

## HMO Benefit Summary ~ KY

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
<b>Preventive Services</b>	
Periodic Routine Physical Exam ( <i>Limited to one per benefit year with no member copay; office visit copay applies to additional visits</i> )	\$0 Copayment
Annual Gynecological Exam (through PCP or self-referral to HPM Affiliated Gynecologist) ( <i>Limited to one per benefit year with no member copay; office visit copay applies to additional visits</i> )	\$0 Copayment
Routine Well-Baby and Well Child Care – <ul style="list-style-type: none"> <li>7 visits per benefit year newborn to age 12 months;</li> <li>6 visits per benefit year 13 months-23 months;</li> <li>3 visits per benefit year 24 months-47 months;</li> <li>1 visit per benefit year 4 years-17 years;</li> <li>Office visit copay applies to any additional visits</li> </ul>	\$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 ( <i>See your benefit rider and the HealthPlus website at <a href="http://www.healthplus.org">www.healthplus.org</a> for other covered preventive services</i> )	\$0 Copayment
<b>Physician Services</b> <i>Some services may require a referral. Please refer to your Benefit Rider.</i>	
Primary Care Physician Office Visit for illness or injury	\$20 Copayment per Visit
Specialist Office Visit (referral required)	\$20 Copayment per Visit
Allergy Testing and Therapy (serum, testing, injections) (Office visit copay may apply)	\$0 Copayment
<b>Maternity Services Provided By a Physician</b> <i>Member may self-refer to HPM Affiliated OB/GYN Provider</i>	
Maternity Care including Pre-Natal Care, Counseling, Delivery, Postpartum Care, Miscarriage and other related Obstetrical Services	\$0 Copayment (Office visit copay may apply to first physician visit)
<b>Emergency Medical Care</b>	
Hospital Emergency Room (in or out of Service Area). ( <i>ER Copayment waived if admitted as inpatient or to observation status.</i> )	\$200 Copayment or 50%, whichever is less, per Visit
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 ( <i>Copay waived for immediate transportation in conjunction with an accident or life threatening situation, or when authorized in advance by HealthPlus</i> )	\$25 Copayment per occurrence
<b>Diagnostic Services</b>	
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
<b>Hospital Care/Ambulatory Surgical Facility Care</b>	
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	\$0 Copayment
Outpatient Services at a hospital or Ambulatory Surgical Facility including use of operating, recovery and treatment rooms, lab test, X-rays, anesthetics, etc.	\$0 Copayment

Services	Member Responsibility
<b>Alternatives to Hospital Care</b>	
Skilled Nursing Facility	\$0 Copayment
Hospice Care	\$0 Copayment
Home Health Care (does not cover custodial care or general housekeeping services)	\$0 Copayment
<b>Mental Health Care and Substance Abuse Treatment</b>	
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>	\$20 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>	\$20 Copayment per Visit
<b>Prescription Drugs (includes birth control pills)</b>	
Generic	\$10 Copayment per prescription
Formulary Brand	\$30 Copayment per prescription
Non-Formulary Brand	\$60 Copayment per prescription
<b>A 90-Day supply is available at Participating “Ask for 90 Rx” Retail Pharmacies or by Mail Order through Express Scripts for one Copayment</b>	
<b>Other Services</b> <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 services
- Routine foot care
- All other benefit limitations and exclusions listed in the HealthPlus Subscriber Contract and applicable Rider(s)

**NOTICE: PRIMARY CARE PROVIDER DESIGNATION AND OB/GYN ACCESS**

HealthPlus of Michigan HMO plans require the designation of a Primary Care Physician (PCP) for each member of your family. You have the right to choose any affiliated PCP who is accepting new patients. You may designate an affiliated pediatrician as your child’s PCP. For information on how to select a PCP or to find a HealthPlus affiliated PCP, please go to our website at [www.healthplus.org](http://www.healthplus.org) or call Customer Service at 1-800-332-9161.

You do not need prior authorization from HealthPlus or from your PCP to obtain access to routine obstetrical or gynecological care from an affiliated provider who specializes in obstetrics or gynecology. Your provider will have to comply with all HealthPlus procedures including prior authorizations for certain services and procedures for making referrals. For information on how to access an OB/GYN health care professional please go to our website at [www.healthplus.org](http://www.healthplus.org) or call Customer Service at 1-800-332-9161.