HealthPlus
The Right Plan for a Healthier You™

Benefit Summary ~ CN
Signature $1750-100% Gold HMO

This is intended to be 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 Benefit Rider(s). **Please refer to your Benefit Rider and the Subscriber Contract for a complete description of your benefits, including preventive services, and benefit limitations and exclusions.** Services must be obtained from affiliated plan physicians and providers.

Services	Member Responsibility
Deductible (Deductible applies to all services except those with a flat dollar copayment. Percent (%) copayment applies after deductible is met.	$1,750 per Member $3,500 per Family
Out-of-Pocket Maximum (all member payments for covered services apply to Out-of-Pocket Maximum)	$3,000 per Member $6,000 per Family
Physician Services	
Primary Care Physician office or home visit for illness or injury	$25 Copayment per Visit
Specialist Office or home visit *(referral required for some specialties)*	$50 Copayment per Visit
Chiropractor services (*referral required)*	$25 Copayment per Visit
Routine maternity care, delivery, postpartum, miscarriage, and related obstetrical services (*no referral required to see an affiliated obstetrician)*	Office Visit Copayment may apply to first Visit—otherwise NONE
Hospital And Ambulatory Surgical Center Services *Referral and/or authorizations required*	
Inpatient Hospital: Semi-Private Room, physician care, general nursing care, maternity care, and newborn nursery care	No copay after deductible met
Outpatient Hospital surgery services	No copay after deductible met
Other outpatient hospital services, such as diagnostic X-rays, radiation therapy, and chemotherapy	No copay after deductible met
Ambulatory Surgical Center: use of operating rooms, and treatment rooms; surgical supplies; support care	No copay after deductible met
Emergency Medical Care and Ambulance Services	
Hospital Emergency Room *(in or out of Service Area)* *(Copayment waived if admitted as inpatient or to observation status)*	$250 Copayment per Visit
Physician /Practitioner services in a hospital emergency department	NONE
Urgent Care Center *(in or out of Service Area)*	$75 Copayment per Visit
Ambulance Services – when medically necessary	No copay after deductible met
Preventive Services *See our website **www.healthplus.org/preventiveservices** or Benefit Rider (Section 2.6) for a complete list of covered preventive services. No referral required to affiliated Pediatrician for well-baby or well-child visits. No referral required to affiliated Gynecologist for annual gynecological visit.* ***Deductible does not apply***	
Annual preventive exam, well baby and child visits, annual gynecological visit, immunizations, cancer screenings, and other preventive services	NONE
Mental Health And Substance Abuse Treatment Services *Referral/authorization for inpatient service*	
Inpatient Mental Health Hospitalization	No copay after deductible met
Outpatient Mental Health Services	$25 Copayment per Visit
Inpatient Substance Abuse Detoxification and/or Treatment	No copay after deductible met
Outpatient Substance Abuse Services	$25 Copayment per Visit
Diagnostic Services	
Laboratory Services	NONE
Pathology Services	No Copayment for pathologist services after deductible met
Diagnostic and Therapeutic Radiological and Imaging Services, including radiation therapy, chemo therapy, dialysis, etc.	No copay after deductible met

Services	Member Responsibility
Short Term Rehabilitation Services *Referral and/or authorization required*	
Physical and Occupational Therapy for treatment of illness or injury (limited to 30 combined visits per benefit year including chiropractor visits)	No copay after deductible met
Speech Therapy for the treatment of illness or injury (limited to 30 visits per benefit year)	No copay after deductible met
Habilitation Services (Autism Spectrum Disorder) *Referral and/or authorization required*	
Applied Behavior Analysis Therapy to diagnose and treat ASD	No copay after deductible met
Physical, Occupational, and Speech Therapy as part of ASD treatment	No copay after deductible met
Outpatient Mental Health Services to diagnose and treat ASD	$25 Copayment per Visit
Alternatives to Hospital Care *Referral and/or authorizations required for some services*	
Skilled Nursing Facility *(Limited to 45 days per Member per benefit year)*	No copay after deductible met
Hospice Care	No copay after deductible met
Home Health Care *(does not cover custodial care or general housekeeping services)*	No copay after deductible met
Prescription Drug Coverage *Prior authorization, step therapy, mandatory specialty pharmacy and 90 supply requirements apply—See Benefit Rider for details* ***Deductible does not apply***	
Generic	$10 Copayment (30 day supply)
Formulary Brand	$80 Copayment (30 day supply)
Non-Formulary Brand	$160 Copayment (30 day supply)
Specialty drugs	25% up to maximum $250 Copayment (30 day supply)
90 Day Mail Order and Retail "Ask for 90" programs: 2 Copayments for 90 day supply—See Benefit Rider for details	
Other Services *Some services may require a referral and/or authorization—See Benefit Rider for details*	
Durable Medical Equipment, Orthotic and Prosthetic Appliances	No copay after deductible met
Pediatric Dental Services (up to age 19) including exams, X-rays, fillings, and extractions (see Benefit Rider for additional covered services) **Administered by AVESIS and uses AVESIS Dental Network**	NONE
Pediatric Vision Services (up to age 19) including annual eye exam and glasses (see Benefit rider for limitations and exclusions) **Administered by AVESIS and uses AVESIS Vision Network**	NONE

Not Covered: See your Benefit Rider (Benefit Limitations and Exclusions) for detailed list of services that are not covered.

- Services not provided or authorized by your primary care physician, except for emergencies
- Services and supplies not medically necessary, except checkups and related care to help maintain good health
- Hearing aids, eye glasses, or contact lenses (except for the initial pair prescribed after cataract surgery)
- Exams for employment, licensing, insurance, travel, education, or sport purposes
- Personal or comfort items, such as a television set or telephone
- Orthopedic footwear (unless attached to a brace or outflow shoes)
- Experimental treatments; wigs or prosthetic hair; private duty nursing services; routine foot care
- Sex transformation surgery and all expenses connected with that surgery; all forms of assisted reproduction
- All 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 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 or call Customer Service at 1-800-332-9161.