

CITY OF ALBUQUERQUE

**MY CARE FAMILY
HMO PLAN
(HHH10049)**

The following Schedule of Benefits is a summary that describes the Copayment amounts that apply to specific types of services. Some benefits require Benefit Certification by Presbyterian Health Plan (PHP). Benefits may have limits and certain services are excluded altogether. When the Copayment is expressed as a percentage, the percentage will be applied to the Total Allowable Charges for the particular procedure allowed by PHP. For a more complete description, please refer to Sections of the *Group Subscriber Agreement* that discuss How the Plan Works, General Information, Benefits, Benefit Certification, Limitations and Exclusions.

CITY OF ALBUQUERQUE MY CARE FAMILY (HHH10049) BENEFITS AND COVERAGE	LIMITS
ANNUAL CALENDAR YEAR DEDUCTIBLE	None
ANNUAL OUT-OF-POCKET MAXIMUM	2 x Annual premium
SPECIALTY PHARMACEUTICAL ANNUAL CALENDAR YEAR OUT-OF-POCKET MAXIMUM	\$1,500 per Calendar Year
MAXIMUM LIFETIME BENEFIT	Unlimited
AUTISM SPECTRUM DISORDER DIAGNOSIS AND TREATMENT MAXIMUM LIFETIME BENEFIT	\$200,000 per member per lifetime Beginning January 1, 2011 the maximum benefit shall be adjusted manually on January 1 to reflect any change from the previous year in the medical component of the then-current consumer price index for all urban consumers published by the Bureau of Labor Statistics of the United States Department of Labor.
BENEFITS AND COVERAGE	COPAYMENT – Note: “Child” is any enrolled Dependent child, regardless of age. “Adult” is the Contract holder and Dependent spouse or domestic partner, regardless of age.
PHYSICIAN SERVICES including: Office visits <ul style="list-style-type: none"> • Non-specialist • Specialist Home visits if Medically Necessary Outpatient Surgery (In Physician’s office) Specialty Pharmaceuticals ⁽¹⁾ (Injectable forms administered in Physician’s office) Allergy Services <ul style="list-style-type: none"> • Testing • Serum (extracts) • Injections Injections such as insulin, heparin and injectable antibiotics Infertility Services including drugs and injections ⁽¹⁾ On-campus Student Health Center Hospital and Skilled Nursing Care visits	\$30 Copayment per visit – Adult \$0 Copayment per visit – Child \$45 Copayment per visit – Adult \$30 Copayment per visit – Child \$45 Copayment per visit – Adult \$30 Copayment per visit – Child Included in office visit Copayment \$50 per injection 20% Copayment 20% Copayment Included in office visit Copayment (waived if nursing visit only) Included in office visit Copayment (waived if nursing visit only) 50% Copayment \$30 Copayment per visit – Adult \$0 Copayment per visit – Child \$0 Copayment
HOSPITAL SERVICES – Inpatient ⁽¹⁾ Coverage Includes: <ul style="list-style-type: none"> • Room and Board • Newborn delivery and other Hospital Obstetrical services • In-Hospital Physician visits, Surgeons, Anesthesiologist and other Inpatient Services • Detoxification 	\$500 Copayment per admission – Adult \$350 Copayment per admission – Child

⁽¹⁾ Benefit Certification will be required

CITY OF ALBUQUERQUE MY CARE FAMILY (HHH10049) BENEFITS AND COVERAGE	COPAYMENT
MEDICAL SERVICES – Outpatient <ul style="list-style-type: none"> • Surgeries⁽¹⁾ (at facility) • X-ray and laboratory tests • PET⁽¹⁾/MRI⁽¹⁾ scans • Cardiac Cath • GI Lab • CAT⁽¹⁾ scans • Radiation Therapy (Non-surgical) • Chemotherapy <ul style="list-style-type: none"> Specialty Pharmaceuticals⁽¹⁾ Oral or inhalation forms/Self-administered Specialty Pharmaceuticals⁽¹⁾ Intravenous (IV) • Home/ Sleep Studies • Administration of blood/blood components 	20% up to a maximum of \$500 Copayment per visit – Adult 20% up to a maximum of \$200 Copayment per visit – Child \$0 Copayment \$200 Copayment per test – Adult \$100 Copayment per test – Child \$300 Copayment per visit – Adult \$175 Copayment per visit – Child \$175 Copayment per visit – Adult \$150 Copayment per visit – Child \$125 Copayment per test – Adult \$75 Copayment per test – Child \$0 Copayment \$0 Copayment \$50 per prescription/injection \$0 Copayment \$50 Copayment per study \$0 Copayment
RECONSTRUCTIVE SURGERY⁽¹⁾	Included in Hospital Services – Inpatient, Medical Services – Outpatient and Physician Services
EMERGENCY ROOM CARE Including trauma services	\$150 Copayment per visit (waived if admitted into a Hospital, then Hospital Copayment applies) (Adult and Child)
URGENT CARE <ul style="list-style-type: none"> • Participating Provider/Practitioner • Non-Participating Provider/Practitioner (In or out of the Service Area) 	\$40 Copayment per visit – Adult \$10 Copayment per visit – Child \$50 Copayment per visit – Adult \$30 Copayment per visit – Child
AMBULANCE SERVICES including: Emergency or high-risk <ul style="list-style-type: none"> • Ground ambulance • Air ambulance Inter-Facility transfer services <ul style="list-style-type: none"> • Ground ambulance • Air ambulance 	\$50 Copayment per occurrence \$100 Copayment per occurrence \$0 Copayment \$100 Copayment per occurrence
CLINICAL PREVENTIVE SERVICES Well Child Care including vision and hearing screening Preventive physical exam Adult and child immunizations Office Based Health education Family planning services Cytologic Screening (Pap smear) Human Papillomavirus (HPV) Screening HPV Vaccine for females Health Education Mammography Colonoscopy	Plan pays 100%

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CITY OF ALBUQUERQUE MY CARE FAMILY (HHH10049) BENEFITS AND COVERAGE	COPAYMENT
PRESCRIPTION DRUGS (RETAIL) <ul style="list-style-type: none"> • Generic (Preferred) • Brand (Preferred) • Brand (when a generic equivalent is available) • Non-Preferred 	\$10 Copayment (Per 30-day supply up to the maximum dosing recommended by the manufacturer) \$30 Copayment (Per 30-day supply up to the maximum dosing recommended by the manufacturer) Generic Copayment plus the difference in the cost of the brand and generic per 30-day supply up to the maximum dosing recommended by the manufacturer) \$50 Copayment (30-day supply up to the maximum dosing recommended by the manufacturer)
PRESCRIPTION DRUGS (MAIL ORDER) <ul style="list-style-type: none"> • Generic (Preferred) • Brand (Preferred) • Brand (when a generic equivalent is available) • Non-Preferred 	2 x generic Copayment (90-day supply up to the maximum dosing recommended by the manufacturer) 2.5 x brand Copayment (90-day supply up to the maximum dosing recommended by the manufacturer) 2 x generic Copayment plus the difference in the cost of the brand and generic (90-day supply up to the maximum dosing recommended by the manufacturer) 3 x Non-Preferred Copayment (90-day supply up to the maximum dosing recommended by the manufacturer)
MENTAL HEALTH SERVICES⁽¹⁾ Outpatient Inpatient Partial Hospitalization	\$30 Copayment per visit – Adult \$0 Copayment per visit – Child \$500 Copayment per admission – Adult \$350 Copayment per admission – Child \$500 Copayment per admission – Adult \$350 Copayment per admission – Child (waived if immediately following an Inpatient hospitalization discharge)
ALCOHOL AND SUBSTANCE ABUSE SERVICES⁽¹⁾ Detoxification <ul style="list-style-type: none"> • Outpatient • Inpatient Rehabilitation <ul style="list-style-type: none"> • Outpatient • Inpatient • Partial Hospitalization 	\$30 Copayment per visit – Adult \$0 Copayment per visit – Child \$500 Copayment per admission – Adult \$350 Copayment per admission – Child \$30 Copayment per visit – Adult \$0 Copayment per visit – Child \$500 Copayment per admission – Adult \$350 Copayment per admission – Child \$500 Copayment per admission – Adult \$350 Copayment per admission – Child (waived if immediately following an Inpatient hospitalization discharge)

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CITY OF ALBUQUERQUE MY CARE FAMILY (HHH10049) BENEFITS AND COVERAGE	COPAYMENT
DURABLE MEDICAL EQUIPMENT, PROSTHETICS, AND APPLIANCES⁽¹⁾ <ul style="list-style-type: none"> • Hearing Aids (for school aged children under age 18 or 21 years of age if still attending high school). 	50% Copayment Up to \$2,200 every 36 months “per hearing impaired ear”
EYEGASSES AND CONTACT LENSES Limited to the following: <ul style="list-style-type: none"> • Eyeglasses and contact lenses within 12 months following cataract surgery or for the correction of Keratoconus, or when related to Genetic Inborn Errors of Metabolism • Refraction eye exam associated with post cataract surgery or Keratoconus correction 	50% Copayment Included in office visit Copayment
DENTAL SERVICES/(CMJ/TMJ) (Limited)	Included in office visit Copayment
FAMILY, INFANT AND TODDLER PROGRAM Family, Infant and Toddler Program (FIT): Medically Necessary early intervention services provided as part of an individualized family service plan and delivered by certified and licensed personnel as defined in NMAC Title 7, Chapter 30, Part 8 Health Family & Children Health Care Services.	No Copayment \$3,500 per Member per Calendar Year Maximum benefit Not applicable to any Lifetime Maximums or annual limits
AUTISM SPECTRUM DISORDER⁽¹⁾ Treatment though or provided by: <ul style="list-style-type: none"> PCP Specialist Outpatient Physical Therapy Outpatient Occupational Therapy Outpatient Speech Therapy Applied Behavioral Analysis (ABA)⁽¹⁾ Diagnosis and Treatment for all children up to age 19 or up to age 22 if still attending high school	\$0 Copayment per visit – Child \$30 Copayment per visit – Child \$0 Copayment per visit – Child Up to \$36,000 per member per Calendar Year

⁽¹⁾ Benefit Certification will be required

EXCLUSIONS FOR CITY OF ALBUQUERQUE MY CARE FAMILY (HHH10049):

Refer to the Group Subscriber Agreement for a more complete description of Exclusions & Limitations.

Any exclusion listed would not be applicable if covered under the FIT Program in accordance with that which is defined in NMAC Title 7, Chapter 30, Part 8 Health, Family & Children Care Services. Refer to your *Group Subscriber Agreement* for details.

- **Alternative/complementary therapies**, except as specified in the *Group Subscriber Agreement* (GSA).
- **Any service**, treatment, procedure, facility, equipment, drugs, drug usage, device or supply determined to be **not Medically Necessary** or accepted medical practice.
- **Artificial aids** including speech synthesis devices except items identified in the *Group Subscriber Agreement* (GSA).
- **Athletic trainers.**
- **Autopsies** and/or transportation costs for deceased Members.
- **Baby food** (including baby formula or breast milk) or other regular grocery products that can be blenderized for oral or tube feedings.
- **Benefits and services not specified as Covered.**
- **Biofeedback**, except as specified in the *Group Subscriber Agreement* (GSA).
- **Cancer Clinical Trials** are limited and must be provided for in the State of New Mexico in **accordance with the provisions set forth in the *Group Subscriber Agreement* (GSA).**
- **Care for conditions which State or local law requires** be treated in a public or correctional facility.
- **Care for military service connected disabilities** to which the Member is legally entitled and for which facilities are reasonably available to the Member.
- **Charges that are determined to be unreasonable by PHP.**
- **Circumcisions** performed other than during the newborn's Hospital stay unless Medically Necessary.
- **Clothing** or other protective devices including prescribed photoprotective clothing, windshield tinting, lighting fixtures and/or shields, and other items or devices whether by prescription or not.
- **Co-dependency treatment.**
- **Convenience items.**
- **Cosmetic Surgery, treatments, devices, Orthotics, and medications**, including treatment of hair-loss.
- **Costs for extended warranties** and premiums for other insurance Coverage.
- **Counseling** – sex, pastoral/spiritual, and bereavement counseling.
- **Court ordered evaluation or treatment**, or treatment that is a condition of parole or probation or in lieu of sentencing, such as Alcohol or Substance Abuse programs and/or psychiatric evaluation or therapy.
- **Covered services obtained from a Non-Participating Provider/Practitioner**, except as provided in the *Group Subscriber Agreement* (GSA).
- **Custodial or Domiciliary Care.**
- **Dental care** and dental x-rays, except as provided in the *Group Subscriber Agreement* (GSA).
- **Dental implants.**
- **Disposable medical supplies**, except when provided in a Hospital or a Physician's office or by a home health professional.
- **Donor Sperm.**
- **Durable Medical Equipment/Prosthetics/Orthotics** except as listed as Covered in this Schedule of Benefits and the *Group Subscriber Agreement* – additional wheelchairs, duplicate items, convenience items, upgraded or deluxe items, repair or replacement due to loss, neglect, misuse, abuse, to improve appearance, for convenience or items under the manufacturer or supplier's warranty.
- **Elastic support hose.**
- **Elective abortions** after the 24th week of pregnancy.
- **Elective Home Birth** and any prenatal or postpartum services connected with an Elective Home Birth.
- **Emergency facility** used for non-emergent services.
- **Exercise equipment** and videos, personal trainers, club memberships and weight reduction programs.
- **Experimental/Investigational**, as determined by PHP, drugs, medicines, treatments or procedures.
- **Extracorporeal shock wave therapy** involving the musculoskeletal system.
- **Eye movement therapy.**
- **Eye refractive procedures** including radial keratotomy, laser procedures, and other techniques.

EXCLUSIONS FOR CITY OF ALBUQUERQUE MY CARE FAMILY (HHH10049):

- **Eyeglasses (Corrective)** or sunglasses, frames, lens prescription, contact lenses or the fitting thereof except as provided in the *Group Subscriber Agreement (GSA)*.
- **Foot care (routine)**, except as provided in the *Group Subscriber Agreement (GSA)*.
- **“Get acquainted” visits** without physical assessment or diagnostic or therapeutic intervention provided.
- **Gloves**, unless part of a wound treatment kit.
- **Hair-loss** (or baldness) treatments, medications, supplies and devices including wigs, and special brushes.
- **Halfway houses**.
- **Hearing aids** and the evaluation for the fitting of hearing aids except for school aged children under 18 years old (or under 21 years of age if still attending high school).
- **Hospice benefits are not available for the following services:** food, housing and delivered meals, volunteer services, comfort items such as, but not limited to, aromatherapy, clothing, pillows, special chairs, pet therapy, fans, humidifiers, and special beds (excluding those Covered under Durable Medical Equipment benefits), homemaker and housekeeping services, private duty nursing, pastoral and spiritual counseling or bereavement counseling.
- **Hypnotherapy** except as part of anesthesia preparation or chronic pain management.
- **Infant formula**.
- **In-vitro, GIFT and ZIFT fertilization**.
- **Lay midwife** – Services of a lay midwife or an unlicensed midwife.
- **Malocclusion treatment**, if part of routine dental care and orthodontics.
- **Massage Therapy**, unless performed by a licensed physical therapist and as part of a prescribed short-term physical therapy program.
- **Medical and Hospital services of a donor** when the recipient of an Organ transplant is a not a Member or when the transplant procedure is **not Covered**.
- **New medications** for which the determination of criteria for Coverage has not yet been established by PHP’s Pharmacy and Therapeutics Committee.
- **Nutritional supplements** except as provided in the *Group Subscriber Agreement (GSA)*.
- **Organ transplants (Non-human)**, except for porcine (pig) heart valve.
- **Orthodontic appliances, endodontics, dental prosthetics, crowns, bridges, and dentures**.
- **Orthodontic appliances** and orthodontic treatment, crowns, bridges, and dentures used for the treatment of Craniomandibular and Temporomandibular Joint disorders, unless the disorder is trauma related.
- **Orthopedic or corrective shoes**, arch supports, shoe appliances, foot orthotics, and custom fitted braces or splints except for patients with diabetes or other significant peripheral neuropathies.
- **Orthotics (functional foot)**, except as provided in the *Group Subscriber Agreement (GSA)* for patients with diabetes or other significant peripheral neuropathies.
- **Orthotics/orthosis (Custom Fabricated)** except as specified in the Groups Subscriber Agreement (GSA).
- **Over-The-Counter (OTC) medications except as specified in the *Group Subscriber Agreement (GSA)***.
- **Personal or comfort items, services or treatments**.
- **Photophoresis** for all conditions other than mycosis fungoides.
- **Physical examinations**, vaccinations, drugs and immunizations for the primary intent of medical research or non-Medically Necessary purpose(s) such as, but not limited to, licensing, certification, employment, insurance, flight, travel, passports or functional capacity examinations related to employment.
- **Prescription Drugs** (as listed as Covered in this Schedule of Benefits and the *Group Subscriber Agreement*) received upon Hospital discharge, provided by a Hospital pharmacy unless a Participating outpatient pharmacy is not available.
- **Prescription Drugs requiring a Benefit Certification when Benefit Certification was not obtained**.
- **Prescription Drugs ordered by a Non-Participating Provider** or purchased at a Non-Participating Pharmacy unless required due to an emergency occurring outside of the Service Area.
- **Prescription Drug**, compounded medications.
- **Prescription Drug replacements** due to loss, theft, or destruction.
- **Private duty nursing**.
- **Psychological testing** when not Medically Necessary.
- **Residential Treatment Centers** unless for the treatment of Alcoholism and/or Substance Abuse rehabilitation.
- **Reversals of voluntary sterilization**.
- **Services for which the Member is eligible under any governmental program** (except Medicaid), or services for which, in the absence of any health service plan or insurance plan, no charge would be made to the Member or Dependent.

EXCLUSIONS FOR CITY OF ALBUQUERQUE MY CARE FAMILY (HHH10049):

- **Services requiring Benefits Certification** when Benefit Certification was not obtained.
- **Sex transformation surgery and drugs** relating to sex transformation.
- **Sexual dysfunction treatment**, including medication, counseling, and clinics, except for penile prosthesis as provided in the *Group Subscriber Agreement (GSA)*.
- **Special education**, school testing or evaluations, counseling, therapy or care for learning deficiencies or disciplinary problems. This applies whether or not associated with manifest mental illness or other disturbances. Except as provided for under the Family, Infant and Toddler (FIT) Program. Refer to the *Group Subscriber Agreement (GSA)* for more information.
- **Special Medical Foods**, except as listed as Covered in the *Group Subscriber Agreement (GSA)* for Genetic Inborn Errors of Metabolism.
- **Storage or banking** of sperm, ova (human eggs), embryos, zygotes, or other human tissue.
- **“Telephone visits”** by a Provider/Practitioner or “consultation” by telephone for which a change is made to the patient is Not Covered **except for members that have been diagnosed with diabetes**. Also, “get acquainted” visits without physical assessment or diagnostic or therapeutic intervention provided are Not Covered.
- **Transportation costs** for deceased Members.
- **Travel and lodging** expense, except as provided in the *Group Subscriber Agreement (GSA)*.
- **Vision care (routine) and Eye Refractions** for determining prescriptions for corrective lenses, except as listed as Covered in the *Group Subscriber Agreement (GSA)*.
- **Visual training**.
- **Vocational Rehabilitation Services and Long-Term Rehabilitation Services**.
- **Weight reduction or control treatments**, except for Medically Necessary treatment for morbid obesity.
- **Work-related accidents** or injuries or occupational illness or disease if the Member is required to be Covered under workers’ compensation insurance, whether or not such Coverage actually exists.

Refer to the Group Subscriber Agreement for a more complete description of Exclusions & Limitations.

This Schedule of Benefits and services is subject to the provisions of the Contract and cannot modify or affect the Group Subscriber Agreement in any way; nor shall you accrue rights because of any statement in or omission from this schedule.

Plan ID's - HHH10049 (for internal use)