Genesee County Community Mental Health

Danis Russell
Chief Executive Officer

November 10, 2011

RE: Non-Medicare Retiree Options
Teamsters Retired after 11/19/2007

Retiree Open Enrollment is under way 11/21/2011 through 12/02/2011. Please see the GCCMH website for additional information at www.gencmh.org . During this open enrollment, there are a number of additional plans available to you. The Agency will even pay **up to a $2,000 Signing Incentive** to those who elect to participate in a Health Plus HDHP HMO plan. Please note that the regular HealthPlus and BCN products are NOT offered during the 2012 Open Enrollment.

Healthcare Meetings are scheduled for November 22nd at 1pm and November 30th at 10:00 am. All meetings will be held in the 420 W. 5th Avenue Building. Please review the enclosed Healthcare Options: Under "65" Retirees benefit comparison sheet as well as other information to assist you in making your decision in selecting the plan that best meets your needs. GCCMH pays the entire healthcare premium cost for these plans. The Health Savings Account funding and the Health Reimbursement amounts and procedures are similar to previous years.

Please complete the required paperwork contained in this packet and return to: GCCMH-Payroll Dept., 725 Mason Street, Flint, MI 48503. If you have any questions, please contact the Payroll Department at (810) 257-3736 at ext. 4110 or 4111.

As a final reminder, as you will be participating in a High Deductible Health Plan, your HSA account must be open and active in order that GCCMH place the HSA contributions into your account for 2012. Newly retired Teamsters members must setup an HSA Bank HSA Account for funding to occur. Contact me directly, 810-496-5366, for information to set up your HSA Bank Account.

Sincerely,

R. David Hunter
Contract Manager – GCCMH
Attachments

HEALTHCARE ENROLLMENT CHECKLIST

Please mark each box when item has been completed:

- ☐ Review enclosed healthcare information

- ☐ Healthcare meetings are scheduled
  Non Medicare: Nov. 22 @ 1PM; Nov. 30 @ 10AM;
  Medicare: Nov. 22 @ 2PM; Nov. 30 @ 11AM;

- ☐ Complete Enrollment Form in its entirety
  Attach a copy of the following:
  - ☐ Marriage Certificate, if applicable
  - ☐ Medicare Card(s), if applicable
  - ☐ Birth Certificates of dependents – if 19 through 25 years of age qualified adult child, must complete **"Considerations for adding adult children aged 19-26"** form. Call Payroll Dept. for this form.
  - ☐ "No Dual Hospital/Medical Coverage Certification" form - Signed

Please return all requested documentation by Monday, November 28, 2011 to:

Genesee County CMH
Attn: Payroll Department
725 Mason
Flint, MI 48503

NO DUAL HOSPITAL / MEDICAL COVERAGE CERTIFICATION

I have exercised my option to enroll in one of the Genesee County Community Mental Health Hospital/Medical Plans. I understand that anyone enrolled in a High Deductible Health Plan covered under a Health Savings Account is prohibited from participating in the plan if any one of those enrolled has other hospital/medical insurance. All enrollees are prohibited from having dual hospital/medical insurance due to federal requirements for participation in a HDHP w/ HSA. In addition, GCCMH prohibits retirees and anyone else on their hospital/medical policy from maintaining dual insurance coverage.

In accordance with the CMH prohibition against dual hospital/medical coverage, I hereby certify that neither I, my spouse, nor any dependent under age 19, nor qualified adult child aged 19-26 listed on the enrollment application form have any other hospital/medical coverage. Regarding the possible enrollment of a qualified adult child aged 19-26, the child is governed by the rules associated with plans which qualify to be "grandfathered" or "not grandfathered". I also understand that if I have failed to disclose or falsified documentation regarding this paragraph, that CMH will bill me the amount overpaid by CMH for myself, spouse, dependent or qualified adult child aged 19-26 that was inappropriately dual covered. Falsification of documents constitutes fraud and is subject to termination.

I understand that CMH will require documentation of involuntary termination of coverage if I am transferring either my spouse, dependent, or qualified adult child aged 19-26 to a CMH hospital/medical plan from another employer paid source, outside the CMH open enrollment period.

I understand that I must notify the payroll department within 30 days of any qualifying event, which would require a spouse, dependent, or qualified adult child aged 19-26 to be removed from my insurance. I also understand that if I do not comply with this rule that CMH will bill me the amount overpaid by CMH for a spouse, dependent, or qualified adult child aged 19-26 that should have been removed from my insurance. Charges will become effective as of the last day of the month in which the qualifying event occurs.

I understand that I must notify the payroll department within 30 days of any qualifying event, which would require a spouse, dependent, or qualified adult child aged 19-26 to be added to my insurance. I also understand that if I do not comply with this rule, the spouse, dependent, or qualified child aged 19-26 must wait until the CMH open enrollment period to be added to my insurance.

For those staff considering the addition of a qualified adult child aged 19-26, you must obtain and sign the "Considerations for adding adult children aged 19-26" form from the GCCMH Payroll Department. If adult child is eligible to enroll in your group hospital/medical health plan, then coverage will terminate on the last day of the month in which the child turns 26, or child becomes otherwise ineligible.

_____

Name Printed

_____ _____

Signature Date

2012 Retiree Health Plan Year
Additional Clarification for
High Deductible Health Plan Considerations

(Warning: *Retirees selecting a High Deductible Health Plan can **NOT** have other health insurance; No Dual Coverage is allowed if participating in a High Deductible Health Plan*)

GCCMH Retiree Under Age 65, and will not turn 65 during 2012.

With No Spouse

- Single Retiree may select a HDHP

GCCMH Retiree Under Age 65, and will not turn 65 during 2012.

With Spouse who will not turn 65 during 2012

- Retiree may select a HDHP – Double Coverage
- Deductible set at $2,500.
- GCCMH will contribute toward the Deductible in HSA account.

GCCMH Retiree Under Age 65, and will not turn 65 during 2012.

With Spouse who will turn 65 during 2012

- Retiree may select a HDHP – Double Coverage through month prior to Spouse turning 65.
- Retiree will remain on the HDHP, as a Single moving forward. 65-aged Spouse must enroll in BC Medicare Plus Blue Group or H+ Advantage associated with the Retiree's selection.
- Deductible set at $2,500 for the Year. If the full annual deductible is met prior to the 65-birthdate, the then retiree on Single coverage will have been said to have met the annual deductible.
- If the combined retiree/spouse amount toward meeting the deductible of $2,500 has not been met for a double plan by the 65th birthday of the spouse, the retiree must meet the Single Deductible of $1,250 on their own for the year before services are covered by the insurance at 100%.
- GCCMH will contribute to the HSA account on a Prorated Basis, in the prescribed amounts for Double and Single coverages during the year.
  Calculated as 1/12th of annual contribution per month associated with the months under Double or Single coverage.

If the above information were reversed regarding the ages of the Retiree and Spouse, the scenarios above would still hold true.

GCCMH Retiree who will turn 65 during 2012.

With no Spouse

- Will be allowed to select a HDHP plan (pro-rations apply)

GCCMH Retiree who will turn 65 during 2012.

With Spouse who will turn 65 during 2012.

- Will be allowed to select a HDHP plan (pro-rations apply)

GCCMH will pay an

Incentive up to $2,000

($1,000 Single)

for selecting the Health HDHP HMO plan.

(Shaded area for Payroll Department only)

GENESEE COUNTY COMMUNITY MENTAL HEALTH
Teamsters Retiree Under 65 – Retired After 11/19/2007
2012 INSURANCE ENROLLMENT

Enrollment/Change Status: Open Enrollment ☐

EMPLOYEE NAME _____ (PRINT)

SOCIAL SECURITY # _____-_____-_____

ADDRESS _____

TELEPHONE # (_____) _____ - _____

CITY/ZIP _____

DATE OF HIRE _____/_____/_____

DATE OF BIRTH _____/_____/_____

MEDICAL INSURANCE OPTIONS

Effective Date _____/_____/_____

	Single	Two-Party	Family	Group No./Suffix	Service Code
Blue Cross Flex 2 High Deductible Plan	☐	☐	☐		
*Health Plus High Deductible Plan (PPO)	☐	☐	☐		
*Health Plus High Deductible Plan (HMO)	☐	☐	☐		

OPTICAL/DENTAL INSURANCE

Effective Date _____/_____/_____

Blue Cross of Michigan - Vision	☐	☐	☐		
Delta Dental of Michigan	☐	☐	☐		

(For Official Use Only)

CONTRACT ADDITION ☐ ***DELETION*** ☐

Last Name (Print)	First Name	Relation-ship	F/M	SSN	DOB	Pcp - Healthplus only
		SELF				
		SPOUSE				
		DEPEND.				
		DEPEND.				
		DEPEND.				
		DEPEND.				

Please Note: All dependent coverage is subject to verification of eligibility. A copy of birth certificate and Social Security # are needed for any currently enrolled eligible 19 – 26 year old Qualified Adult Child age 19-26. A qualified adult child age 19-26 who is eligible to enroll in a group health care plan from their employer are ***NOT ELIGIBLE*** to be added to the parent's BC Flex Blue 2 plan. The same qualified adult child aged 19-26 may qualify for coverage with the H+ HDHP HMO or H+ PPO plans. Provisions and penalties described in the "No Dual Hospital/Medical Coverage Certification" form apply.

* I understand and acknowledge that I am voluntarily selecting Health Plus as my health insurance provider. My ability, at some future date, to switch back to a Blue Cross product may or may not be an option._____
INITIALS

I certify that I read the important information on this form. The statements and answers given are complete and correct to the best of my knowledge and belief. No information required to be given, either expressly or by implication, has been knowingly withheld. I understand that the insurance carriers will rely upon the completeness and truthfulness of the information given and the statements made, and that if I have made false statements or misrepresentations, or have failed to disclose any material fact, the carriers will be entitled to declare the health care contract void and refuse all allowance of the benefits to any person under the contract. I understand that anyone listed above, is not allowed any other employer paid medical coverage including Medicare.

_____ _____
Employee's Signature (Do Not Print) Date Employer's Signature Date

Healthcare Otions

Under "65" Retirees

Teamsters Retired After 11/19/2007

January 1, 2012 - December 31, 2012

Benefit	BCBS Flexible Blue "2" HDHP	H+ HDHP PPO	H+ HDHP HMO
Deductible	$1,250 Single/$2,500 Double, Family (Agency to fund **0%** into HSA Account)	$1,250 Single/$2,500 Double, Family (Agency to fund **0%** into HSA Account)	$1,250 Single/$2,500 Double, Family (Agency to fund **$1000/$2000** into HSA Account)
Co-insurance (after deductible is met)	$1,000 per single or $2,000/family (Agency to Reimburse **90%** of Expenses)	$1,000 per single or $2,000/family (Agency to Reimburse **100%** of Expenses)	$1,000 per single or $1,000/family (Agency to Reimburse **100%** of Expenses)
Prescription Co-pay	$10 Generic / $60 Brand (During Co-Insurance Period)	$10 Generic / $50 Brand (During Co-Insurance Period)	$10 Generic / $50 Brand (During Co-Insurance Period)
Office Co-pay	20% after in-network deductible is met	$15 co-pay (During Co-Insurance Period)	$15 co-pay (During Co-Insurance Period)
Premium Co-pay/Month (Single/Double Coverage)	None	None	None
Comments **Questions? Please call 810-257-3736**	Projected maximum out of pocket for Retiree is $2700 / year (includes deductible, co-insurance and co-pays)	Projected maximum out of pocket for Retiree is **$0.00** / year (includes deductible, co-insurance and co-pays)	**$1,000 Single/2,000 Family Signing Incentive-** Projected maximum out of pocket for Retiree is **$0.00** / year (includes deductible, co-insurance and co-pays)

Rev. 2011-11-07

Flexible Blue[SM] Plan 2 Medical Coverage with 20% In-Network Copay / 40% Out-of-Network Copay Benefits-at-a-Glance Genesee Mental Health Proposal

This is intended as an easy-to-read summary and provides only a general overview of your benefits. **It is not a contract.** Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificates and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by your plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and will be construed under the jurisdiction of and according to the laws of the state of Michigan.

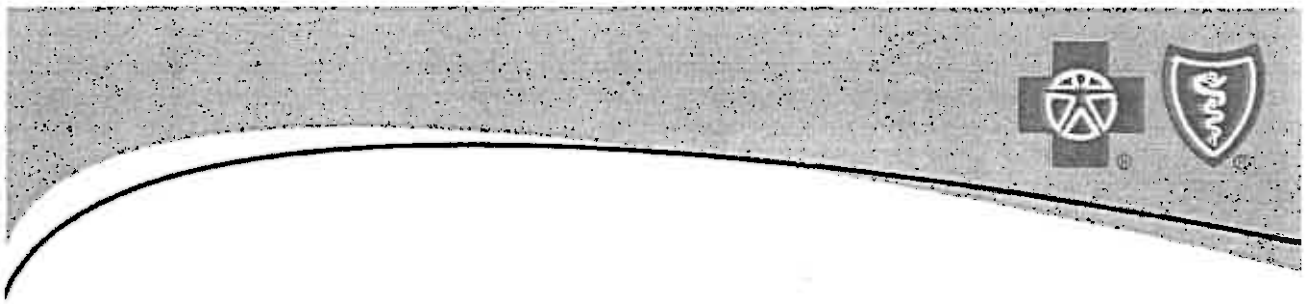
Member's responsibility (deductibles, copays and dollar maximums)

Note: Services without a PPO network and emergency services are covered at the in-network level. **If a PPO provider refers you to a non-network provider, all covered services obtained from that non-network provider will be subject to applicable out-of-network cost-sharing.** If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

	In-network	Out-of-network
Deductibles **Note:** The full family deductible **must** be met under a two-person or family contract before benefits are paid for any person on the contract.	$1,250 for a one-person contract or $2,500 for a family contract (2 or more members) each calendar year (**no 4th quarter carry-over**)	$2,500 for a one-person contract or $5,000 for a family contract (2 or more members) each calendar year (**no 4th quarter carry-over**)
	Deductibles are based on amounts defined annually by the federal government for Flexible Blue-related health plans. Please call your customer service center for an annual update.	
Copays **Note:** Copays apply once the deductible has been met. • Fixed dollar copays	None	None
• Percent copays	20% of approved amount	40% of approved amount
Copay dollar maximums	$1,000 for a one-person contract or $2,000 for a family contract (2 or more members) each calendar year	$2,000 for a one-person contract or $4,000 for a family contract (2 or more members) each calendar year
Dollar maximums	$1 million lifetime maximum per covered specified human organ transplant type and a **separate** $5 million lifetime maximum per member for all other covered services and as noted above for individual services	

Preventive care services – *Payment for preventive services is limited to a combined maximum of $500 per member per calendar year

	In-network	Out-of-network
Health maintenance exam – includes chest X-ray, EKG, cholesterol screening and other select lab procedures	Covered – 100% (no deductible or copay)*, one per member per calendar year	Not covered
Gynecological exam	Covered – 100% (no deductible or copay)*, one per member per calendar year	Not covered
Pap smear screening – laboratory and pathology services	Covered – 100% (no deductible or copay)*, one per member per calendar year	Not covered
Well-baby and child care	Covered – 100% (no deductible or copay) * • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 2 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • 1 visit per birth year, 48 months through age 15	Not covered



Childhood immunizations as recommended by the Advisory Committee on Immunizations Practices and the American Academy of Pediatrics	Covered – 100% (no deductible or copay)*	Not covered
Fecal occult blood screening	Covered – 100% (no deductible or copay)*, one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	Covered – 100% (no deductible or copay)*, one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	Covered – 100% (no deductible or copay)*, one per member per calendar year	Not covered

Mammography

Mammography screening	Covered – 100% (no deductible or copay)	Covered – 80% after out-of-network deductible
	One per member per calendar year, no age restriction	

Physician office services

Office visits	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
Outpatient and home medical care visits	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
Office consultations	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
Urgent care visits	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible

Emergency medical care

Hospital emergency room	Covered – 80% after in-network deductible	Covered – 80% after in-network deductible
Ambulance services – must be medically necessary	Covered – 80% after in-network deductible	Covered – 80% after in-network deductible

Diagnostic services

Laboratory and pathology services	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
Diagnostic tests and x-rays	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
Therapeutic radiology	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible

Maternity services provided by a physician

Prenatal and postnatal care	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
	Includes care provided by a certified nurse midwife	
Delivery and nursery care	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
	Includes delivery provided by a certified nurse midwife	

Hospital care

Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note:** Nonemergency services must be rendered in a **participating** hospital.	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
	Unlimited days	
Inpatient consultations	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
Chemotherapy	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible

	In-network	Out-of-network

Alternatives to hospital care

Skilled nursing care	Covered – 80% after in-network deductible, in **participating** skilled nursing facilities **only** Limited to 90 days per member per calendar year
Hospice care	Covered – 80% after in-network deductible, through a **participating** hospice program **only** Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically
Home health care – must be medically necessary	Covered – 80% after in-network deductible, by a **participating** home health care agency **only**
Home infusion therapy – must be medically necessary	Covered – 80% after in-network deductible, by **participating** providers **only**

Surgical services

Surgery – includes presurgical consultations, related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
Colonoscopy	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
	One per member per calendar year	
Voluntary sterilization	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible

Human organ transplants

Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 80% after in-network deductible, in designated facilities **only**, limited to $1 million **lifetime** maximum per member per transplant type for transplant procedure(s) and related professional, hospital and pharmacy services	
Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
Specified oncology clinical trials	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
Kidney, cornea and skin transplants	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible

Mental health care and substance abuse treatment

Inpatient mental health care and inpatient substance abuse treatment	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
Outpatient mental health care	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible, in participating facilities **only**
Outpatient substance abuse treatment – in approved facilities **only**	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible, in approved facilities **only**

Other covered services

Outpatient Diabetes Management Program (ODMP)	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
Allergy testing and therapy	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
Osteopathic manipulative therapy Chiropractic spinal manipulation	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
	Up to 24 visits per member per calendar year	

Outpatient physical, speech and occupational therapy services – provided for rehabilitation	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible **Note:** Outpatient physical therapy is **not** covered at nonparticipating facilities.
	Limited to a **combined** maximum of 60 visits per member per calendar year	
Durable medical equipment	Covered – 80% after in-network deductible	Covered – 80% after in-network deductible
Prosthetic and orthotic appliances	Covered – 80% after in-network deductible	Covered – 80% after in-network deductible
Private duty nursing services	Covered – 80% after in-network deductible	Covered – 80% after in-network deductible

Prescription drugs		
Rider FB RX-PD-GB $10/$60 Mail Order 2X	Adds $10 copay for generic and $60 for brand name drugs and doubles the copay for mail order drugs for a 35- to 90-day supply after deductible. Maximum copay applys..	
Rider RX-90-2x	Expands retail coverage of prescription drugs to include 84 to 90-day supplies (prescriptions with days supply between 35 to 83-days are not covered via retail), subject to one member copay that is double the amount that would apply for a 34-day refill. Requires all retail 90-day supplies of medication be obtained from a "**90-Day Retail Network**" provider. You must be on your medication for at least 60 out of the past 120 days under your BCBSM coverage before using this option.	

HealthPlus

HealthPlus Insurance Company

Genesee County Mental Health
Non Union Employees
PPO High Deductible Health Plan Benefit Summary ~ 91

Proposed Custom Benefit Summary 90

This is document is provided as an easy to read summary of your benefits. This Benefit Summary does not modify or take the place of your Schedule of Benefits, Certificate of Coverage or Benefit Riders. Please read your Schedule of Benefits, Certificate of Coverage and Benefit Riders for complete coverage details, benefit limitations and exclusions, and your cost sharing responsibility.

Services Deductible must be met for all services, including any services provided by optional rider, before HPI begins paying for services. The only exceptions are Immunizations and Routine Preventive Services listed below. .	**Preferred Provider (In-Network) Member Responsibility** Member is responsible for flat dollar Copays and/or percent Coinsurance shown below. Coinsurance dollar amounts are based on HealthPlus reimbursement rates for Covered services. Deductible must be met before coinsurance applies. **Coinsurance: HealthPlus pays 90%** **Member Pays 10%**	**Non-Preferred Providers (Out-of-Network) Member Responsibility** Member is responsible for flat dollar Copays and/or percent Coinsurance shown below. Coinsurance amounts are based on Allowed Amount for Covered services. Member is also responsible for any excess charges. Deductible must be met before coinsurance applies **Coinsurance: HealthPlus pays 70%** **Member Pays 30%**
Deductible and Out-of-Pocket Maximum		
Deductible *For those with family coverage, entire family Deductible must be met before any benefits paid*	$1,250 Single or Self Only Coverage $2,500 Family Coverage	$2,500 Single or Self Only Coverage $5,000 Family Coverage
	*Deducible applies to all services **except preventive** and including prescription drugs if a prescription drug Rider is included. Benefits are not paid for Covered services until Deductible is met*	
Out-of-Pocket Maximum (OOP Max)	$2,250 Single or Self Only Coverage $4,500 Family Coverage	$3,500 Single or Self Only Coverage $7,000 Family Coverage
	Deductible applies to OOP Max, all in-network Copays apply to OOP Maximum, including any for optional rider services. Penalty payments and excess charge payments do not apply to OOP Max	
Lifetime Maximum Benefits	$5,000,000 per Member (In and Out-of-Network). Additionally, each Transplant Type has a $1,000,000 per Member limit.	
Routine Immunizations *Deductible does not apply to in-network services; see Certificate of Coverage for age restrictions and benefit limitations*		
Routine Childhood Immunizations: up through age 18	Immunizations Covered at 100%; $25 Office Visit Copay may apply	30% of allowed amount after Deductible plus any excess charges
Adult Immunizations: Flu vaccine, Pneumonia vaccine, Tetanus/Diphtheria	Vaccines Covered at 100%: $25 Office Visit Copay may apply	
Routine Preventive Services *Deductible does not apply to in-network services; see Certificate of Coverage for age restrictions and benefit limitations*		
Adult Routine Health Maintenance Exam - one per benefit year beginning at age 18	Covered 100% after Office Visit Copay	30% of allowed amount after Deductible plus any excess charges
Adult Gynecological Exam - one per benefit year	Covered 100% after Office Visit Copay	
Well-Baby and Well Child Care Visits: 6 Visits per benefit year through age 23 months 2 Visits per benefit year ages 24 – 47 months 1 Visit per benefit year ages 4 – 17 years	Covered 100% after Office Visit Copay	
Childhood Screenings: Lead testing, Urinalysis Hemoglobin/Hemocrit	Lab tests Covered at 100%	
Cervical Cancer Screening Pap Smear–laboratory and pathology services–*beginning at age 18*	Labs Covered at 100%	
Breast Cancer Screening Mammogram–*beginning at age 40 (baseline between age 35 and 40)*	Mammogram Covered at 100%	
Colorectal Cancer Screening: *beginning at age 50*	Screening test Covered at 100%	
Diabetes Screening; *beginning at age 45*	Lab tests Covered at 100%	
Prostate Cancer Screening; PSA test; *at age 45*	Lab test and prostate exam Covered at 100%	
Physician Services—Office and Home Visits		
Office and Home Visits for Illness or Injury	Covered 100% after Office Visit Copay	30% of allowed amount after Deductible plus any excess charges
Other Physician and Professional Services		
Hospital inpatient or outpatient Visits and/or consultations	10% Coinsurance after Deductible is met	30% of allowed amount after Deductible plus any excess charges
Delivery and newborn nursery services	10% Coinsurance after Deductible is met	
All other physician and professional services including surgical and anesthesiology services	10% Coinsurance after Deductible is met	

Services	Member Responsibility- Preferred Providers	Member Responsibility- Non Preferred Providers
Emergency Medical Care		
Hospital Emergency Room	10% Coinsurance after Deductible is met	30% of allowed amount after Deductible plus any excess charges
Emergency Room Physician/Professional Services	10% Coinsurance after Deductible is met	In Network Deductible and Coinsurance apply
Freestanding Emergency Center or Urgent Care Center	10% Coinsurance after Deductible is met	30% of allowed amount after Deductible plus any excess charges
Ambulance Services – when medically necessary	10% Coinsurance after Deductible is met	In Network Deductible and Coinsurance apply
Diagnostic Services		
Laboratory and Pathology Tests	10% Coinsurance after Deductible is met	30% of allowed amount after Deductible plus any excess charges
Diagnostic and Therapeutic Radiological Services	10% Coinsurance after Deductible is met	
Maternity Services Provided By a Physician *Certified Nurse Midwife Covered if He/She provides services under the direction of a physician, No home birth coverage*		
Pre-Natal and Post-Natal Care	10% Coinsurance after Deductible is met	30% of allowed amount after Deductible plus any excess charges
Delivery and Nursery Care (physician services)	10% Coinsurance after Deductible is met	
Hospital Care *All elective hospitalizations and some outpatient procedures require HPM prior authorization, emergency admissions require authorization within 24 hours. Copayment penalty applied to facility charges before benefits are paid if proper prior authorization processes are not followed*		
Inpatient Care including newborn nursery	10% Coinsurance after Deductible is met	30% of allowed amount after Deductible plus any excess charges
Outpatient Surgery, Other Services and Supplies (Prior authorization required for selected procedures)	10% Coinsurance after Deductible is met	
Alternatives to Hospital Care *Prior authorization required for some of the following services*		
Skilled Nursing Facility *(Limited to 120 days per Member per benefit year)*	10% Coinsurance after Deductible is met	30% of allowed amount after Deductible plus any excess charges
Hospice Care (Inpatient, residential and home hospice services)	10% Coinsurance after Deductible is met	
Home Health Care—first 30 Visits no prior authorization required *(custodial care is not Covered)*	10% Coinsurance after Deductible is met	
Transplants *Prior authorization required, must be in designated facility, $1 million lifetime limit per transplant type*		
Specific Human Organ / Tissue Transplants	10% Coinsurance after Deductible is met	Not Covered
Mental Health and Substance Abuse Treatment *Prior authorization requirements and limitations apply*		
Inpatient Mental Health Care and Day Treatment *Limited to medically necessary treatment*	10% Coinsurance after Deductible is met	30% of allowed amount after Deductible plus any excess charges
Outpatient Mental Health *Prior authorization required after 30 visits*	$25 Office Visit Copay after Deductible is met	
Inpatient Substance Abuse Care *Limited to medically necessary treatment*	10% Coinsurance after Deductible is met	
Outpatient Substance Abuse Treatment *Prior authorization required after 30 visits*	$25 Office Visit Copay after Deductible is met	
Other Services *Some services in this section require prior authorization and/or have Visit limitations*		
Allergy Injections	10% Coinsurance after Deductible is met ($25 Office Visit Copay may apply)	30% of allowed amount after Deductible plus any excess charge
Family Planning Services	10% Coinsurance after Deductible is met ($25 Office Visit Copay may apply)	30% of allowed amount after Deductible and any excess charges
Infertility Services *(Restrictions apply)*	50% Coinsurance after Deductible is met	Not Covered
Outpatient Physical, Speech and Occupational Therapy *(Visit limits apply)*	10% Coinsurance after Deductible is met	30% of allowed amount after Deductible plus any excess charges
Durable Medical Equipment, Orthotic, and Prosthetic Devices	10% Coinsurance after Deductible is met	Not Covered (except breast prosthesis after mastectomy—30% of allowed amount after Ded)
Optional Chiropractic Rider (CHIRDED) office Visit and manipulative treatment only *(38 Visit limit)*	$0 Copay after deductible is met	After Out- of- Network Deductible is met, Out-of-Network Coinsurance applies + excess charges
Optional Prescription Drug Riders		
All Riders include prescription contraceptive coverage and a 30% Copay for infertility drugs. Benefits are not paid for Covered prescription drugs until the member Deductible is met. Mail order and "Ask for 90" retail program available.	Pharmacy Rider: QW - $10/$50 $10 Generic $50 Brand	Member must pay for prescriptions from Out-of-Network pharmacy and submit claim to HPI.

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HMO HDHP Benefit Summary ~ 17YK

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	Deductible waived, $0 Copayment
Annual Gynecological Exam (Through PCP or self-referral to HPM Affiliated Gynecologist)	Deductible waived, $0 Copayment
Routine Well-Baby and Well Child Care • Up to 6 Visits per year through age 1 • Up to 3 Visits per year ages 1 - 3 years • 1 Visit per year ages 3 - 10 years • Additional Visits beyond those specified above	Deductible waived, $0 Copayment After Deductible, $15 Copayment per Visit
Pediatric and Adult Immunizations in accordance with accepted medical practice	Deductible waived, $0 Copayment
Breast Cancer Screening Mammograms	Deductible waived, $0 Copayment
Prostate Cancer Screening	Deductible waived, $0 Copayment
Lab and Pathology associated with routine Preventive Health Services when provided by an Affiliated Laboratory	Deductible waived, $0 Copayment
Routine prenatal care and counseling—includes one postpartum Visit. (Member may self-refer to Affiliated Provider for prenatal care)	Deductible waived, $0 Copayment
Physician Services	
Primary Care Physician Office Visit for illness or injury	After Deductible, $15 Copayment per Visit
Specialist Office Visit (see Rider for details)	After Deductible, $15 Copayment per Visit
Delivery, postpartum (beyond 1 Visit), miscarriage, and other related obstetrical services.	After Deductible, 10% Copayment
Chiropractic and/or Podiatry Services (referral required) *Limited to 12 combined Visits per Member per benefit year*	After Deductible, 50% Copayment
Allergy Testing and Therapy	After Deductible, 50% Copayment
Emergency Medical Care	
Hospital Emergency Room (in or out of the Service Area)	After Deductible, $100 Copayment per Visit
Freestanding Emergency Center or Urgent Care Center (in or out of the Service Area)	After Deductible, $50 Copayment per Visit
Physician services when billed separately from facility charges	After Deductible, 10% Copayment
Ambulance Services – when medically necessary	After Deductible, 50% Copayment per use
Diagnostic Services	
Laboratory and Pathology Tests (other than Preventive Health Services), including those due to a pregnancy, when provided by an Affiliated Laboratory	After Deductible, 10% 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, including such services due to a pregnancy; physician services when required to read/administer specific tests	After Deductible, 10% Copayment
Hospital Care	
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies, Maternity Care and Routine Newborn Nursery Care during an eligible mother's hospital stay.	After Deductible, 10% Copayment
Outpatient Surgery Services including use of operating, delivery, recovery and treatment rooms, lab test, X-rays, anesthetics, etc.	After Deductible, 10% Copayment

Services	Member Responsibility
Physician and Other Professional Surgical and/or Related Service Fees	
Professional fees by surgeons, physicians and other professionals	After Deductible, 10% Copayment
Anesthesia and related professional services	After Deductible, 10% Copayment
Pre-operative and post-operative consultations	After Deductible, 10% Copayment
Alternatives to Hospital Care	
Skilled Nursing Facility *(Limited to 60 days per Member per benefit year)*	After Deductible, 10% Copayment
Hospice Care	After Deductible, 10% Copayment
Home Health Care (does not cover custodial care or general housekeeping services)	After Deductible, 10% Copayment
Mental Health Care and Substance Abuse Treatment	
Mental Health Care – Inpatient and Day Treatment *(Limited to Medically Necessary treatment)*	After Deductible, 10% Copayment
Mental Health Care – Outpatient *(Limited to Medically Necessary treatment)*	After Deductible, $15 Copayment per Visit
Substance Abuse Care – Inpatient and Intermediate care *(Limited to Medically Necessary treatment)*	After Deductible, 10% Copayment
Substance Abuse Care – Outpatient care *(Limited to Medically Necessary treatment)*	After Deductible, $15 Copayment per Visit
Other Services	
Family Planning Services *(Limited to $25,000 lifetime maximum)*	After Deductible, 50% Copayment
Outpatient Physical, Speech and Occupational Therapy *(Limited to 60 combined Visits per benefit year)*	After Deductible, 10% Copayment
Durable Medical Equipment	After Deductible, 50% Copayment
Prosthetic and Orthotic Appliances	After Deductible, 50% Copayment

Code#	Deductible (Deductible applies to Out-of-Pocket Maximum)		Out-of-Pocket Maximum	
	Single	Family	Single	Family
YK (Low Option)	$1,250	$2,500	$2,250	$3,500

If a pharmacy rider has been selected, please read applicable rider for more details about your coverage.

***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
- 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
- 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 services
- Orthopedic footwear (unless attached to a brace, or cutflow 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)

PRESCRIPTION DRUG BENEFIT RIDER XJ

(Attach this rider to your contract)

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THIS PRESCRIPTION DRUG BENEFIT RIDER MUST BE READ TOGETHER WITH THE HEALTHPLUS OF MICHIGAN GROUP SUBSCRIBER CONTRACT, APPLICABLE BENEFIT RIDER AND APPLICABLE DEDUCTIBLE RIDER

Under this Benefit Rider, Covered Services must be provided by Affiliated Pharmacy Providers. Section I below explains the Annual Deductible and Out-of-Pocket Maximum. Section II below specifies Covered Services and applicable Copayments. Section III below specifies the Limitations of and Exclusions from Covered Services.

SECTION I
ANNUAL DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM

Annual Deductible shall mean the amount a Member or family of Members must pay for Covered Services, including Covered Prescription Drugs, in a benefit year before HPM will begin paying for Covered Services, including Covered Prescription Drugs, in that benefit year. The Annual Deductible for family coverage may be met by one or more Members in a family. The entire Annual Deductible must be satisfied before any individual Member within the family may receive benefits under this Rider.

Out-of-Pocket Maximum is the total amount of Copayments and Deductibles that a Member or family of Members will pay for Covered Services, including Covered Prescription Drugs, in a benefit year. After the Out-of-Pocket Maximum is reached, HPM will pay one hundred percent (100%) for Covered Services, including Covered Prescription Drugs, during the remainder of the benefit year.

The Deductible Rider provides more detailed information about the Annual Deductible and Out-of-Pocket Maximum amounts.

SECTION II
COVERED SERVICES

The services and benefits described in this Section II are offered in accordance with HPM's policies and procedures for benefit administration. Only services that are Medically Necessary according to generally accepted standards of practice as determined by an HPM Medical Director are Covered Services under this Rider.

Subject to the Limitations and Exclusions of Section III, Covered Services include:

	COPAYMENT: After Deductible is met
2.1 **PRESCRIPTION DRUGS** Benefits for Prescription Drugs and certain over the counter nonprescription drugs in the HPM Formulary, when prescribed by a Plan Physician, Dentist, a Non-Plan Provider to whom a Member was Appropriately Referred, or a Non-Plan Provider to whom a Member self-referred consistent with the terms of a Point of Service Benefit Rider and when the Prescription is filled at an Affiliated Pharmacy Provider.	
A. Generic	$10/Prescription
B. Brand	$50/Prescription
C. Fertility Prescription Drugs	50%

	COPAYMENT: After Deductible is met
Coverage under this Section 1.1 will include: Federal Food and Drug Administration (FDA) approved drugs used for off-label purposes and the reasonable cost of supplies medically necessary to administer the drug in accordance with Section 3406q of the Insurance Code; and FDA approved drugs used in antineoplastic therapy in accordance with Section 3406e of the Insurance Code.	
A. Generic	$10/Prescription
B. Brand	$50/Prescription
C. Fertility Prescription Drugs	50%
Coverage under this Section 1.1 will include a ninety (90) day supply of select Prescription Drugs filled retail by participating Affiliated Pharmacy Providers through the "Ask for 90" program or through the designated mail order provider.	
A. Generic	$20/Prescription (two Copayments)
B. Brand	$100/Prescription (two Copayments)
C. Fertility Prescription Drugs	50%

SECTION III
BENEFIT LIMITATIONS AND EXCLUSIONS

3.1 LIMITATIONS

The Covered Services set forth in Section II of this Rider shall be limited in the following ways:

A. **Prescription Drugs.** Benefits for Prescription Drugs in the HPM Formulary will be limited to the reasonable cost of generically available products, unless no generically equivalent product exists or a Member specific review for medical necessity by HPM determines the need for brand name medication. HPM reserves the right to determine generic equivalency of products available to HPM Members. HPM reserves the right to review Prescription Drug products and procedures for medical necessity, efficacy of use and quality to determine if they should be available to HPM Members. Prior authorization, quantity or dose limits may apply for certain medications.

B. **Prescription Drugs for Treatment of Impotency.** Benefits for Prescription Drugs for the treatment of impotency in males 35 years of age or older shall be limited to those who have a diagnosis of erectile dysfunction. Benefits for Prescription Drugs for the treatment of impotency in males under 35 years of age shall be limited to those who meet HPM medical necessity criteria and whose Primary Care Physician or participating treating urologist has obtained prior authorization from HPM. Coverage for both age groups shall not exceed six (6) doses per thirty (30) day period and shall be limited to the original prescription and up to two (2) refills prior to follow up with treating physician. There shall be no coverage for replacement of lost, stolen or destroyed medication.

C. Any other Limitation stated in the applicable Benefit Rider that could relate to coverage of Prescription Drugs.

3.2 EXCLUSIONS

Coverage for services and products not specifically identified by this Rider are not Covered Services, including, but not limited to:

A. Nonprescription drugs (or their Prescription Drug equivalents), dietary and other supplements, articles, and supplies provided on an outpatient basis, and not specifically identified as Health Care Benefits by this Contract. HPM may elect to cover and include certain over the counter nonprescription drugs on the HPM Formulary based on recommendations made by our Pharmacy and Therapeutics Committee.

B. Any other Exclusion stated in the applicable Benefit Rider that could relate to coverage of Prescription Drugs.