids 	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> ● Personal comfort items, such as television and telephone ● Custodial care ● Rest cures, domiciliary or convalescent care 	<p><i>All charges</i></p>

Hospice care	
<p>Hospice care for a patient who as certified by a Plan doctor is in the terminal stages of illness and who has a life expectancy of six months or less.</p> <p>Hospice care services include:</p> <ul style="list-style-type: none"> ● Inpatient care ● Outpatient care ● Physician services ● Psychologist, social worker or family counselor services for individual or family counseling 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> ● <i>Independent nursing</i> ● <i>Homemaker services, including services and supplies that are primarily to aid you or your dependent in daily living</i> ● <i>Services of a person who is a member of your family who normally resides in your house</i> ● <i>Services or supplies not listed in the Hospice Care Program</i> ● <i>Services for curative or life-prolonging procedures</i> ● <i>Bereavement counseling</i> ● <i>Services for respite care</i> ● <i>Nutritional supplements, non-prescription drugs or substances, medical supplies, vitamins or minerals</i> 	<i>All charges</i>
Ambulance	
Local professional ambulance service when medically appropriate	Nothing

Section 5(d) Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible except for \$200 under the External Prosthetic Appliance benefit.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

Emergency Services Both In and Out of our Service Area:

In the event of an emergency, get help immediately. Go to the nearest emergency room, the nearest hospital or call or ask someone to call 911 or your local emergency service, police or fire department for help. You do not need a referral from your PCP for emergency services, but you do need to call your PCP as soon as possible for further assistance and advice on follow-up care. If you require specialty care or a hospital admission, your PCP will coordinate it and handle the necessary authorizations for care or hospitalization. Participating providers are on call twenty-four (24) hours a day, seven (7) days a week, to assist you when you need Emergency Services.

If you receive emergency services outside the service area, you must notify us as soon as reasonably possible. We may arrange to have you transferred to a participating provider for continuing or follow-up care if it is determined to be medically safe to do so.

Emergency services are defined as the medical, psychiatric, surgical, hospital and related health care services and testing, including ambulance service, which are required to treat a sudden unexpected onset of a bodily injury or a serious illness which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts, and broken bones. The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the hospital on the UB92 claim form or its successor, or the final diagnosis, whichever reasonably indicated an emergency medical condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency.

Continuing or follow-up treatment, whether in or out of the service area, is not covered unless it is provided or arranged for by your PCP or upon Prior Authorization of our Medical Director.

Benefit Description	You pay
Emergency within our service area	
<ul style="list-style-type: none"> ● Emergency care at a doctor’s office ● Emergency care at an urgent care center ● Emergency care as an outpatient at a hospital, including doctors’ services <p>Note: We waive the ER copay if you are admitted to the hospital.</p>	<p>\$15 per office visit</p> <p>\$30 per visit. Urgent care copayment waived if admitted to hospital.</p> <p>\$75 per visit. Emergency care copayment waived if admitted to hospital.</p>
<i>Not covered: Elective care or non-emergency care.</i>	<i>All charges</i>
Emergency outside our service area	
<ul style="list-style-type: none"> ● Emergency care at a doctor’s office ● Emergency care at an urgent care center ● Emergency care as an outpatient at a hospital, including doctors’ services <p>Note: We waive the ER copay if you are admitted to the hospital.</p>	<p>\$15 per office visit</p> <p>\$30 per visit. Urgent care copayment waived if admitted to hospital.</p> <p>\$75 per visit. Emergency care copayment waived if admitted to hospital.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> ● <i>Elective care or non-emergency care</i> ● <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> 	<i>All charges</i>
Ambulance	
<p>Professional ambulance service when medically appropriate. Air ambulance is covered when medically necessary.</p> <p>Note: See 5(c) for non-emergency service.</p>	Nothing

Section 5(e) Mental health and substance abuse benefits

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible except for \$200 under the External Prosthetic Appliance benefit.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay
Mental health and substance abuse benefits	
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> ● Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers ● Medication management 	<p>\$25 per office visit</p>
<ul style="list-style-type: none"> ● Diagnostic tests ● MRI, Cat Scan and PET Scans 	<p>Nothing</p> <p>\$75 per test</p>

Mental health and substance abuse benefits – continued on next page.

Mental health and substance abuse benefits <i>(continued)</i>	You pay
<ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, facility based intensive outpatient treatment 	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
<p><i>Not covered: Services we have not approved.</i></p> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<i>All charges</i>
Preauthorization	<p>To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes:</p> <p>You do not need a referral to receive these services. However, to obtain these services, you must call Lovelace Mental Health Services directly, at the phone number listed on your ID Card. You can also call, to get more information or speak with someone about a specific problem. A representative is available to assist you twenty-four (24) hours a day, seven (7) days a week. The representative will provide you with a choice of providers in your area and will authorize an appropriate number of visits.</p>
Limitation	We may limit your benefits if you do not obtain a treatment plan.

Section 5(f) Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible except for \$200 under the External Prosthetic Appliance benefit.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

There are important features you should be aware of. These include:

- Who can write your prescription. **A plan physician or licensed dentist must write the prescription.**
- Where you can obtain them. **You may fill the prescription at a plan retail pharmacy, or by plan mail-order pharmacy. You must fill the prescription at a plan pharmacy, or by mail through a plan mail-order pharmacy for a maintenance medication.**
- We use a formulary. **A formulary is a listing of approved drug products. The drugs and medications included have been approved in accordance with parameters established by us. This list is subject to periodic review and is amended as required.**

If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call (505) 262-7363 Albuquerque area or 1-800-808-7363 statewide.

- These are the dispensing limitations. **Your copayment for generic retail prescription drugs that are on the formulary is \$7. Your copayment for name brand retail prescription drugs that are on the formulary but do not have a generic equivalent is \$15. Your copayment for name brand drugs that are on the formulary but do have a generic equivalent OR for drugs that are not on the formulary is \$35. Each prescription order or refill is limited to a consecutive thirty (30) day supply at a retail participating pharmacy, unless limited by the drug manufacturer's packaging.**
- Maintenance medications prescribed by Plan doctors may also be obtained through our mail order program. Your copayment for generic mail order prescription drugs that are on the formulary is \$14. Your copayment for name brand mail order prescription drugs that are on the formulary but do not have a generic equivalent is \$30. Your copayment for name brand drugs that are on the formulary but do have a generic equivalent OR for drugs that are not on the formulary is \$70. Each prescription order or refill is limited to a consecutive ninety(90) day supply at a mail order participating pharmacy, unless limited by the manufacturer's packaging.
- Members called to active military duty in a time of national or other emergency who need to obtain a greater-than-normal supply of prescribed medications should call our Customer Care Center at (505) 262-7363 or outside of Albuquerque at 1-800-808-7363.
- **A generic equivalent will be dispensed if it is available.** When a member or provider insists on obtaining a formulary name brand drug that has a generic equivalent, the prescription is available to the member at the \$35 copayment level (i.e., the third tier).
- Why use generic drugs? **Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic prescription costs you – and us – less than a name brand prescription.**
- Prior Authorization: As part of the Prior Authorization process, the Plan uses a "Step Therapy" program. This program requires that before a member may receive Prior Authorization. He/she must first attempt the use of a lesser-priced alternative medication. This helps the member and the attending physician to determine if an intermediate "step" or course of drug treatment might be just as effective. If using a step therapy medication is not effective for the member, or if it is documented that the member has previously attempted the use of one or more Step Therapy alternative medications, his or her physician may then

apply to the Lovelace Pharmacy Exception Center for a Prior Authorization exception. Examples of Step Therapy drugs are: Cozaar, Hyzaar, Estratest, Diovan, Lotrel, Coreg, Oxytrol, Neurontin, Singulair and Soriatane.

- When you do have to file a claim. **Please refer to Section 7 Filing a claim for covered services.**
- Member must meet Lovelace’s Prior Authorization process to obtain certain drugs, including but not limited to Actos, Amaryl, Arava, Celebrex, Detrol, Aciphex, Nexium and Prevacid.

Prescription drugs	
Benefit Description	You pay
Covered medications and supplies	
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>. • Oral and injectable contraceptive drugs and contraceptive devices; contraceptive diaphragms • Insulin, glucose test strips, and other prescription diabetic supplies • Disposable needles and syringes for the administration of covered medications • Oral fertility medications • Intravenous fluids and medication for home use, implantable drugs, and some injectable drugs are covered under Medical and Surgical Benefits. • Drugs to treat sexual dysfunction are limited. Contact the Plan for dose limits and prior authorization. • Oral agent for controlling blood sugar • Growth Hormones (Requires a Prior Authorization) 	<p>Retail Pharmacy</p> <p>\$7 per generic formulary drug</p> <p>\$15 per name brand formulary drug with no generic equivalent.</p> <p>\$35 per name brand formulary drug with generic equivalent OR per non-formulary drug</p> <p>Mail Order (Maintenance medications only)</p> <p>\$14 per generic formulary drug</p> <p>\$30 per name brand formulary drug with no generic equivalent</p> <p>\$70 per name brand formulary drug with generic equivalent OR per non-formulary drug</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay</p>

<ul style="list-style-type: none"> ● Implanted time-release medications, such as Norplant. There is no charge when the device is implanted during a covered hospitalization. There will be no refund of any portion of this copay if the implanted time-release medication is removed before the end of its expected life. 	<p>\$100 one-time copay per prescription</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> ● <i>Drugs and supplies for cosmetic purposes</i> ● <i>Drugs to enhance athletic performance</i> ● <i>Injectable fertility drugs (see Infertility benefit under Medical and Surgical Benefits for limited coverage)</i> ● <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> ● <i>Vitamins (except for prenatal vitamins), nutrients and food supplements even if a physician prescribes or administers them</i> ● <i>Nonprescription medicines, over the counter drugs</i> ● <i>Medical supplies such as dressings and antiseptics</i> ● <i>Smoking cessation drugs and medications, except as shown under Educational classes and programs</i> ● <i>Diet pills or appetite suppressants (except when used in the treatment of morbid obesity)</i> ● <i>Replacement of drugs due to loss or theft</i> ● <i>Prescriptions more than one year from the original date of issue</i> 	<p><i>All charges</i></p>

Section 5(g) Special features

Feature	Description
Flexible benefits option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> ● We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. ● Alternative benefits are subject to our ongoing review. ● By approving an alternative benefit, we cannot guarantee you will get it in the future. ● The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. ● Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
24 hour nurse line	<p>For any of your health concerns, 24 hours a day, 7 days a week, you may call 1-800-366-3401 and talk with a registered nurse who will discuss treatment options and answer your health questions.</p>
Services for deaf and hearing impaired	<p>Certified Languages International is a company that is contracted by Lovelace Health Plan to supply interpreters for patients and providers in any language including sign language, either by phone or in person if certified employee interpreters are not available.</p> <p>Deaf/Hearing impaired individuals may access the member services department by calling their state relay line. Or Lovelace Health Plans Telecommunication Device for the Deaf (TDD) at 505-232-1810 or 1-800-288-5605.</p>
Centers of excellence	<p>Lovelace Health Plan members have access to the Lifesource Organ Transplant Network[®] which is an organization of participating hospitals which provides organ transplant services. As part of the rigorous credentialing program, each hospital's transplant program is evaluated for patient outcome, as well as waiting period, housing arrangements, "patient friendly" environment and the availability of transportation, before it is included in the Lifesource Organ Transplant Network[®].</p>
Travel benefit/services overseas	<p>We cover you for emergency services anywhere in the world.</p>

Section 5(h) Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- Plan dentists must provide or arrange your care.
- We have no calendar year deductible except \$200 under the External Prosthetic Appliance benefit.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5© for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Accidental injury benefit	You pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	\$15 per office visit

Dental benefits

We have no other dental benefits.

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums.

DentalSource Sandia Dental Plan	Delta Dental
<p>The DentalSource Sandia Dental Plan is a cost effective alternative to dental insurance that provides our members significant savings on their dental care. As a member of the DentalSource Sandia Dental Plan you receive special savings with guaranteed low, preset fees on virtually all types of dental work. You can save as much as 20% to 60% off most dental procedures. This dental plan provides reduced fees on preventive and comprehensive dental procedures. This is an In-Network plan only. You must utilize the providers on our participating Sandia Provider list. For the most current listing visit our website at: www.dentalsourcenm.com.</p> <ul style="list-style-type: none"> ● Monthly premiums began at \$4.75 ● No deductibles or claim forms ● No pre-enrollment exams ● No prior authorization required ● No limits on the amount of benefits ● No waiting periods for benefits to begin ● Orthodontia benefit available <p>It is easy to enroll. You may pay the entire annual membership fee or select the monthly bank draft option. Simply complete the enrollment/authorization form and send it with the correct payment to DentalSource in the self addressed return envelope.</p> <p>Please refer to the enclosed DentalSource packet for annual and monthly premiums and for complete information about this dental plan.</p>	<p>Delta Dental is proud once again to be selected to offer dental benefits for Federal Employees enrolled in the FEHB Lovelace Health Plan.</p> <p style="text-align: center;">Why Delta Dental? The Choice is Simple...</p> <ul style="list-style-type: none"> ● DeltaPreferred Option is a preferred provider (PPO) arrangement with one of every four dentists in New Mexico participating in the network. Log on to www.deltadentalnm.com for a complete list of our DeltaPreferred Option dentists. ● You receive full in-network benefits and avoid any unexpected charges when you visit a DeltaPreferred Option dentist because participating dentists cannot bill above the DeltaPreferred Option fee schedule ● Direct access to ANY licensed dentist! Benefits even when you visit a licensed dentist not participating in the DeltaPreferred Option network, including DeltaPremier dentists and non-participating dentists (though you typically pay more out of pocket). ● Delta Dental is an industry leader with excellent customer service, quick claims turnaround times, and the speed of our telephone response. <p>Comprehensive Dental Benefits Include:</p> <ul style="list-style-type: none"> ● Cleaning, exams and x-rays covered twice a year with NO deductible! ● No waiting period for Preventive or Basic services. ● A reduced waiting period for Major Services—the waiting period is now 6 months instead of 12 months. <p>For complete enrollment and benefit information, please refer to the material in the enclosed Delta Dental packet.</p> <p style="text-align: center;"><i>Delta Dental</i></p> <p style="text-align: center;"><i>Advancing Solutions for Great Oral Health!</i></p>

Benefits on this page are not part of the FEHB contract.

Section 6 General exclusions – things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition and we agree, as discussed under *Services Requiring Our Prior Approval* on page 11.**

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see Emergency services/accidents);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7 Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at (505)262-7363 Albuquerque area or 1-800-808-7363 statewide.

When you must file a claim – such as for services you receive outside the Plan’s service area – submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member’s name and ID number;
- Name and address of the physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer – such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Submit your claims to: Please refer to your ID card for the address to mail any claims.

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

Section 8 The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval:

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none">Write to us within 6 months from the date of our decision; andSend your request to us at: Lovelace Health Plan, Altura Office Complex, 4101 Indian School Road, NE, Albuquerque, NM 87110; andInclude a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andInclude copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	<p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none">Pay the claim (or, if applicable, arrange for the health care provider to give you the care); orWrite to you and maintain our denial – go to step 4; orAsk you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	<p>You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none">90 days after the date of our letter upholding our initial decision; or120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or120 days after we asked for additional information. <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.</p>

The disputed claims process *(continued)*

	<p>Send OPM the following information:</p> <ul style="list-style-type: none"> • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. <p>Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.</p>
	<p>Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.</p> <p>Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.</p>
5	<p>OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.</p>
	<p>If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.</p> <p>OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.</p>
	<p>You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.</p>

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

- a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at (505)262-7363 Albuquerque area or 1-800-808-7363 statewide and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You may call OPM's Health Insurance Group 3 at (202)606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9 Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member have coverage under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called “double coverage.”

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ guidelines.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age or older.
- Some people with disabilities under 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We, Lovelace Health Plan, offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare’s Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

• Should I enroll in Medicare?

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It’s easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don’t have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep

FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share. Some things are not covered under Original Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. Your care must continue to be authorized by your Plan PCP, or recertified as required.

We will not waive any of our copayments or coinsurance.

Please note, if your Plan physician does not participate in Medicare, you will have to file a claim with Medicare.

Claims process when you have the Original Medicare Plan – You probably will never have to file a claim form when you have both our Plan and the Original Medicare Plan. Please note, if your Plan physician does not participate in Medicare, you will have to file a claim with Medicare.

When we are the primary payer, we process the claim first.

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at (505)262-7363 Albuquerque area or 1-800-808-7363 statewide or see our Web site at www.Lovelacehealthplan.com. In this case we do not waive any out-of-pocket costs.

We do not waive any costs if the Original Medicare Plan is your primary payer.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and our Medicare Advantage plan: You may enroll in our Medicare Advantage plan and also remain enrolled in our FEHB plan. In this case, we will waive our copayments, coinsurance, or deductibles for your coverage.

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	The primary payer for the individual with Medicare is...	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #1 above	✓	
4) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and ... You have FEHB coverage on your own or through your spouse who is also an active employee You have FEHB coverage through your spouse who is an annuitant		✓
5) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and... • It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period) • It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD		✓
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and... • This Plan was the primary payer before eligibility due to ESRD		✓ for 30-month coordination period
• Medicare was the primary payer before eligibility due to ESRD	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse		
	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the program.

Workers' Compensation

We do not cover services that:

- You need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

Medicaid

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

Section 10 Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 11.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 11.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Custodial care is care you receive when you need help performing activities of daily living — such as walking, grooming, bathing, dressing, getting in and out of bed, toileting, eating, preparing foods, or taking medications that can usually be self-administered. Custodial care that lasts 90 days or more is sometimes known as Long Term Care. We do not cover Custodial Care.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 11.
Experimental or investigational services	<p>Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Medical Director to be:</p> <ul style="list-style-type: none">• not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, The American Medical Association Drug Evaluations; or the American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal;• the subject of review or approval by an Institutional Review Board for the proposed use;• the subject of an ongoing clinical trial that meets the definition of a phase I, II or III Clinical Trial as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight; or• not demonstrated, through existing peer-reviewed literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.
Medical necessity	<p>Medically necessary covered Services and Supplies are those covered Services and Supplies that are determined by our Medical Director to be:</p> <ul style="list-style-type: none">• No more than required to meet your basic health needs; and• consistent with the diagnosis of the condition for which they are required; and• consistent in type, frequency and duration of treatment with scientifically based guidelines as determined by medical research; and• required for purposes other than the comfort and convenience of the patient or his Physician; and• rendered in the least intensive setting that is appropriate for the delivery of healthcare; and• of demonstrated medical value.
Us/We	Us and We refer to Lovelace Health Plan.
You	You refers to the enrollee and each covered family member.

Section 11 FEHB Facts

Coverage information

- **No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Where you can get information about enrolling in the FEHB Program**

See www.opm.gov/insure/health for enrollment as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; and
- When the next open season for enrollment begins.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

- **Types of coverage available for you and your family**

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2006 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2005 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

- **Spouse equity coverage**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide To Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

- **Getting a Certificate of Group Health Plan Coverage**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site at www.opm.gov/insure/health; refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

Section 12 Two Federal Programs complement FEHB benefits

Important information

OPM wants to make sure you are aware of two Federal programs that complement the FEHB Program. First, the **Federal Flexible Spending Account (FSA) Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket. Second, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB.

The Federal Flexible Spending Account Program – *FSAFEDS*

• What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%.*

There are two types of FSAs offered by FSAFEDS:

Health Care Flexible Spending Account (HCFSA)

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have.
- Eligible dependents for this account include anyone you claim on your Federal Income Tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal Income Tax return, even if you don't have self and family health benefits coverage. *Note:* The IRS has a broader definition of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum annual amount that can be allotted for the HCFSA is \$5,000. *Note:* The Federal workforce includes a number of employees married to each other. If each spouse/employee is eligible for FEHB coverage, both may enroll for a HCFSA up to the maximum of \$5,000 each (\$10,000 total). Both are covered under each other's HCFSA. The minimum annual amount is \$250.

Dependent Care Flexible Spending Account (DCFSA)

- Covers eligible dependent care expenses incurred so you, and your spouse, if married, can work, look for work, or attend school full-time.
- Qualifying dependents for this account include your dependent children under age 13, or any person of any age whom you claim as a dependent on your Federal Income Tax return and who is mentally or physically incapable of self care.
- The maximum annual amount that can be allotted for the DCFSA is \$5,000. The minimum annual amount is \$250. *Note:* The IRS limits contributions to a DCFSA. For single taxpayers and taxpayers filing a joint return, the maximum is \$5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is \$2,500 per year.

• Enroll during Open Season

You **must make an election** to enroll in an FSA during the 2006 FEHB Open Season. Even if you enrolled during 2005, you must make a new election to continue participating in 2006. Enrollment is easy!

- Online: visit www.fsafeds.com and click on Enroll.
- Telephone: call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, from 9 a.m. until 9 p.m. Eastern Time. TTY: 1-800-952-0450.

What is SHPS?

SHPS is a third-party administrator hired by OPM to manage the FSAFEDS Program. SHPS is responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

Who is eligible to enroll?

If you are a Federal employee eligible for FEHB – even if you’re not enrolled in FEHB – you can choose to participate in either, or both, of the FSAFEDS accounts. *However, if you enroll in an FSA and enroll in a High Deductible Health Plan (HDHP), you are not eligible for a Health Savings Account (HSA) under your HDHP and will be enrolled in a Health Reimbursement Arrangement (HRA) instead.*

Almost all Federal employees are eligible to enroll for a DCFSA. The only exception is intermittent (also called “when actually employed” [WAE]) employees expected to work fewer than 180 days during the year.

Note: FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers have signed on to participate. Under IRS law, FSAs are not available to annuitants. Also, the U.S. Postal Service and the Judicial Branch, among others, have their own plans with slightly different rules. However, the advantages of having an FSA are the same regardless of the agency for which you work.

• How much should I contribute to my FSA?

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits an FSA provides, the IRS requires that you forfeit any money for which you did not incur an eligible expense under your FSA account(s) during the Plan Year. This is known as the “Use-it-or-Lose-it” rule. FSAFEDS has adopted the “grace period” permitted by the IRS. You now have an additional 2 ½ months to incur eligible expenses and reduce any potential forfeitures. In addition, you will have until May 31, following the end of the Plan Year to submit claims for your eligible expenses incurred from January 1 through March 15 of the following year. For example if you enrolled in FSAFEDS for the 2005 Plan Year, you will have from January 1, 2005 until March 15, 2006 to incur eligible expenses and, you may submit claims for those expenses through May 31, 2006.

The FSAFEDS Calculator at www.FSAFEDS.com will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

• What can my HCFSA pay for?

Every FEHB plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on page xx and detailed throughout this brochure. Your HCFSA will reimburse you when those costs are for qualified medical care that you, your spouse and/or your dependents receive that is NOT covered or reimbursed by this FEHB Plan or any other coverage that you have.

Under this plan, typical out-of-pocket expenses include: office visit copays, prescription drug copays and emergency care copays. Common but significant expenses not covered by the Plan include glasses, laser vision surgery and hearing aids.

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. Since Publication 502 is primarily meant to help on preparing your Federal income tax return, there are two important differences to note. **Note:** **While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes. In addition, over-the-counter medicines and products ARE an eligible expense under your HCFSA, and this is not included in Publication 502.** Publication 502 can be found on the IRS Web site at <http://www.irs.gov/pub/irs-pdf/p502.pdf>. The FSAFEDS Web site also has a comprehensive list of eligible expenses at www.FSAFEDS.com/fsafeds/eligibleexpenses.asp. If you do not see your service or expense listed, please call an FSAFEDS Benefits Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions.

• Tax savings with an FSA

An FSA lets you allot money for eligible expenses *before* your agency deducts taxes from your paycheck. This means the amount of income that your taxes are based on will be lower, so your tax liability will be less. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after Federal (and often state and local) taxes are deducted. The following chart illustrates a typical tax savings example:

Annual Tax Savings Example	With FSA	Without FSA
If your taxable income is:	\$50,000	\$50,000
And you deposit this amount into an FSA:	\$2,000	-\$0-
Your taxable income is now:	\$48,000	\$50,000
Subtract Federal & Social Security taxes:	\$13,807	\$14,383
If you spend after-tax dollars for expenses:	-\$0-	\$2,000
Your real spendable income is:	\$34,193	\$33,617
Your tax savings:	\$576	-\$0-

Note: This example is intended to demonstrate a typical tax savings based on 27% Federal and 7.65% FICA taxes. Actual savings will vary based upon the retirement system in which you are enrolled (CSRS or FERS), your state of residence, and your individual tax situation. In this example, the individual received \$2,000 in services for \$1,424 - a discount of almost 36%! You may also wish to consult a tax professional for more information on the tax implications of an FSA.

- **Tax credits and deductions**

- **Health care expenses**

You *cannot* claim expenses on your Federal Income Tax return if you receive reimbursement for them from your HCFSA or DCFSA. Below are some guidelines that may help you decide whether to participate in FSAFEDS.

The HCFSA is Federal Income Tax-free from the first dollar. In addition, you may be reimbursed from your HCFSA at any time during the year for expenses up to the annual amount you've elected to contribute.

Only health care expenses exceeding 7.5% of your adjusted gross income are eligible to be deducted on your Federal Income Tax return. Using the example shown above, only health care expenses exceeding \$3,750 (7.5% of \$50,000) would be eligible to be deducted on your Federal Income Tax return. In addition, money set aside through an HCFSA is also exempt from FICA taxes. This exemption is not available on your Federal Income Tax return.

Paperless Reimbursement – This plan participates in the FSAFEDS paperless reimbursement program. When you enroll for your HCFSA, you will have the opportunity to enroll for paperless reimbursement. You must re-enroll every Open Season to remain in the paperless reimbursement program. If you do, we will send FSAFEDS the information they need to reimburse you for your out-of-pocket costs so you can avoid filing paper claims.

- **Dependent care expenses**

The DCFSA generally allows many families to save more than they would with the Federal tax credit for dependent care expenses. Note that you may only be reimbursed from the DCFSA up to your current account balance. If you file a claim for more than your current balance, it will be held until additional payroll allotments have been added to your account.

Visit www.FSAFEDS.com and download the Dependent Care Tax Credit Worksheet from the Forms and Literature page to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

- **Does it cost me anything to participate in FSAFEDS?**

No. Section 1127 of the National Defense Authorization Act (Public Law 108-136) requires agencies that offer FSAFEDS to employees to cover the administrative fee(s) on behalf of their employees. However, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance during your period of coverage for the Plan Year plus 2 ½ month grace period, resulting in the forfeiture of funds remaining in your account (the IRS "Use-it-or-Lose-it" rule).

- **Contact us**

To learn more or to enroll, please visit the **FSAFEDS Web site** at www.FSAFEDS.com, or contact SHPS directly via email or by phone. FSAFEDS Benefits Counselors are available Monday through Friday, from 9 a.m. until 9 p.m. Eastern Time.

- E-mail: FSAFEDS@shps.net
- Telephone: 1-877-FSAFEDS (1-877-372-3337)
- TTY: 1-800-952-0450

The Federal Long Term Care Insurance Program

- **It's important protection**

Why should you consider applying for coverage under the **Federal Long Term Care Insurance Program (FLTCIP)**?

- **FEHB plans do not cover the cost of long term care.** Also called “custodial care,” long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later.** In order to qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.

- **To request an Information Kit and application**

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

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Summary of benefits for the Lovelace Health Plan - 2006

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: \$15 primary care; \$25 specialist	14
Services provided by a hospital:		
● Inpatient	\$250 per admission copay	28
● Outpatient	\$150 per facility use	29
Emergency benefits:		
● In-area	\$15 per office visit; \$30 per urgent care visit; \$75 per hospital emergency care visit	32
● Out-of-area	\$15 per office visit; \$30 per urgent care visit; \$75 per hospital emergency care visit	32
Mental health and substance abuse treatment:		
	Regular cost sharing	33
Prescription drugs:		
● Retail pharmacy	\$7 per generic formulary; \$15 per name brand formulary; \$35 per name brand non-formulary.	35
● Mail order	\$14 per generic formulary; \$30 per name brand formulary; \$70 per name brand non-formulary. Note: If there is no generic equivalent available, you will still have to pay the name brand copay.	35
Dental care (Accidental dental injury only)		
	\$15 per office visit	39

<p>Vision care:</p>	<p>Eye exam, including refractions once every calendar year, \$5 copay. One pair of eyeglasses or one set of contact lenses once every calendar year, subject to the following maximum Plan payment every calendar year:</p> <p>Single lenses-\$20; Bifocal lenses-\$30; Trifocal lenses-\$40; Contact lenses-\$75; Frames-\$30. You pay the difference above amount shown for lenses and more costly frames.</p> <p>Disease or Injury to the eye – when medically necessary \$15 primary care; \$25 specialist.</p>	<p>20</p>
<p>Special features:</p>	<p>Flexible benefits option; 24 hour nurse line; Services for deaf and hearing impaired; Centers of Excellence; Travel benefit/services overseas.</p>	<p>38</p>
<p>Protection against catastrophic costs (out-of-pocket maximum):</p>	<p>Nothing after \$2,500/Self Only or \$5,000/ Family enrollment per year. This copay maximum does not include Prescription drugs, Dental services, Mental Health/ Substance Abuse services, External Prosthetics or Infertility services.</p>	<p>11</p>

2006 Rate Information for

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable FEHB Guide.

Type of Enrollment	Enrollment Code	<i>Non-Postal Premium <u>Biweekly</u> Government Share</i>	<i>Non-Postal Premium <u>Biweekly</u> Your Share</i>	<i>Non-Postal Premium <u>Monthly</u> Government Share</i>	<i>Non-Postal Premium <u>Monthly</u> Your Share</i>	<i>Postal Premium <u>Biweekly</u> USPS Share</i>	<i>Postal Premium <u>Biweekly</u> Your Share</i>
Self Only	Q11	\$120.05	\$40.02	\$260.12	\$86.70	\$142.06	\$18.01
Self and Family	Q12	\$294.60	\$98.20	\$638.30	\$212.77	\$348.61	\$44.19