

MiChild Benefit Summary (MI)

This is intended to serve as an easy-to-read summary of benefits. It is not a contract. It does not modify or take the place of the Subscriber Contract. Services must be obtained from participating plan physicians and providers. **Please refer to the Subscriber Contract for a complete description of the specific benefits available. There are no copays or deductibles for covered authorized services.**

Services	
Physician Services <i>physician and other professional provider services and medical/surgical supplies include:</i>	
Office Visits	Allergy Testing
Surgery	Cataract Surgery
Anesthesia/Oxygen	Chemotherapy
Inpatient/Outpatient Medical Care	Physical/Occupational/Speech Therapy
Inpatient/Outpatient Consultation	Hemodialysis
Emergency Medical Treatment	Dermatology
Treatment of Accidental Injuries treated within 48 hours of injury	Private Duty Skilled Nursing
Diagnostic testing, lab, and X-rays	Certain Dental Work or Oral Surgery
Prenatal and postnatal care services	Blood/Blood Storage
PAP Testing once every 12 consecutive months	Second Surgical Opinion
Family Planning Services	Peritoneal Services
Pediatric Well-Child Care <i>pediatric Well-Child is covered for the following services:</i>	
Physician Office Visits/Well-Child care – birth to 24 months	Immunizations – birth to age 19
Physician Office Visits/Physician Exams – 24 months to age 19	Blood lead testing
Inpatient Hospital Services <i>inpatient hospital and admissions are covered up to 365 days per benefit year, including the following services/supplies:</i>	
Semi-private room/ICU	Chemotherapy
Surgery/Anesthesia	Maternity Care
Diagnostic Care and Tests	Physician Services
Medication and Supplies	
Outpatient Hospital Services <i>outpatient hospital is covered for the following services:</i>	
Surgery	Chemotherapy
Pre-Admission Testing within 72 hours of inpatient admission	Hemodialysis
Emergency Room Services for an illness or disease if the condition is life threatening (do not use the emergency room for illness that can be treated by your doctor during office hours).	Diagnostic Services
Emergency Health Services <i>emergency treatment is covered without prior authorization if medically necessary and includes:</i>	
Treatment In-Area and Out-of-Area	Available 24 hours, 7 days a week
Skilled Nursing Facility Services <i>skilled nursing facility benefits are covered up to 120 days per admission for skilled care in a skilled nursing or extended care facility while convalescing from general conditions and pulmonary TB including:</i>	
Semi-private room and meals	Nursing Services
Medical Supplies and Medications	Physical/Speech/Occupational/Therapy
Lab and X-rays	Oxygen/Gas Therapy
Short-Term Medical Rehabilitation Services <i>The following services are covered for a combined 60 visits per calendar year:</i>	
Physical Therapy	Occupational Therapy
Speech Therapy	
Home Health Services <i>home health services is covered for 120 days per calendar year and includes:</i>	
Nursing care by a RN/LPN	Home Health Aide Services
Medical and Surgical Supplies	Social Services
Lab and Medications	Physical/Speech/Occupational Therapy
Oxygen	
Ambulance Services	
Emergency transportation services are covered if medically necessary	To or from the hospital, skilled nursing facility or home when prior authorized

Services

Durable Medical Equipment, Orthotic Appliances, and Prosthetic Devices	
<p>DME is covered on a rental or purchase basis when:</p> <ul style="list-style-type: none"> • Reasonably and medically necessary for treatment of illness, injury or disease • Prescribed by Physician and used in course of medical treatment • Purchased from a professional supplier 	<p>PROSTHETIC ORTHOTIC DEVICES are covered when prescribed by a physician as medically necessary.</p> <ul style="list-style-type: none"> • Please see your Subscriber Contract for limitations and exclusions
Hearing Services <i>hearing care supplies are payable once every 36 consecutive months. The following benefits are covered:</i>	
Audiometric Exam	Hearing Aid Evaluation Tests
Dispensing Fees	Hearing Aid Conformity Tests
Hearing Aids	
Prescription Drugs <i>pharmacy benefits are covered for each prescription drug or refill purchased up to a 30-day supply for acute medications and up to a 100-day supply for maintenance medications. Prescriptions are to be filled with a generic medication unless otherwise indicated by the prescribing physician and any required prior authorizations are obtained. Benefits include:</i>	
Prescribed medications	Insulin syringes/needles
Birth Control prescriptions	Injectable insulin
Certain Over-the-Counter Drugs defined by HPM Commercial formulary	Tobacco cessation prescription and non-prescription agents approved by the FDA.
Oral Surgery and Related Services	
See Subscriber Contract	
Organ and Tissue Transplants <i>the following benefits are covered:</i>	
Hospital and professional medical services to receive a non-experimental transplant of a human organ or body tissue as defined by established utilization guidelines.	HPM will pay for the covered services for donors if the donor does not have transplant benefits under any other health care plan.
Vision Services <i>the following vision care benefits are covered:</i>	
Annual Vision Exam	Annual Glaucoma Testing
Eye glasses every 24 months or once every 12 months with a prescription change	
Hospice Services <i>hospice care is covered for up to 210 days, two periods of 90 days each, and one period of 30 days during the patient's lifetime. Covered benefits include:</i>	
Nursing Care by a RN	Medical Social Services
Short-term inpatient care	Bereavement Counseling up to 30 days following patient's death
Home Health Aide Services	Homemaker Services
Medical supplies and Medications	
Acupuncture Therapy <i>acupuncture treatments are covered up to a maximum of 20 visits/calendar year when performed by a physician for the treatment of:</i>	
Sciatica	Chronic headaches
Tic douloureux	Myofascial complaints
Rheumatoid arthritis	Post-herpetic neuralgia
Neuritis	Osteoarthritis
Chiropractic Services <i>chiropractic care benefits include:</i>	
Initial Office Exam & X-Rays	First Aid Treatment
Manipulations	24 visits per calendar year
Weight Loss	
Weight loss counseling is covered for morbid obesity when prescribed by a physician	
Other Services	
Tobacco cessation, diagnostic therapy and diagnostic services	Flouride varnish (ages 3 and under)
NOT COVERED by HealthPlus	
Routine Dental	Hearing Aid Repairs/Replacement Parts
Services provided by school district and billed through the Intermediate School district	Drug Refills Beyond Prescribed Amount
	Transplants of artificial organs
	Elective Abortions
	Prescriptions for mental health/substance abuse medications written by the Community Mental Health Services Programs (CMHSP) providers, with the exception of mental health pharmacy services for Attention Deficit Hyperactive Disorder (ADHD) and Attention Deficit Disorder (ADD) when prescribed by the HealthPlus provider network.