

**CITY OF ALBUQUERQUE  
MY CARE INDEPENDENT  
HMO POINT OF SERVICE PLAN  
(HHG10008)**

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 INDEPENDENT POS (HHG10008) BENEFITS AND COVERAGE	LIMITS	
	In-network Copayment	Out-of-network Copayment <sup>(3)</sup>
<b>ANNUAL CALENDAR YEAR DEDUCTIBLE</b> – Does not apply to Out-of-pocket maximum	None	\$500 per Individual Family: \$1,500
<b>ANNUAL OUT-OF-POCKET MAXIMUM</b>	2x Annual Premium	Individual: \$6,000 Family: \$18,000  Includes % Copayment only – does not include Deductible, Copayments, charges above Reasonable and Customary, Prescription Drug Copayments, or non-Covered charges including charges incurred after the benefit maximum has been reached. PHP pays 100% of Covered charges after the Out-of-pocket maximum is met and up to Reasonable and Customary when applicable.
<b>MAXIMUM LIFETIME BENEFIT</b>	Unlimited	Unlimited
<b>AUTISM SPECTRUM DISORDER DIAGNOSIS AND TREATMENT MAXIMUM LIFETIME BENEFIT</b>	\$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.	
<b>UNIQUE SERVICES PROGRAM</b> – Refer to the <i>Group Subscriber Agreement</i> for more details.	\$250 reimbursement per family per Calendar Year for: <ul style="list-style-type: none"> <li>• Prescription Drug costs – Copayments, Prescriptions not covered by the Prescription Drug benefits, delivery charges for home delivered prescriptions</li> <li>• Routine vision care – Eye refraction’s, glasses, contact lenses</li> <li>• Disease management classes*</li> <li>• Alternative Therapies such as yoga, acupuncture, massage therapy, chiropractic, hypnotherapy and biofeedback above and beyond those services covered by the benefit portion of this plan*</li> <li>• Dental Treatments*</li> <li>• Diagnostic Devices*</li> <li>• Hearing Aids</li> </ul> <p>* If recommended by a Physician to treat a specific medical condition. A note or Prescription from the Provider and the Unique Services Reimbursement Form must be submitted.</p>	

<sup>(1)</sup> Benefit Certification will be required <sup>(2)</sup>Not subject to Deductible <sup>(3)</sup> Benefits are limited to Reasonable and Customary Charges. You are responsible for any balance due above Reasonable and Customary Charges.

Eff. 7/1/11

*Refer to the Group Subscriber Agreement for a more complete description of benefits*

<b>CITY OF ALBUQUERQUE MY CARE INDEPENDENT POS (HHG10008) BENEFITS AND COVERAGE</b>	<b>In-network</b>	<b>Out-of-network<sup>(3)</sup></b>
<b>PHYSICIAN SERVICES</b> including: Office visits <ul style="list-style-type: none"> <li>• Non-specialist</li> <li>• Specialist</li> </ul> Home visits if Medically Necessary Outpatient Surgery (In Physician’s office) Specialty Pharmaceuticals <sup>(1)</sup> (Injectable forms administered in Physician’s office) Allergy Services <ul style="list-style-type: none"> <li>• Testing</li> <li>• Serum (extracts)</li> <li>• Injections</li> </ul> Injections such as insulin, heparin and injectable antibiotics Infertility Services including drugs and injections <sup>(1)</sup> On-campus Student Health Center Hospital and Skilled Nursing Care visits	\$30 Copayment per visit \$45 Copayment per visit  \$45 Copayment per visit 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 \$0 Copayment	40% 40%  40% 40%  <b>Not Covered</b>  40% 40% 40%  40%  <b>Not Covered</b>  \$30 Copayment per visit 40%
<b>HOSPITAL SERVICES – Inpatient<sup>(1)</sup></b> Coverage Includes: <ul style="list-style-type: none"> <li>• Room and Board</li> <li>• Newborn delivery and other Hospital Obstetrical services</li> <li>• In-Hospital Physician visits, Surgeons, Anesthesiologist and other Inpatient Services</li> <li>• Detoxification</li> </ul>	\$500 Copayment per admission	40%
<b>MEDICAL SERVICES – Outpatient</b> <ul style="list-style-type: none"> <li>• Surgeries<sup>(1)</sup> (at facility)</li> <li>• X-ray and laboratory tests</li> <li>• PET<sup>(1)</sup> scans</li> <li>• Magnetic Resonance Imaging (MRI)<sup>(1)</sup> tests</li> <li>• Cardiac Cath</li> <li>• GI Lab</li> </ul> <b>MEDICAL SERVICES – Outpatient</b> <i>continued on next page</i>	20% Copayment up to a maximum of \$500 per visit \$0 Copayment \$125 Copayment per test \$125 Copayment per test  \$200 Copayment per visit \$175 Copayment per visit	40% 40% 40% 40%  40% 40%

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<b>MEDICAL SERVICES – Outpatient</b> <i>continued from previous page</i> <ul style="list-style-type: none"> <li>• CAT<sup>(1)</sup> scans</li> <li>• Radiation Therapy (Non-surgical)</li> <li>• Chemotherapy</li> <li>Specialty Pharmaceuticals<sup>(1)</sup> Oral or inhalation forms/ Self-administered</li> <li>Specialty Pharmaceuticals<sup>(1)</sup> Intravenous (IV)</li> <li>• Home/Sleep Studies</li> <li>• Administration of blood/blood components</li> </ul>	\$75 Copayment per test \$0 Copayment  \$0 Copayment \$50 per prescription  \$0 Copayment  \$50 Copayment per study \$0 Copayment	40% 40%  40% <b>Not Covered</b>  <b>Not Covered</b>  40% 40%
<b>RECONSTRUCTIVE SURGERY<sup>(1)</sup></b>	Included in Hospital Services – Inpatient, Medical Services – Outpatient, and Physician Services	40%
<b>EMERGENCY ROOM CARE</b> Including trauma services	\$150 Copayment per visit (waived if admitted into a Hospital, then Hospital Copayment applies)	\$150 Copayment per visit <sup>(2)</sup> (waived if admitted into a Hospital, then Hospital Copayment applies)
<b>URGENT CARE</b> <ul style="list-style-type: none"> <li>• Participating Provider/ Practitioner</li> <li>• Non-Participating Provider/ Practitioner (In or out of the Service Area)</li> </ul>	\$45 Copayment per visit  NA	NA  \$55 Copayment per visit <sup>(2)</sup>
<b>AMBULANCE SERVICES</b> including: Emergency or high-risk <ul style="list-style-type: none"> <li>• Ground ambulance</li> <li>• Air ambulance</li> </ul> Inter-Facility transfer services <ul style="list-style-type: none"> <li>• Ground ambulance</li> <li>• Air ambulance</li> </ul>	\$50 Copayment per occurrence \$100 Copayment per occurrence  \$0 Copayment \$100 Copayment per occurrence	\$50 Copayment per occurrence \$100 Copayment per occurrence  \$0 Copayment \$100 Copayment per occurrence
<b>CLINICAL PREVENTIVE SERVICES</b> 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%	40% <sup>(2)</sup>

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<b>CITY OF ALBUQUERQUE MY CARE INDEPENDENT POS (HHG10008) BENEFITS AND COVERAGE</b>	<b>In-network</b>	<b>Out-of-network<sup>(3)</sup></b>
<b>WOMEN'S HEALTH CARE</b> Gynecological Care In office Obstetrical/Maternity Care/Prenatal & Postnatal care Specialist (i.e. Perinatologist)  Cytologic (Pap Smear), Human Papillomavirus (HPV) screening, and Mammograms refer to Clinical Preventive Services. Newborn Delivery and other Hospital Obstetrical Services Implantable contraceptive devices <ul style="list-style-type: none"> <li>• Insertion</li> <li>• Removal</li> </ul>	\$30 Copayment per visit \$30 Copayment per visit up to a maximum of \$300 per pregnancy \$45 Copayment per visit not included in \$300 maximum listed above  \$500 Copayment per admission  50% Copayment per insertion Included in office visit Copayment	40% 40% 40%    40%  50% 40%
<b>DIABETES SERVICES</b> Office visit and Diabetes education Certified Diabetes Educator Telephone visits Diabetic supplies <sup>(1)</sup> (Purchased through a Participating Durable Medical Equipment Supplier) Diabetic supplies including Insulin and diabetic oral agents for controlling blood sugar (Purchased through a Participating Pharmacy)	Included in office visit Copayment Included in office visit Copayment 50% Copayment  Generic (Preferred)-\$10 Copayment Brand (Preferred)-\$30 Copayment Non-Preferred-\$50 Copayment (Per 30-day supply up to the maximum dosing recommended by the manufacturer)	40% 40% 50%  <b>Not Covered</b>
<b>COVERED MEDICATIONS-</b> Outpatient (Purchased at a Participating Pharmacy, unless due to an emergency occurring outside of the PHP Service Area) <ul style="list-style-type: none"> <li>• Medically Necessary Nutritional Supplements for prenatal care</li> <li>• Insulin and diabetic oral agents</li> <li>• Diabetic supplies (purchased through a Participating Pharmacy)</li> <li>• Smoking cessation drugs (Limited to two (2) 90-day courses of treatment per Calendar Year)</li> <li>• Contraceptive Drugs</li> </ul> <b>COVERED MEDICATIONS</b> <i>continued on next page</i>	Generic (Preferred)-\$10 Copayment Brand (Preferred)-\$30 Copayment Non-Preferred-\$50 Copayment (Per 30-day supply up to the maximum dosing recommended by the manufacturer)	<b>Not Covered</b>

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CITY OF ALBUQUERQUE MY CARE INDEPENDENT POS (HHG10008) BENEFITS AND COVERAGE	In-network	Out-of-network <sup>(3)</sup>
<b>PRESCRIPTION DRUGS (MAIL ORDER)</b> – <i>Continued from prev page</i> <ul style="list-style-type: none"> <li>• Brand (when a generic equivalent is available)</li> <li>• Non-Preferred</li> </ul>	2 x brand Copayment (90-day supply up to the maximum dosing recommended by the manufacturer) 3 x generic Copayment (90-day supply up to the maximum dosing recommended by the manufacturer)	<b>Not Covered</b>  <b>Not Covered</b>
<b>MENTAL HEALTH SERVICES<sup>(1)</sup></b> Outpatient Inpatient Partial Hospitalization	\$30 Copayment per visit \$500 Copayment per admission \$500 Copayment per admission (waived if immediately following an Inpatient hospitalization discharge)	40% 40% 40%
<b>ALCOHOL AND SUBSTANCE ABUSE SERVICES<sup>(1)</sup></b> Detoxification <ul style="list-style-type: none"> <li>• Outpatient</li> <li>• Inpatient</li> </ul> Rehabilitation <ul style="list-style-type: none"> <li>• Outpatient</li> <li>• Inpatient</li> <li>• Partial hospitalization</li> </ul>	\$30 Copayment per visit \$500 Copayment per admission \$30 Copayment per visit \$500 Copayment per admission \$500 Copayment per admission (waived if immediately following an Inpatient hospitalization discharge)	40% 40% 40% 40% 40%
<b>REHABILITATION AND THERAPY SERVICES</b> Cardiac Rehabilitation (up to 12 sessions continuous ECG monitoring and 24 sessions intermittent ECG monitoring per Calendar Year) Dialysis/Plasmapheresis/Photophoresis Pulmonary Rehabilitation (up to 24 sessions per Calendar Year)  <b>REHABILITATION AND THERAPY SERVICES</b> <i>continued on next page</i>	\$30 Copayment per session  20% Copayment per visit \$30 Copayment per session	<b>Not Covered</b>  40% <b>Not Covered</b>

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<b>CITY OF ALBUQUERQUE MY CARE INDEPENDENT POS (HHG10008) BENEFITS AND COVERAGE</b>	<b>In-network</b>	<b>Out-of-network<sup>(3)</sup></b>
<b>DURABLE MEDICAL EQUIPMENT, PROSTHETICS, AND APPLIANCES<sup>(1)</sup></b>  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”	50% Copayment
<b>EYEGASSES AND CONTACT LENSES<sup>(1)</sup></b>  Limited to the following: <ul style="list-style-type: none"> <li>• 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</li> <li>• Refraction eye exam associated with post cataract surgery or Keratoconus correction</li> </ul>	50% Copayment  Included in office visit Copayment	<b>Not Covered</b>  <b>Not Covered</b>
<b>DENTAL SERVICES/(CMJ/TMJ)</b> (Limited)	Included in office visit Copayment	40%
<b>FAMILY, INFANT AND TODDLER PROGRAM</b> 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	
<b>AUTISM SPECTRUM DISORDER<sup>(1)</sup></b>  Treatment through or provided by: <ul style="list-style-type: none"> <li>PCP</li> <li>Specialist</li> <li>Outpatient Physical Therapy</li> <li>Outpatient Occupational Therapy</li> <li>Outpatient Speech Therapy</li> <li>Applied Behavioral Analysis (ABA)<sup>(1)</sup></li> </ul> Diagnosis and Treatment for all children up to age 19 or up to age 22 if still attending high school.	\$30 Copayment per visit \$45 Copayment per visit \$30 Copayment per visit  Up to \$36,000 per member per Calendar Year combined In and Out-of-network \$200,000 per member per lifetime combined In and Out-of-network	40% Copayment per visit 40% Copayment per visit

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## EXCLUSIONS FOR CITY OF ALBUQUERQUE MY CARE INDEPENDENT POS PLAN (HHG10008):

*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) and as provided or under the Unique Services Reimbursement Program.
- **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) and as provided for under the Unique Service Reimbursement Program.
- **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 except as provided for under the Unique Service Reimbursement Program.
- **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.
- **Custodial or domiciliary care** except as provided for under the Unique Service Reimbursement Program.
- **Dental care** and dental x-rays, except as provided in the *Group Subscriber Agreement* (GSA) and as provided for under the Unique Services Reimbursement Program.
- **Dental implants** except as provided for under the Unique Services Reimbursement Program.
- **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 24<sup>th</sup> 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.

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- **Eyeglasses (Corrective)** or sunglasses, frames, lens prescription, contact lenses or the fitting thereof except as provided in the *Group Subscriber Agreement (GSA)* and as provided for under the Unique Services Reimbursement Program.
- **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 as provided for under the Unique Services Reimbursement Program.
- **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 and as provided for under the Unique Services Reimbursement Program.
- **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 and as provided for under the Unique Service Reimbursement 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)* and as provided for under the Unique Services Reimbursement Program.
- **Organ transplants (Non-human)**, except for porcine (pig) heart valve.
- **Orthodontic appliances, endodontics, dental prosthetics, crowns, bridges, and dentures** except as provided for under the Unique Services Reimbursement Program.
- **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 and as provided for under the Unique Services Reimbursement Program.
- **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).
- **Out-of-network services** for Transplants, Infertility services, Cardiac and Pulmonary Rehabilitation, Covered medications, Prescription Drugs, Specialty Pharmaceuticals, and Special Medical Foods except as provided for under the Unique Service Reimbursement Program.
- **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 except as provided for under the Unique Service Reimbursement Program.
- **Prescription Drugs requiring a Benefit Certification when Benefit Certification was not obtained** except as provided for under the Unique Reimbursement Program.

## **EXCLUSIONS FOR CITY OF ALBUQUERQUE MY CARE INDEPENDENT POS PLAN (HHG10008):**

- **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 and as provided for under the Unique Service Reimbursement Program.
- **Prescription Drug**, compounded medications except as provided for under the Unique Service Reimbursement Program.
- **Prescription Drug replacements** due to loss, theft, or destruction except as provided for under the Unique Service Reimbursement Program.
- **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.
- **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)* and as provided for under the Unique Services Reimbursement Program.
- **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 – HHG10008 *(for internal use only)*