

HMO Benefit Summary ~ BU

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
Preventive Services	
Periodic Routine Physical Exam	\$10 Copayment per Visit
Annual Gynecological Exam (through PCP or self-referral to HPM Affiliated Gynecologist)	\$10 Copayment per Visit
Routine Well-Baby and Well Child Care	\$10 Copayment per Visit
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
Physician Services <i>Some services may require a referral. Please refer to your Benefit Rider.</i>	
Primary Care Physician Office Visit for illness or injury	\$10 Copayment per Visit
Specialist Office Visit (referral required)	\$10 Copayment per Visit
Professional services by Specialist Physicians other than Office Visits (referral required)	\$0 Copayment
Allergy Testing and Therapy (serum, testing, injections). An office visit copay may apply	\$0 Copayment
Maternity Services Provided By a Physician	
Maternity Care including Pre-Natal Care, Counseling, Delivery, Postpartum Visit, Miscarriage and other related obstetrical services (Member may self-refer to HPM Affiliated OB/GYN Provider)	\$0 Copayment
Prescription Drugs (includes birth control pills)	
Generic	\$5 Copayment per Prescription
Brand	\$10 Copayment per Prescription
A 90-day supply is available at Participating Retail Pharmacies through the "Ask for 90" program or by Mail Order Service through Express Scripts for two Copayments	
Emergency Medical Care	
Hospital Emergency Room (in or out of the Service Area)	\$0 Copayment when admitted to Hospital. \$50 Copayment per Visit for other use.
Freestanding Emergency Center or Urgent Care Center (in or out of the Service Area)	\$10 Copayment per Visit
Physician services when billed separately from facility charge	\$0 Copayment
Ambulance Transportation – when medically necessary	\$0 Copayment for immediate transportation in conjunction with an accident or other life threatening situation, or when authorized in advance by HealthPlus. \$25 Copayment per occurrence for other use.

Services	Member Responsibility
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
Hospital Care <i>All hospital admissions must be authorized in advance by HPM or within 24 hours of an emergency admission</i>	
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	\$0 Copayment
Outpatient Surgery Services including use of operating, recovery and treatment rooms, lab test, X-rays, anesthetics, etc.	\$0 Copayment
Surgical Services – all related services including anesthesia and appropriate professional services	\$0 Copayment
Alternatives to Hospital Care	
Skilled Nursing Facility (<i>Limited to 730 days per Member per lifetime</i>)	\$0 Copayment
Hospice Care	\$0 Copayment
Home Health Care (does not cover custodial care or general housekeeping services)	\$0 Copayment
Mental Health Care and Substance Abuse Treatment	
Mental Health Care – Inpatient and Day Treatment (<i>Limited to Medically Necessary treatment</i>)	\$0 Copayment
Mental Health Care – Outpatient (<i>Limited to Medically Necessary treatment</i>)	\$10 Copayment per Visit
Substance Abuse Care – Inpatient and Intermediate care (<i>Limited to Medically Necessary treatment</i>)	\$0 Copayment
Substance Abuse Care – Outpatient care (<i>Limited to Medically Necessary treatment</i>)	\$10 Copayment per Visit
Other Services <i>Some services may require a referral. Please refer to your Benefit Rider.</i>	
Family Planning Services (may require referral)	\$0 Copayment
Outpatient Physical, Speech and Occupational Therapy; (referral required)	\$0 Copayment
Durable Medical Equipment, Orthotic and Prosthetic Appliances (may require referral)	\$0 Copayment
Human Organ and Tissue Transplants (referral required)	\$0 Copayment
Hearing Aids	\$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
- 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)
- Sex transformation surgery and all expenses connected with that surgery
- 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
- Wigs or prosthetic hair
- 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, Private duty nursing
- Routine foot care
- All other benefit limitations and exclusions listed in the HealthPlus Subscriber Contract and applicable Rider(s)