HealthPlus

State of Michigan $125/$250- 100% Plan
HMO Benefit Summary ~ *(Internal Code MG)*
Effective: 10/12/2014
Excludes MSPTA (T01)

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 and/or applicable rider(s). Services must be obtained from participating plan physicians and providers. **Please refer to the Subscriber Contract and applicable rider(s) for a complete description of the specific benefits available.**

Services	Member Responsibility
Deductible	$125 per Member $250 per Family
Out-of-Pocket Maximum *Includes all flat dollar copayments*	$2,000 per Member $4,000 per Family
Preventive Services	
Periodic Routine Physical Exam *(Limited to one per calendar year with no member copay; office visit copay applies to additional visits)*	$0 Copayment
Annual Gynecological Exam (through PCP or self-referral to HPM Affiliated Gynecologist) *(Limited to one per calendar year with no member copay; office visit copay applies to additional visits)*	$0 Copayment
Routine Well-Baby and Well Child Care – • 7 visits per calendar year newborn to age 12 months; • 6 visits per calendar year 13 months-23 months; • 3 visits per calendar year 24 months-47 months; • 1 visit per calendar year 4 years-17 years; • Office visit copay applies to any additional visits	$0 Copayment
Pediatric and Adult Immunizations in accordance with accepted medical practice	$0 Copayment
Breast Cancer Screening Mammograms	$0 Copayment
Prostate Cancer Screening	$0 Copayment
Lab and Pathology associated with Preventive Services when provided by an Affiliated Laboratory	$0 Copayment
Additional Covered Preventive Services *(See your benefit rider and the HealthPlus website at www.healthplus.org for other covered preventive services)*	$0 Copayment
Physician Services *Some services may require a referral. Please refer to your Benefit Rider.*	
Primary Care Physician Office Visit for illness or injury	$20 Copayment per Visit
Specialist Office Visit (referral required)	$20 Copayment per Visit
Maternity Services Provided By a Physician *Member may self-refer to HPM Affiliated OB/GYN Provider*	
Maternity Care including Pre-Natal Care, Counseling, Miscarriage and other related Obstetrical Services	$0 Copayment
Postpartum Care	$20 Copayment per Visit
Delivery and Nursery Care	$0 Copayment after Deductible
Emergency Medical Care	
Hospital Emergency Room (in or out of Service Area). (*ER Copayment waived if admitted as inpatient or to observation status)*	$200 Copayment (waived if admitted)
Freestanding Emergency Center or Urgent Care Center (in or out of Service Area)	$20 Copayment per Visit
Physician services when billed separately from facility charge	$0 Copayment
Ambulance Services – when medically necessary	$0 Copayment after Deductible
Diagnostic Services	
Laboratory and Pathology Services	$0 Copayment
Diagnostic and Therapeutic Radiological Services such as EKG, EEG, Diagnostic X-rays, Radiation Therapy and other medically acceptable diagnostic or therapeutic procedures when provided by Affiliated Provider	$0 Copayment after Deductible
Hospital Care/Ambulatory Surgical Facility Care	
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	$0 Copayment after Deductible
Outpatient Services at a hospital or Ambulatory Surgical Facility including use of	$0 Copayment after Deductible

Services	Member Responsibility
operating, recovery and treatment rooms, lab test, X-rays, anesthetics, etc.	
Alternatives to Hospital Care	
Skilled Nursing Facility (limited to 120 days per confinement)	$0 Copayment after Deductible
Hospice Care	$0 Copayment after Deductible
Private Duty Nursing	$0 Copayment
Home Health Care (does not cover custodial care or general housekeeping services)	$20 Copayment per Visit after Deductible
Mental Health Care and Substance Abuse Treatment *Limited to Medically Necessary treatment*	
Mental Health Care – Inpatient, Partial Hospitalization and Intensive Outpatient Treatment	$0 Copayment after Deductible
Mental Health Care – Outpatient Treatment	$20 Copayment per Visit
Substance Abuse Care – Inpatient, Partial Hospitalization and Intensive Outpatient Treatment	$0 Copayment after Deductible
Substance Abuse Care – Outpatient Treatment	$20 Copayment per Visit
Autism Spectrum Disorder Services *Most services require referral and/or prior authorization. Dollar limits apply to Applied Behavior Analysis Therapy. Please refer to your Benefit Rider and Amendment for details.*	
Applied Behavior Analysis Therapy to diagnose and treat ASD	$0 Copayment after Deductible
Physical, Occupational, Speech Therapy as part of ASD treatment	$20 Copayment per Day
Outpatient Mental Health Services to diagnose and treat ASD	$20 Copayment per Visit
Prescription Drugs	
Select Generic Maintenance/Preventive Medications	$0 Copayment per prescription
Generic	$10 Copayment per prescription
Formulary Brand	$30 Copayment per prescription
Non-Formulary Brand	$60 Copayment per prescription
A 90-Day supply is available at Participating "Ask for 90 Rx" Retail Pharmacies or by Mail Order through Express Scripts for two Copayments	
Other Services *Some services may require a referral. Please refer to your Benefit Rider.*	
Allergy Testing and Therapy	$0 Copayment after Deductible
Chiropractic Services (referral required)	$20 Copayment after Deductible
Podiatry Services (referral required)	$20 Copayment after Deductible
Family Planning Services (may require referral)	$0 Copayment after Deductible
Human Organ and Tissue Transplants (referral required)	$0 Copayment after Deductible
Outpatient Physical, Speech and Occupational Therapy (referral required; limited to a combined 90 Visits per calendar year)	$20 Copayment per Day
Durable Medical Equipment, Orthotic and Prosthetic Appliances (may require referral)	$0 Copayment
Hearing Aids (limited to 1 standard hearing aid per ear every 12 months)	$0 Copayment

Not Covered: (For a more complete list, please see your Benefit Rider; Benefit Limitations and Exclusions Section)

- Services not provided or authorized by your primary care physician, except for emergencies
- Services and supplies that are not medically necessary, except checkups and related care to help maintain good health
- Dental care, Cosmetic surgery, Custodial care, Routine foot care, Wigs or prosthetic hair
- Eye glasses or contact lenses (except for the initial pair prescribed after cataract surgery)
- Exams for employment, licensing, insurance, travel, education, or sport purposes
- Services to the extent benefits are received or payable under Workers' Compensation, any insurance plan or state or federal laws
- Experimental treatments, Vocational rehabilitation, Personal or comfort items, such as television set or telephone
- Orthopedic footwear (unless attached to a brace, or outflow shoes)
- Reversals of voluntary sterilization, all forms of in vitro fertilization, transsexual surgery, all services related to surrogate parenting arrangements, and all associated services and preparatory treatment related to any of the above. Artificial insemination is not a benefit except when approved by a Plan Physician for treatment of infertility
- Services or supplies from convalescent homes, homes for the aged, or adult foster care facilities
- Drugs, services, or supplies provided on an outpatient basis and not specifically identified as being covered by the plan
- 24-hour skilled nursing care in the home, acupuncture
- All other benefit limitations and exclusions listed in the HealthPlus Subscriber Contract and applicable Rider(s)