

SVSU ~ POS Benefit Summary ~ PE/RJ, Effective 1/1/2010

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 Level 1 (PCP- Directed)	Member Responsibility Level 2 (Self-Directed)
Preventive Services (Self Referral to Affiliated OB/GYN for Annual Gynecological Exam is allowed as Level 1 Benefit)		
Periodic Routine Physical Exam	\$20 Copayment per Visit	20% Copayment
Pediatric and Adult Immunizations in accordance with accepted medical practice	\$0 Copayment	20% Copayment
Breast Cancer Screening Mammograms	\$0 Copayment	20% 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	20% Copayment
Specialist Office Visit (referral required)	\$20 Copayment per Visit	20% Copayment
Annual Gynecological Exam	\$20 Copayment per Visit	20% Copayment
Routine Well-Baby and Well Child Care	\$20 Copayment per Visit	20% Copayment
Allergy Testing and Therapy (serum, testing, injections). An office visit copay may apply	\$0 Copayment	20% Copayment
Maternity Services Provided By a Physician (Self Referral to HPM Affiliated OB/GYN Provider for Routine Maternity Care is allowed as Level 1 Benefit)		
Maternity Care including Pre-Natal Care, Counseling, Delivery, Postpartum Care, Miscarriage and other related obstetrical services	\$0 Copayment	20% Copayment
Emergency Medical Care		
Hospital Emergency Room (in or out of the Service Area)	\$0 when admitted to Hospital. \$100 Copayment per Visit for other use.	\$0 when admitted to Hospital. \$100 Copayment per Visit for other use.
Freestanding Emergency Center or Urgent Care Center	\$25 Copayment per Visit	\$25 Copayment per Visit
Physician services when billed separately from facility charge	\$0 Copayment	\$0 Copayment
Ambulance Transportation	\$25 Copayment per occurrence	\$25 Copayment per occurrence
Diagnostic Services		
Laboratory and Pathology	\$0 Copayment	20% Copayment
Diagnostic and Therapeutic Radiological Services such as EKG, EEG, Diagnostic X-rays, Radiation or Chemo Therapy	\$0 Copayment	20% Copayment
Hospital Care (All hospital admissions must be authorized in advance by HPM or within 24 hours of an emergency admission)		
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	\$0 Copayment	20% Copayment *
Outpatient Surgery, including use of operating, recovery and treatment rooms, lab tests, X-rays, anesthetics, etc.	\$0 Copayment	20% Copayment per surgery
Surgical Services – all related services including anesthesia and appropriate professional services	\$0 Copayment	20% Copayment
Alternatives to Hospital Care		
Skilled Nursing Facility (Limited to 730 days per Member per lifetime)	\$0 Copayment	50% Copayment
Hospice Care	\$0 Copayment	\$0 Copayment
Home Health Care (does not cover custodial care or general housekeeping services)	\$0 Copayment	50% Copayment
Mental Health and Substance Abuse Treatment (Self-referral to HPM Affiliated MH/SA Provider paid as Level 1 benefit)		
Mental Health Care – Inpatient and Day Treatment (Limited to Medically Necessary treatment)	\$0 Copayment	50% Copayment

Services	Member Responsibility Level 1 (PCP- Directed)	Member Responsibility Level 2 (Self-Directed)
Mental Health Care – Outpatient <i>(Limited to Medically Necessary treatment)</i>	\$20 Copayment per Visit	50% Copayment
Substance Abuse Care – Inpatient and Intermediate care <i>(Limited to Medically Necessary treatment)</i>	\$0 Copayment	50% Copayment
Substance Abuse Care – Outpatient care <i>(Limited to Medically Necessary treatment)</i>	\$20 Copayment per Visit	50% Copayment
Other Services <i>(Some services may require a referral. Please refer to your Benefit Rider)</i>		
Family Planning Services (may require referral)	\$0 Copayment	Not covered
Artificial insemination for treatment of infertility (referral required)	50% Copayment	Not covered
Outpatient Physical, Speech and Occupational Therapy; (referral required)	\$0 Copayment	50% Copayment
Durable Medical Equipment, Orthotic and Prosthetic Appliances (may require referral)	\$0 Copayment	50% Copayment
Human Organ and Tissue Transplants (referral required)	\$0 Copayment	50% Copayment
Prescription Drug Rider ~ RJ		
Generic	\$10 Copayment per prescription	
Brand	\$40 Copayment per prescription	
Fertility	50% 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		
<p>Level 1 (PCP-Directed) To utilize the Level 1 benefit option, you must obtain your health care services through, or under the direction of, your Primary Care Physician. Your Primary Care Physician will coordinate all of your health care, and, when medically necessary, refer you to a specialist or other health care provider at little or no cost to you. This option provides you with the highest level of benefits and the lowest out-of-pocket costs.</p> <p>Level 2 (Self-Directed) Under the Level 2 benefit option, you may choose to obtain your health care services by self-referring. When you utilize Level 2, you agree to pay a percentage of the bill for services rendered. The difference between the physician’s charge and the fee HealthPlus considers reasonable may also be your responsibility.</p> <p>Out-of-Pocket Maximum for Level 2 Copayments under Level 2 will be limited each benefit year to \$1,500 per Member or \$3,000 per family.</p> <p>The following expenses will not count toward reaching the Out-of-Pocket Maximum, and Members will continue to be responsible for these expenses after the Out-of-Pocket Maximum has been reached:</p> <ul style="list-style-type: none"> • Prescription Drug Copayments • Emergency Health Services Copayments • Ambulance Copayments • Mental Health and Substance Abuse Copayments • Any expense which is not a Covered Benefit, including the reduction of coverage for not obtaining Hospital authorization, and Non-Affiliated Provider charges in excess of HealthPlus’ fee maximums <p>* Hospital coverage under Level 2 shall be reduced by \$500 for each hospital admission that is not authorized either in advance, or within twenty-four (24) hours of an emergency admission.</p>		
<p>Not Covered: (For a more complete list, please see your Benefit Rider; Benefit Limitations and Exclusions Section)</p> <ul style="list-style-type: none"> • 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) <ul style="list-style-type: none"> • 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 • 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) 		