SMART CARE 5000/30
SMALL GROUP
HMO
(HHH10074)

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.

SMART CARE 5000/30 SMALL GROUP (HHH10074) BENEFITS AND COVERAGE	LIMITS
ANNUAL CALENDAR YEAR DEDUCTIBLE (For Benefits noted with a [2] the Deductible must be met before payments are made)	Individual:$5,000 Family: 3x Individual
ANNUAL OUT-OF-POCKET MAXIMUM – Includes % Copayments which are subject to Deductible only. **Does not include** Deductible, all other Copayments, or non-Covered charges.	Individual: $4,500 Family: 3x Individual
MAXIMUM LIFETIME BENEFIT	Unlimited
BENEFITS AND COVERAGE	**COPAYMENT**
PHYSICIAN SERVICES including:	
Office visits	
• Primary Care Physician (PCP)	$30 Copayment per visit
• Specialist	$40 Copayment per visit
Home visits	**Not Covered**
Outpatient Surgery (In Physician's office)	Included in office visit Copayment
Specialty Pharmaceuticals[1] (Injectable forms administered in Physician's office)	15% Copayment up to a maximum of $250 per injection and $1,500 per Calendar Year
Allergy Services	
• Testing	30% Copayment
• Serum (extracts)	30% Copayment
• Injections	Included in office visit Copayment (waived if nursing visit only)
Injections such as insulin, heparin and injectable antibiotics	Included in office visit Copayment (waived if nursing visit only)
Infertility Services including drugs and injections[1]	50% Copayment
On-campus Student Health Center	$30 Copayment per visit
Hospital and Skilled Nursing Care visits	30% Copayment[2]
HOSPITAL SERVICES – Inpatient[1] Coverage Includes: • Room and Board • Newborn delivery and other Hospital Obstetrical services • In-Hospital Physician visits, Surgeons, Anesthesiologist and other Inpatient Services • Detoxification	30% Copayment per admission[2]
MEDICAL SERVICES – Outpatient	
• Surgeries[1] (at facility)	30% Copayment per visit [2]
• X-ray and laboratory tests	30% Copayment per test[2]
• PET[1]/CAT Scans	30% Copayment per test [2]
• Cardiac Cath/ GI Lab	30% Copayment per visit [2]
• Radiation Therapy (Non-surgical)	30% Copayment per test [2]
• Chemotherapy	30% Copayment per treatment[2]
Specialty Pharmaceuticals[1] Oral or inhalation forms/Self-administered	15% Copayment up to a maximum of $250 per prescription and $1,500 per Calendar Year
Specialty Pharmaceuticals[1] Intravenous (IV)	$0 Copayment
• Magnetic Resonance Imaging (MRI) tests	30% Copayment per test [2]
• Sleep Studies	30% Copayment per study [2]
• Administration of blood/blood components	30% Copayment per visit[2]

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RECONSTRUCTIVE SURGERY[1]	Included in Hospital Services – Inpatient, Medical Services – Outpatient, and Physician Services
EMERGENCY ROOM CARE Including trauma services	$100 Copayment per visit (waived if admitted into a Hospital, then Hospital Copayment applies)
URGENT CARE • Participating Provider/Practitioner • Non-Participating Provider/Practitioner (In or out of the Service Area)	 $40 Copayment per visit $40 Copayment per visit
AMBULANCE SERVICES including: Emergency or high-risk • Ground ambulance • Air ambulance Inter-Facility transfer services • 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) Mammography Human Papillomavirus (HPV) Screening Health Education	 $30 Copayment per visit $30 Copayment per visit Included in office visit Copayment (waived if nursing visit only) Included in office visit Copayment Included in office visit Copayment Included in office visit Copayment Included in office visit Copayment Included in office visit Copayment Included in office visit Copayment
WOMEN'S HEALTH CARE 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 • Insertion • Removal	 $30 Copayment per visit $30 Copayment per visit up to a maximum of $300 per pregnancy $40 Copayment per visit Not included in $300 maximum listed above 30% Copayment per admission[2] 50% Copayment per insertion[2] 50% Copayment per insertion[2]
DIABETES SERVICES Office visit and Diabetes education Diabetic supplies[1] (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 50% Copayment[2] Generic (Preferred) - $10 Copayment Brand (Preferred) - $35 Copayment Non-Preferred – $55 Copayment (Per 30-day supply up to the maximum dosing recommended by the manufacturer)

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COVERED MEDICATIONS – Outpatient (Purchased at a Participating Pharmacy, unless due to an emergency occurring outside of the PHP Service Area)	
• Medically Necessary Nutritional Supplements for prenatal care • Insulin and diabetic oral agents • Diabetic supplies (purchased through a Participating Pharmacy) • Smoking cessation drugs (Limited to two (2) 90-day courses of treatment per Calendar Year)	Generic (Preferred) - $10 Copayment Brand (Preferred) - $35 Copayment Non-Preferred – $55 Copayment (Per 30-day supply up to the maximum dosing recommended by the manufacturer)
Immunosuppressive drugs following transplant surgery	
• Oral	Generic (Preferred) - $10 Copayment Brand (Preferred) - $35 Copayment Non-Preferred – $55 Copayment (Per 30-day supply up to the maximum dosing recommended by the manufacturer)
• Injectable	15% Copayment up to a maximum of $250 per injection and $1,500 per Calendar Year
Specialty Pharmaceuticals[1] Oral or inhalation forms/Self-administered	15% Copayment up to a maximum of $250 per prescription and $1,500 per Calendar Year
Specialty Pharmaceuticals[1] Intravenous (IV)	$0 Copayment
Special Medical Foods[1]	50% Copayment
This plan is considered Creditable per Medicare part D guidelines. For more information regarding Medicare Part D please refer to www.cms.gov.	
PRESCRIPTION DRUGS (RETAIL)	
• Generic (Preferred)	$10 Copayment (30-day supply up to the maximum dosing recommended by the manufacturer)
• Brand (Preferred)	$35 Copayment (30-day supply up to the maximum dosing recommended by the manufacturer)
• Brand (when a generic equivalent is available)	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
• Non-Preferred	$55 Copayment (30-day supply up to the maximum dosing recommended by the manufacturer)
• Pre-packaged items	Applicable Copayment (generic, brand, Non-Preferred) per pre-packaged item
PRESCRIPTION DRUGS (MAIL ORDER)	
• Generic (Preferred)	2 x generic Copayment (90-day supply up to the maximum dosing recommended by the manufacturer)
• Brand (Preferred)	2.5 x brand Copayment (90-day supply up to the maximum dosing recommended by the manufacturer)
• Brand (when a generic equivalent is available)	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)
• Non-Preferred	3 x Non-Preferred Copayment (90-day supply up to the maximum dosing recommended by the manufacturer)

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MENTAL HEALTH SERVICES[1]	
Outpatient	$40 Copayment per visit
Inpatient	30% Copayment per admission[2]
Partial Hospitalization	30% Copayment per admission[2]
ALCOHOL AND SUBSTANCE ABUSE SERVICES[1]	
Detoxification	
• Outpatient	$40 Copayment per visit
• Inpatient	30% Copayment per admission[2]
Rehabilitation	
Outpatient	**Not Covered**
Inpatient or partial hospitalization	**Not Covered**
REHABILITATION AND THERAPY SERVICES	
Cardiac Rehabilitation (up to 12 sessions continuous ECG monitoring and 24 sessions intermittent ECG monitoring per Calendar Year)	30% Copayment per session[2]
Dialysis/Plasmapheresis/Photophoresis	30% Copayment per visit[2]
Pulmonary Rehabilitation (up to 24 sessions per Calendar Year)	30% Copayment per session[2]
Short-term Rehabilitation[1] (Physical and Occupational Therapy up to 2 months per condition)	
• Inpatient	30% Copayment per admission[2]
• Outpatient	30% Copayment per session[2]
Speech and Hearing Therapy[1] (up to 2 months per condition)	30% Copayment per session[2]
TRANSPLANTS[1] Limited to the following organs: Cornea; Kidney; Liver for children with biliary atresia and other rare congenital abnormalities; Bone marrow for aplastic anemia, leukemia, severe combined immunodeficeincy disease (SCID), or Wiskott-Aldrich syndrome.	30% Copayment per admission[2]
COMPLEMENTARY THERAPIES (Limited)	
Acupuncture Services (up to 20 visits per Calendar Year if Medically Necessary as specified in Section IV.E. of the Group Subscriber Agreement)	30%[2] Copayment per session
Chiropractic Services (up to 18 visits per Calendar Year if Medically Necessary)	30%[2] Copayment per session
Biofeedback for specific conditions	30%[2] Copayment per session
SKILLED NURSING FACILITY[1] (Up to 60 days per Calendar Year)	30%[2] Copayment per admission
HOME HEALTH CARE SERVICES[1]**/ HOME INTRAVENOUS SERVICES**[1]	
Services provided by an RN, LPN and other specified specialist	30% Copayment[2]
Home intravenous services and supplies	30% Copayment[2]
Specialty Pharmaceuticals[1] Oral or inhalation forms/Self-administered	15% Copayment up to a maximum of $250 per prescription and $1,500 per Calendar Year
Specialty Pharmaceuticals[1] Intravenous (IV)	$0 Copayment

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HOSPICE CARE[1] Inpatient In-home	 30%[2] Copayment per admission 30% Copayment[2]
DURABLE MEDICAL EQUIPMENT, PROSTHETICS, AND APPLIANCES[1] **Limited Coverage** Coverage is limited to items specified as Covered in the Group Subscriber Agreement in Section IV. G.3. for diabetic supplies, I.6. for lenses for specific conditions, and Z.7. for breast prostheses post Mastectomy.	50% Copayment[2]
EYEGLASSES AND CONTACT LENSES[1] Limited to the following: • 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 [2] Included in office visit Copayment
DENTAL SERVICES/(CMJ/TMJ) (Limited)	30%[2]
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

EXCLUSIONS FOR SMART CARE 5000/30 SMALL GROUP (HHH10074):

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.

- **Alcoholism and Substance Abuse services**, except for Substance Abuse Medical Detoxification.
- **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 to phase 2, 3 and 4 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,** Orthotic Appliances, and Prosthetic Devices, except as provided in the Group Subscriber Agreement (GSA) for diabetic supplies, lenses for specific conditions, and breast prostheses post Mastectomy. Refer to the Group Subscriber Agreement for these Benefits.
- **Durable Medical Equipment/Prosthetics/Orthotics** 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.

EXCLUSIONS FOR SMART CARE 5000/30 SMALL GROUP (HHH10074):

- **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.
- **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.
- **Home Sleep Studies.**
- **Home visits by a Physician.**
- **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, 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 not listed as Covered and Non-human organs,** 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.

EXCLUSIONS FOR SMART CARE 5000/30 SMALL GROUP (HHH10074):

- **Private duty nursing.**
- **Psychological testing** when not Medically Necessary.
- **Residential Treatment Centers.**
- **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** and electronic mail (E-mail)" by a Physician or "environmental intervention" or "consultation" by telephone for which a charge is made to the patient.
- **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 Small – HHH10142