
HEALTHPLUS SENIOR – OPTION 3
BENEFIT RIDER B3 2008



(Attach this rider to your Subscriber Contract)

THIS BENEFIT RIDER MUST BE READ TOGETHER WITH THE HEALTHPLUS OF MICHIGAN MEDICARE ADVANTAGE SUBSCRIBER CONTRACT.

Under this Benefit Rider, Covered Services must be provided by Affiliated Providers unless otherwise indicated. Section I, below, specifies Covered Services. Section II, below, specifies the Limitations and Exclusions from Covered Services.

SECTION I. COVERED SERVICES

The services and benefits described in this Section are offered in accordance with HPM's policies and procedures for benefit administration. HPM covers all services and supplies offered by Medicare. Except for Emergency Services, Urgently Needed Services, and out-of-area renal dialysis services, and except as otherwise provided below, coverage under this Benefit Rider is only available for those services and benefits authorized in advance by the Subscriber's Primary Care Physician and/or HPM in accordance with all HPM policies and procedures. 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 Benefit Rider.

Services obtained by a Subscriber from a Specialist Physician or Non-Plan Physician when the Subscriber was not Appropriately Referred will result in the Subscriber's obligation to pay for such care. **NEITHER HPM NOR MEDICARE WILL PAY FOR THESE SERVICES.**

HPM shall have the authority to make all determinations that are required for administration of this Subscriber Contract, and to construe and interpret the Subscriber Contract whenever necessary to carry out its intent and purpose and to facilitate its administration. All such determinations, constructions and interpretations made by HPM shall be binding upon the Subscriber.

Services designated in *italics* require Prior Authorization from HPM.

1.1 PHYSICIAN SERVICES (other than mental health and substance abuse services) provided by, or under the direction of, the Subscriber's Primary Care Physician, or provided by a Specialist Physician to whom the Subscriber is Appropriately Referred, including:	What you must pay when you get these covered services
A. Office Visits for treatment of illness or injury.	\$15 per Visit
B. Periodic routine physical examinations or health assessments by the Subscriber's Primary Care Physician.	\$15 per Visit
C. Home Visits.	NONE
D. Immunizations in accordance with accepted medical practice.	NONE
E. Professional services by Specialist Physicians that do not require a referral.	\$25 per Visit
F. Professional services by Specialist Physicians which are not Office Visits and which require a referral and/or authorization by HPM.	\$25 per Visit
G. Hospital and Skilled Nursing Facility Visits as part of continued supervision of covered care.	NONE

NOTE: Subscribers may self-refer to any Affiliated Provider for influenza vaccinations without Prior Authorization or an Appropriate Referral. Subscribers may self-refer to any Affiliated Provider for routine and preventive women's health services without Prior Authorization or an Appropriate Referral.

1.2 HOSPITAL SERVICES (other than mental health and substance abuse services) when authorized by HPM and when under the direction of the Subscriber's Primary Care Physician or a Specialist Physician to whom the Subscriber is Appropriately Referred, including:	\$300 Copayment for each Medicare-covered Hospital stay
A. Inpatient services, including:	Unlimited days per stay
1. Semi-private room and board, including general duty nursing care.	
2. Private room and board accommodations for medical reasons when authorized by Plan Physician.	
3. Therapeutic and support care, services, supplies and appliances.	
4. Care in specialized units (i.e., intensive care unit, critical care unit, etc.).	
5. Use of operating, delivery, recovery, and treatment rooms and equipment.	
6. Laboratory tests, X-rays, EKGs, EEGs, and other diagnostic tests performed in conjunction with, or following, admission to the Hospital.	

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7. Anesthetics, oxygen, drugs, and other biologicals.
 8. Dressings, casts, and special equipment when supplied by the Hospital for use in the Hospital.
 9. Special diets.
 10. Radiation, inhalation, and physical therapies.
 11. Medical rehabilitation, including short-term Rehabilitation Services and short-term physical, occupational or speech therapy.
 12. Administration of whole blood and blood derivatives.
- B. Outpatient services, including:
1. Use of operating, delivery, recovery, and treatment rooms and equipment.
 2. Laboratory tests, X-rays, EKGs, EEGs, and other diagnostic tests.
 3. Anesthetics, oxygen, drugs, and other biologicals.
 4. Dressings, casts, and special equipment.
 5. Therapeutic and support care, services, supplies, and appliances.
 6. Administration of whole blood and blood derivatives.

What you must pay when you get these covered services

\$100 Copayment for each Medicare-covered outpatient surgery in an outpatient Hospital facility or an ambulatory surgical center.

1.3 EMERGENCY SERVICES, OUT-OF-AREA RENAL DIALYSIS SERVICES, AND URGENTLY NEEDED CARE including:

- A. Hospital emergency room (worldwide coverage).
- B. Urgently Needed Services provided at a Freestanding Emergency Center (worldwide coverage).
- C. Physician services when billed separately from facility charges.
- D. Out-of-area renal dialysis services.

\$50 for Medicare-covered emergency room Visits; waived if immediately admitted into the Hospital.

\$25 per Visit

NONE

NONE

HPM reserves the right NOT to pay for Emergency Services for non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency.

1.4 PREVENTIVE HEALTH SERVICES provided to a Subscriber by, or under the direction of, the Subscriber's Primary Care Physician or provided by a Specialist Physician to whom the Subscriber is Appropriately Referred, including:	What you must pay when you get these covered services
A. Periodic routine physical examinations or health assessments by the Subscriber's Primary Care Physician, including hearing and vision screening as a preventive and early detection mechanism.	\$15 per Visit
B. Immunizations in accordance with accepted medical practice.	NONE
C. Health education and health counseling services, including medical nutrition therapy services.	NONE
D. Diabetes education and home blood glucose monitoring (to include lancets, reagent strips and other Medically Necessary supplies, in accordance with Medicare guidelines).	NONE
E. Pelvic exams, bone mass measurement, pap smears, mammography screenings.	NONE
F. Prostate and colorectal screenings.	NONE
G. Prenatal care and counseling.	NONE
H. Cardiovascular screenings.	NONE
I. End-Stage Renal Disease: in-an out-of-area dialysis and nutrition therapy.	NONE

NOTE: Subscribers may self-refer to any Affiliated Provider for screening mammographies and influenza vaccinations without Prior Authorization or an Appropriate Referral. Subscribers may self-refer to any Affiliated Provider for routine and preventive women's health services without Prior Authorization or an Appropriate Referral.

1.5 MENTAL HEALTH SERVICES when authorized by HPM and when under the direction or care of a Plan Provider, including:	\$300 for each Medicare-covered Hospital stay
A. Hospital inpatient care. Coverage for mental health inpatient care is limited to a lifetime maximum of one hundred ninety (190) days in a Medicare-certified psychiatric facility (not a general acute-care-hospital). Inpatient days used under Medicare or another Medicare contracting organization while not a Subscriber of HPM also count toward the one hundred ninety (190) day lifetime maximum.	
B. Intermediate care, including: 1. Day Treatment program.	NONE
C. Outpatient care	\$25 per Visit

<p>1.6 SUBSTANCE ABUSE SERVICES when authorized by HPM and when under the direction or care of a Plan Provider, including:</p> <p>A. Hospital inpatient care.</p> <p>B. Intermediate care, including:</p> <ol style="list-style-type: none"> 1. Day Treatment program 2. Residential <p>C. Outpatient care.</p> <p>*There is no limit to the number of Hospital inpatient days covered by the Plan each Benefit Period.</p>	<p>What you must pay when you get these covered services</p> <p>\$300 for each Medicare-covered Hospital stay</p> <p>Unlimited days per stay</p> <p>NONE</p> <p>\$25 per Visit</p>
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<p>1.7 DIAGNOSTIC LABORATORY AND DIAGNOSTIC AND THERAPEUTIC RADIOLOGY SERVICES (other than provided in a Hospital) when:</p> <ul style="list-style-type: none"> • Provided by Affiliated Laboratories; • Ordered and/or authorized in advance by the Subscriber's Primary Care Physician, a Specialist Physician to whom the Subscriber is Appropriately Referred, or HPM; and • Said services are in support of other Basic Benefits set forth in this Benefit Rider. <p>Including:</p> <ol style="list-style-type: none"> A. Electrocardiograms. B. Electroencephalograms. C. Diagnostic X-rays. D. Breast cancer screening mammograms. E. Radiation therapy. F. Cardiovascular blood tests. G. Other medically acceptable diagnostic or other therapeutic procedures. 	<p>NONE</p>
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NOTE: Subscribers may self-refer to any Affiliated Provider for screening mammographies without Prior Authorization or an Appropriate Referral.

1.8 SHORT-TERM MEDICAL REHABILITATION SERVICES, (Including Short-term Rehabilitation Services, and short-term physical, occupational or speech therapy) when:	What you must pay when you get these covered services
<ul style="list-style-type: none"> • Provided on an outpatient basis by Affiliated Providers; and • Authorized in advance by the Subscriber’s Primary Care Physician or HPM. 	\$25 per Visit
<p>1.9 HOME HEALTH SERVICES when:</p> <ul style="list-style-type: none"> • Provided in the Subscriber’s home by Affiliated Providers; • The Subscriber is confined to home; • The level of care is skilled (as determined by HPM according to Medicare guidelines); and • Authorized in advance by the Subscriber’s Primary Care Physician and/or HPM. <p>Including:</p> <ol style="list-style-type: none"> A. Intermittent Skilled Nursing Care (when the level of care is skilled as determined by HPM according to Medicare guidelines). B. Short-term physical therapy. C. Short-term speech therapy in conjunction with Skilled Nursing Care. D. Medical-social services in conjunction with Skilled Nursing Care. E. Short-term occupational therapy in conjunction with Skilled Nursing Care. 	NONE
<p>1.10 AMBULANCE SERVICES to an institution (like a Hospital or SNF), from an institution to another institution, from an institution to your home, and services dispatched through 911, only if transportation in any other vehicle could endanger your health. You have the right to call 911 if you believe you have an Emergency Medical Condition.</p>	NONE
<p>1.11 HOSPICE SERVICES in a Medicare-certified Hospice are not covered by HPM but are covered under Medicare, subject to Medicare coverage limits, when the Subscriber enrolls in a Medicare-certified Hospice. HPM will refer the Subscriber to a Medicare-certified Hospice if the Subscriber wishes to elect such coverage. The Subscriber may remain enrolled in HPM even though the Subscriber has elected Hospice coverage. The Subscriber may continue to receive care unrelated to the terminal condition through HPM and may also use a Plan Physician as the Subscriber’s Hospice attending physician. If the Subscriber uses Non-Affiliated Providers for routine care, Original Medicare (rather than</p>	NONE

HealthPlus Senior) will cover the care and the Subscriber will have to pay Original Medicare out-of-pocket amounts.

What you must pay when you get these covered services

1.12 DURABLE MEDICAL EQUIPMENT, ORTHOTIC APPLIANCES AND PROSTHETIC DEVICES when:

- Obtained from Affiliated Providers or suppliers;
- Determined by HPM to be an eligible item; and

Ordered and/or authorized in advance by the Subscriber's Primary Care Physician, a Specialist Physician to whom the Subscriber is Appropriately Referred, or HPM.

20% of the cost for each item

1.13 SKILLED NURSING FACILITY CARE Up to one hundred (100) days per Benefit Period* in an HPM-approved and Medicare-certified Skilled Nursing Facility. Room and board and other necessary services furnished by a Skilled Nursing Facility when:

- A. The Subscriber requires Skilled Care Services of the type provided by such a facility;
- B. Admission to a Skilled Nursing Facility is arranged and authorized by the Subscriber's Primary Care Physician or Specialist Physician to whom the Subscriber has been Appropriately Referred;
- C. The admission is approved, in advance, by HPM; and
- D. Admission is appropriate for the necessary care and rehabilitation of the Subscriber.

*A Benefit Period begins on the first day a Subscriber goes to a Medicare-covered inpatient Hospital or a SNF. The Benefit Period ends when the Subscriber has not been an inpatient at any Hospital or SNF care for sixty (60) days in a row. If the Subscriber goes to the Hospital (or SNF) after one Benefit Period has ended, a new Benefit Period begins. There is no limit to the number of Benefit Periods a Subscriber can have.

NONE for days 1-20.

\$50 each day for days 21-100, per each Benefit Period*

1.14 ORAL SURGERY AND RELATED SERVICES only when provided by Affiliated Providers and authorized in advance by the Subscriber's Primary Care Physician and HPM, and according to Medicare guidelines for the following conditions

- A. Prompt repair and treatment of jaw fractures and dislocation of the jaw immediately following an accident or traumatic injury.
- B. Prompt repair of injury to the jaw, tongue, cheeks, lips, and roof-floor of the mouth immediately following an accident or traumatic injury (repair/restoration of the teeth is not a Covered Service).

NONE

NONE

	What you must pay when you get these covered services
C. Orthognathic surgery prior to age twenty-one (21) for congenital defects directly affecting the growth, development and function of the jaw.	NONE
D. Treatment of tumors, cysts and lesions on or in the mouth except when in connection with an extraction.	NONE
E. Hospitalization charges for multiple extractions that must be performed in a Hospital due to a concurrent hazardous medical condition.	NONE
F. General or routine dentistry is <u>not</u> a covered benefit.	
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1.15 ORGAN AND TISSUE TRANSPLANTS only when provided by a Provider approved in advance by HPM to perform such services, and only when authorized in advance by HPM and the Subscriber's Primary Care Physician. Benefits are limited to human organ or tissue transplant procedures that are Medically Necessary and not considered to be experimental.	NONE
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1.16 VISION CARE	
A. One (1) vision exam (including a refractory eye exam and glaucoma screening) during any twelve (12) month period performed by an Affiliated Provider.	\$25 per Visit
B. Diagnosis and treatment for diseases and conditions of the eye provided by an Affiliated Provider when authorized in advance by Subscriber's Primary Care Physician.	\$25 per Visit
C. One (1) pair of eyeglasses or contact lenses from an Affiliated Provider following cataract surgery.	NONE
D. Frames and Lenses. Maximum \$100 allowance toward the purchase of one (1) pair of contact lenses or one (1) pair of lenses and frames every year.	
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1.17 HEARING CARE	
A. Benefits for one (1) hearing screening test during any twelve (12) month period performed by an Affiliated Provider.	\$25 per Visit
B. Benefits for a diagnostic hearing exam when authorized in advance by the Subscriber's Primary Care Physician and obtained from an Affiliated Provider.	\$25 per Visit
C. Benefits for fitting and evaluation for a Hearing Aid.	\$25 per Visit
D. You are covered up to \$400 for Hearing Aids every two (2) years.	

**What you must
pay when you get
these covered
services**

1.18 SPINAL MANIPULATION Benefits for manual manipulation of the spine to correct a subluxation that can be demonstrated by X-ray when performed by the Subscriber's Primary Care Physician or other Affiliated Provider to whom the Subscriber is Appropriately Referred. \$25 per Visit

1.19 PODIATRIC SERVICES Benefits for Medically Necessary foot care performed by a Medicare-certified Affiliated Podiatrist if Appropriately Referred by the Subscriber's Primary Care Physician. \$25 per Visit

1.20 PRESCRIPTION DRUGS Benefits for Prescription Drugs in the HPM Medicare Formulary and certain over-the-counter nonprescription drugs, when prescribed by a Plan Physician, Dentist, or a Non-Plan Provider to whom the Subscriber was Appropriately Referred and when furnished by a Plan Pharmacy Provider.

How much do you pay for drugs covered by this Plan?

If you qualify for extra help with your drug costs, your costs for your drugs may be different than those described below. For more information, see "Qualifying for extra help" later in this section.

When you fill a prescription for a covered drug, you may pay part of the costs for your drug.

The amount you pay for your drugs depends on what coverage level you are in (i.e., Initial Coverage Period, Catastrophic Coverage, after you reach your initial coverage limit, and catastrophic level), the type of drug it is, and whether you are filling your drug at a Plan Pharmacy or a Non-Plan Pharmacy.

Deductible

You do not have to pay a yearly Deductible under this Plan. That means that there is not an amount that you pay each year before we begin paying for part of your drug costs.

Initial Coverage Level

During the initial coverage level (\$0-\$2,510), we will pay part of the costs for your covered drugs and you will pay the other part. The amount you pay when you fill a covered prescription is called the Copayment or coinsurance. Your Copayment or coinsurance will vary depending on the drug and where the prescription is filled.

Once your total drug costs reach \$2,510, you will reach your initial coverage limit. Your initial coverage limit is calculated by adding payments made by this Plan and you. If other individuals, organizations, current or former employer/union, and another insurance plan or policy help pay for your drugs under this Plan, the amount they spend may count towards your initial coverage limit.

The table on the next page explains the Subscriber's Copayments on each drug tier as well as his/her option to receive 90 days of some medications per fill:

Drug Tier	Retail Copayment (34-day supply)	Retail Copayment (90-day supply)	Long Term Care Pharmacy (34-day supply)	Mail-Order Copayment (34-day supply)	Mail-Order Copayment (90-day supply)	Out of Network Copayment
Tier 1 – Generic	\$5	\$10	\$5	\$5	\$10	\$5
Tier 2 – Preferred Brand	\$25	\$50	\$25	\$25	\$50	\$25
Tier 3 – Non-Preferred Brand	\$50	\$100	\$50	\$50	\$100	\$50
Tier 4 Injectable and Miscellaneous Drugs	Lesser of \$125 or 25% of the cost	NA	Lesser of \$125 or 25% of the cost	NA	NA	Lesser of \$125 or 25% of the cost

You may incur a cost in addition to the Copayment if you select a higher-cost drug when a lesser-cost drug is available. If a Subscriber chooses a Brand Name Drug when a Generic Drug is available, he/she must pay the Generic Copayment plus the difference between the cost of the Brand Name Drug and the Generic Drug.

Coverage after you reach your Initial Coverage Limit and before you qualify for

Catastrophic Coverage (Coverage Gap): Once your total drug costs reach \$2,510, you will reach the **coverage gap**. Generic Drugs continue to be a covered benefit, and selected over-the-counter-drugs continue to be covered with no Copayment. The Copayment is \$5 for a month’s supply (or less) and \$10 for a 90-day supply either through mail or 90-day at retail. Within the coverage gap, You, or others on your behalf, will pay 100% for your Brand Name or specialty Drugs. You qualify for catastrophic coverage once your True Out-of-Pocket (TrOOP) Part D Prescription Drug costs reach \$4,050.

Catastrophic Coverage

Your HealthPlus Senior Plan includes catastrophic coverage for people with high drug costs. In order to qualify for catastrophic coverage, you must spend \$4,050 out-of-pocket for the year. When the total amount you have paid (i.e., Copayments and coinsurance), and the cost for covered Part D Drugs (if applicable) reaches \$4,050, you will qualify for catastrophic coverage. During catastrophic coverage you will pay: the greater of \$2.25 for Generic Drugs (including Brand Name Drugs treated as Generic) or \$5.60 for all other drugs, or 5% co-insurance. We will pay the rest.

Note: As mentioned earlier, some enhanced plans may offer additional coverage on some Prescription Drugs not normally covered in a Medicare Drug Plan. The amount you pay when you fill a prescription for these drugs does not count towards your Deductible (if applicable), initial coverage limit, or total out of pocket expenditure (that is, the amount you pay does not help you get catastrophic coverage).

Vaccines (including administration)

As noted in Section 2 of the Subscriber Contract, our Plan’s Prescription Drug benefit covers a number of vaccines (including vaccine administration). The amount you will be responsible for will depend on how the vaccine is dispensed and who administers it. The following chart

describes some of these scenarios. Note that in some cases, you will be receiving the vaccine from someone who is not part of our pharmacy network and you may have to pay in advance for the entire cost of the vaccine and its administration, mail us the receipts along with a completed HPM Reimbursement Form (available on the HPM website or by calling Customer Service), and then be reimbursed by us for covered costs at the usual and customary fee rate. The following chart provides examples of how much it might cost to obtain a vaccine (including its administration) under our Plan. Actual vaccine costs will vary by vaccine type and by whether your vaccine is administered by a pharmacist or by another provider.

- Remember you are responsible for all of the costs associated with vaccines (including their administration) during any Deductible (if applicable) or coverage gap phases of your benefit.
- Your Copayment or coinsurance amount will depend on what tier level the drug being administered is on (Tier 1-Generic, Tier 2-Preferred Brand, Tier 3-Non-Preferred Brand, or Tier 4-Injectable and Miscellaneous Drugs), whether you are in the initial coverage level, the coverage gap, or catastrophic coverage.

If you obtain the vaccine at:	And get it administered at:	You pay (<i>and are reimbursed</i>)
The Pharmacy	The Pharmacy	You pay your <u>Copayment/coinsurance</u>
Your Doctor	Your Doctor	You pay <i>up-front for the entire cost of the vaccine and its administration.</i> You are reimbursed this amount less your <u>Copayment/coinsurance plus any difference charged by the Doctor above what we normally pay.</u> <u>Or if your doctor agrees to submit your claim on your behalf, you pay your Copayment/coinsurance plus any difference charged by the doctor above what we normally pay.*</u>
The Pharmacy	Your Doctor	You pay your <u>Copayment/coinsurance at the pharmacy and the full amount charged by the doctor for administering the vaccine</u> You are reimbursed <u>the latter amount less your Copayment/coinsurance if applicable, plus any difference charged by the doctor for administering the vaccine above what we normally pay.*</u>

* If you receive extra help, we will reimburse you for this difference.

We can help you understand the costs associated with vaccines (including administration) available under our Plan, especially in advance of going to your doctor. For more information, please contact Customer Service at 1-800-332-9161 (in Genesee, Lapeer and Shiawassee Counties), 1-800-462-7060 (outside of Michigan, or 1-800-992-5070 (TTY).

How your out-of-pocket cost is calculated

The type of Prescription Drug payments that count toward your out-of-pocket costs

The following type of payments for Prescription Drugs can count toward your out-of-pocket costs and help you qualify for catastrophic coverage so long as the drug you are paying for is a Part D Drug, on the Formulary (or if you get a favorable decision on a Coverage Determination,

Exception request or Appeal), obtained at a Plan Pharmacy (or you have an approved claim from a Non-Plan Pharmacy); and otherwise meets our coverage requirements:

- Your Copayments; payments you make after the initial coverage limits.
- Payments you make while in the coverage gap, if applicable.

When you have spent a total of \$4,050 for these items, you will reach the catastrophic coverage level. (The amount you pay for your monthly premium **does not** count toward reaching the catastrophic coverage level.)

Purchases that will **not** count toward your out-of-pocket costs:

- Prescription Drugs purchased outside the United States and its territories.
- Prescription Drugs not covered by the Plan.
- Prescription Drugs obtained at a Non-Plan Pharmacy when that purchase does not meet our requirements for out-of-network coverage.
- Prescription Drugs covered by Part A or Part B.
- Over-the-counter non-Prescription Drugs covered by the Plan.

Who may pay for your Prescription Drugs, and how do these payments apply to your out-of-pocket costs

Except for your premium payments, any payments you make for covered Part D Drugs count toward your out-of-pocket costs and will help you qualify for catastrophic coverage. In addition, when the following individuals or organizations pay your Prescription Drug costs, these payments will count toward your out-of-pocket costs (and will help you qualify for catastrophic coverage):

- Family members or other individuals;
- Medicare programs that provide extra help with Prescription Drug coverage; and
- Most charities or charitable organizations. Please note that if the charity is established, run or controlled by your current or former employer or union, the payments usually will not count toward your out-of-pocket costs.

Payments made by the following do **not** count toward your out-of-pocket costs:

- Group Health Plans;
- Insurance Plans and government funded health programs (e.g., TRICARE, the VA, the Indian Health Service); and
- Third party arrangements that obligate the third party to pay for prescription costs (e.g., Workers Compensation).

If you have coverage from a third party such as those listed above that pays part or all of your out-of-pocket costs, you must disclose this information to us. An example of third party coverage would be an employer-sponsored health plan that offers Prescription Drug coverage.

We are responsible for keeping track of your out-of-pocket cost amount and will let you know when you have qualified for catastrophic coverage. If you are in a coverage gap and have purchased a covered Part D Drug at a Plan Pharmacy under a special price or discount card that is outside the Plan's benefit, you may submit documentation and have it count towards

qualifying you for catastrophic coverage. If you or another party on our behalf have purchased drugs outside of our plan benefit, you will be responsible for submitting appropriate documentation of such purchases to HealthPlus Senior. In addition, every month you purchase covered Prescription Drugs through us, you will get an Explanation of Benefits that shows your out-of-pocket cost amount to date.

Extra help that is available

Medicare provides “extra help” to pay Prescription Drug costs for people who meet specific income and resources limits. Resources include your savings and stocks, but not your home or car. If you qualify, you will get help paying for your Medicare drug plan’s monthly premium, yearly Deductible (if applicable), and prescription Copayments. If you qualify, this extra help will count toward your out-of-pocket costs.

Qualifying for extra help

People with limited income and resources may qualify for extra help one of two ways. The amount of extra help you get will depend on your income and resources.

1. **You automatically qualify for extra help and don’t need to apply.** If you have full coverage from a state Medicaid program, get help from Medicaid paying your Medicare premiums (belong to a Medicare Savings Program), or get Supplemental Security Income benefits, you automatically qualify for extra help and do not have to apply for it. Medicare mails letters monthly to people who automatically qualify for extra help.
2. **You apply and qualify.** You may qualify if your yearly income in 2007 is less than \$15,315 (single with no dependents) or \$20,535 (married and living with your spouse and with no dependents), and your resources are less than \$11,710 (single with no dependents) or \$23,535 (married and living with your spouse and with no dependents). Resources include your savings and stocks but not your home or car. If you think you may qualify, call Social Security at 1-800-772-1213, visit www.socialsecurity.gov on the web, or apply at your State Medical Assistance (Medicaid) office. TTY users should call 1-800-325-0778. After you apply, you will get a letter in the mail letting you know if you qualify and what you need to do next.

The above income and resource amounts are for 2007 and will change in 2008. If you live in Alaska or Hawaii, or pay at least half of the living expenses of dependent family members, income limits are higher.

Costs that change when you qualify for extra help

The extra help you get from Medicare will help you pay for your Medicare drug plan’s monthly premium, yearly Deductible (if applicable), and prescription Copayments. The amount of extra help you get is based on your income and resources.

If you qualify for extra help, we will send you by mail an “Evidence of Coverage Rider for those who receive extra help from Medicare for their Prescription Drugs” that explains your costs as a member of our Plan. If the amount of your extra help changes during the year, we will also mail you an updated “Evidence of Coverage Rider for those who receive extra help from Medicare for their Prescription Drugs”.

If you believe you have qualified for extra help and you believe that you are paying an incorrect Copayment amount

If you believe you have qualified for extra help and you believe that you are paying an incorrect Copayment amount when you get your Prescription Drug benefit at a Pharmacy, our Plan has established a process that will allow you to provide evidence of your proper Copayment amount.***

Please be assured that if you overpay your Copayment, we will generally reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future Copayments. Of course, if the pharmacy hasn't collected a Copayment from you and is carrying your Copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a State paid on your behalf, we may make payment directly to the State. Please contact Customer Service if you have questions.

Getting more information

For more information on who can get extra help with Prescription Drug costs and how to apply, call the Social Security Administration at 1-800-772-1213, or visit www.socialsecurity.gov on the Web. TTY/TDD users should call 1-800-325-0778.

In addition, you can look at the 2007 *Medicare & You* Handbook, visit www.medicare.gov on the Web, or call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048.

If you have any questions about our Plan, please refer to our Customer Service numbers listed on the cover and in the Benefits at a Glance section. Or, visit our website.

Ask for 90 Rx

Ask for 90 Rx is a program that allows you to get up to a 90-day supply of medications at participating retail pharmacies. You will pay the same Copayment for your medication if you use Ask for 90 Rx or mail order, both of which offer a savings advantage over filling your Prescription Drugs on a monthly basis. Ask for 90 Rx is convenient and allows for personal interaction with a pharmacist. For more information or to find a pharmacy near you, visit www.healthplus.org or call 1-800-332-9161. It is not medically appropriate to fill all drugs in a 90-day quantity. Talk to your physician to decide what is best for you. Then ask your physician to write you a new prescription for a 90-day supply of medication, and take it to a participating retail pharmacy.

Explanation of Benefits

What is the Explanation of Benefits document?

The Explanation of Benefits is a document you will get each month you use your Prescription Drug coverage. It will tell you the total amount you have spent on your Prescription Drugs and the total amount we have paid for your drugs. You will get your Explanation of Benefits in the mail each month that you use the benefits provided by us. (Please note that the Explanation of Benefits contains a summary of your year-to-date Prescription Drug costs up to the prior month. If you need real time (current) information about the amount Prescription Drug costs you have incurred, please contact Customer Service.)

What information is included in the Explanation of Benefits?

Your Explanation of Benefits will contain the following information:

- A list of Prescription Drugs you filled during the month, as well as the amount paid for each Prescription Drug.
- Information about how to request an Exception and Appeal our coverage decisions.
- A description of changes to the Formulary affecting the prescriptions you filled that will occur at least 60 days in the future.
- A summary of **your** coverage this year, including information about:
 - **Annual Deductible (if applicable)** – the amount you pay, and/or others, before you start receiving Prescription Drug coverage.
 - **Amount Paid For Prescription Drugs** - the amounts paid that count towards your initial coverage limit.
 - **Total Out-Of-Pocket Costs That Count Towards Catastrophic Coverage** - the total amount you and/or others have spent on Prescription Drugs that count towards you qualifying for catastrophic coverage. This total includes the amounts spent for your Deductible (if applicable), Copayments and coinsurance, and payments made on covered Part D Drugs after you reach the initial coverage limit. (This amount does not include payments made by your current or former employer/union, another insurance plan or policy or other excluded parties.)

What should you do if you don't get an Explanation of Benefits or if you wish to request one?

An Explanation of Benefits is also available upon request. To obtain a copy, please contact Customer Service.

1.21 MISCELLANEOUS HPM will cover Medically Necessary Reconstructive surgery including breast Reconstructive surgery following a mastectomy, when authorized in advance by:

- The Subscriber's Primary Care Physician;
- A Specialist Physician to whom the Subscriber is Appropriately Referred; or
- HPM

What you must pay when you get these covered services

NONE

SECTION II
BENEFIT LIMITATIONS AND EXCLUSIONS

2.1 LIMITATIONS

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

- A. Inpatient and Day Treatment Mental Health Services. Coverage for mental health inpatient care is limited to a lifetime maximum of one hundred ninety (190) days in a Medicare-certified psychiatric facility (not a general acute-care-hospital). Inpatient days used under Medicare or another Medicare contracting organization while not a Subscriber of HPM also count toward the one hundred ninety (190) day lifetime maximum. Each two (2) days of Day Treatment shall be counted as one (1) day of inpatient confinement.
- B. Substance Abuse Services. The maximum benefit for substance abuse services shall be limited to Medically Necessary treatment on either an outpatient, intermediate, or inpatient basis, whichever is determined by HPM to be appropriate.
- C. Major Disasters. In the event of any major disaster, epidemic, or other circumstances beyond its control, HPM shall attempt to arrange Covered Services insofar as practical, according to its best judgment, within the limitations of facilities and personnel then available. However, no liability or obligations are incurred for delay or failure to provide any such benefits due to lack of available facilities or personnel, if such lack is the result of disaster, epidemic or other circumstances beyond HPM's control. Such circumstances include complete or partial disruption of facilities, network or Plan staff; war; riot; civil insurrection; or similar causes.
- D. Emergency Services. HPM reserves the right not to pay for Emergency Services for non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency. Subscribers hospitalized at Non-Affiliated Hospitals may be transferred to an Affiliated Hospital upon request by the Subscriber's Primary Care Physician as soon as it is medically appropriate in the opinion of the attending physician. Should a Subscriber, or his or her designee, refuse a transfer to an Affiliated Hospital, continued care provided to that Subscriber at a Non-Affiliated Hospital shall not constitute Covered Services and shall no longer be the financial responsibility of HPM. Coverage of Emergency Services provided by a Non-Affiliated Provider shall be limited to the HPM Reimbursement Amount for said services. Follow up Visits to Non-Affiliated Providers of Emergency Services within the Service Area shall be limited to two (2) Visits within thirty (30) days of the emergency. Follow-up Visits to Non-Affiliated Providers of Emergency Services outside the Service Area shall be limited to two (2) Visits within thirty (30) days of the emergency, or the number of Visits specified in a treatment plan approved by HPM.
- E. Durable Medical Equipment, Orthotic Appliances and Prosthetic Devices. Coverage shall be provided only for non-deluxe items determined by HPM to be eligible for reimbursement. This includes the following diabetic equipment and supplies: blood glucose monitors and blood glucose monitors for the legally blind; test strips for glucose monitors, visual reading and urine testing strips, lancets, and spring-powered lancet devices; and insulin pumps and medical supplies required for the use of an insulin pump. Inhaled solutions for nebulizers are also covered. Orthotic Appliances are covered only when they are used to support, align, prevent, correct, or improve a defect of body form or

function. Prosthetic Devices are covered only when they replace a limb or other part of the body after accidental or surgical removal and/or when the Subscriber's body growth necessitates a replacement. Comfort and convenience equipment, exercise and hygiene equipment, dental appliances, experimental or research equipment, and self-help devices not medical in nature are not a Covered Service. Any equipment, appliance, or device ordered before the Effective Date of coverage will not be covered, even if delivered after the Effective Date of coverage. Equipment, appliances, or devices ordered while a Subscriber, but delivered after the Effective Date of termination, will not be covered.

- F. Prescription Drugs. Benefits for Prescription Drugs in the HPM Medicare Formulary will be limited to the reasonable cost of generically available products, unless no generically equivalent product exists or a Subscriber specific review for medical necessity by HPM determines the need for a Brand Name Drug. HPM reserves the right to determine generic equivalency of products available to HPM Subscribers. 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 Subscribers. Affiliated Pharmacy Providers will provide Subscriber with up to a thirty-four (34) day supply for all covered Prescription Drugs, or a ninety (90) day supply of drugs through mail order or participating retail Plan Pharmacies. You may incur a cost in addition to the Copayment if you select a higher-cost drug when a lesser-cost drug is available. If a Subscriber chooses a Brand Name Drug when a Generic Drug is available, he/she must pay the Generic Copayment plus the difference between the cost of the Brand Name Drug and the Generic Drug.
- G. Skilled Nursing Facility Care. Benefits for care in a Skilled Nursing Facility shall be limited to one hundred (100) days per Benefit Period per Subscriber.
- H. Hearing Care. Benefits for Hearing Aids are limited to four hundred dollars (\$400) every two (2) years.
- I. Inappropriate and Unnecessary Services. Benefits shall be limited to providing coverage for necessary treatment as determined by reviewing the intensity of services, severity of illness, appropriateness of services rendered, and appropriateness of placement in special units and selected clinical support facilities. Services may be reviewed prospective, concurrent or retrospective to the time of service. Such review shall impact only the level of coverage provided by HPM and shall not serve, or be construed as, any limitation or infringement of any Subscriber's right to select and pay for any level of care desired in any location.

2.2 EXCLUSIONS

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

- A. Services not provided by or under the direction of the Subscriber's Primary Care Physician, except Emergency Services, Urgently Needed Services, out-of-area renal dialysis services, and services rendered by a Non-Affiliated Provider after being Appropriately Referred.
- B. Services and supplies to the extent not Medically Necessary for the diagnosis and treatment of injury, illness, or pregnancy.
- C. Charges that are in excess of Reasonable Charges.

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- D. Dental Care and associated supplies, services and tests, except as specifically provided above.
 - E. Cosmetic surgery and other services and products for Cosmetic purposes, such as procedures to correct baldness or wrinkling. However, this exclusion would not apply to Medically Necessary Reconstructive surgery.
 - F. Custodial or domiciliary Care, basic care or housekeeping provided on an inpatient, outpatient, or in-home basis.
 - G. Examinations, reports or any other services related to requirements or documentation of health status for employment, licenses, insurance, travel, or for educational or sports/recreational purposes.
 - H. Services for any injury or illness to the extent any benefits, settlements, awards, or damages are available under workers' compensation, automobile no-fault, or other liability insurance, or any insurance plan or other third party payor. This includes services provided to veterans in Veteran's Affairs (VA) facilities. However, in the case of Emergency Services received at a VA hospital, if the VA cost sharing is more than the cost sharing required under HealthPlus Senior, HPM will reimburse veterans for the difference. Subscribers are still responsible for the HealthPlus Senior cost sharing amount (i.e., Copayment).
 - I. Services for which, in the absence of any health service plan or insurance plan, no charge would be made to the Subscriber.
 - J. Medical, surgical, or psychiatric procedures, treatment or devices, pharmacological regimens, and associated health care services, which are considered experimental in nature under accepted standards of practice.

Something may be considered by HPM to be experimental if one of the following circumstances applies:

1. FDA approval, if applicable, has not been granted at the time of its use or proposed use.
 2. It is the subject of an investigational new drug or device application on file with the FDA.
 3. It is being provided as part of a Phase I, II, or III clinical trial.
 4. It is being provided under the supervision of an Institutional Review Board formally designated by an institution to review, approve and conduct biomedical research involving human subjects as required and defined by applicable federal regulations.
 5. It is being provided pursuant to experimental or research protocol testing for factors such as safety, efficacy, or toxicity.
 6. Published authoritative literature concerning the particular procedure, treatment, device, or regimen indicates that further research is needed to define factors such as safety, efficacy, or toxicity.
- K. Mental health services and supplies which are:
 1. Rendered in connection with mental illness not classified in the International Classification of Diseases of the World Health Organization, as modified by the U.S. Center for Health Statistics;

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2. Extended beyond the period necessary for the evaluation and diagnosis of mental retardation; or
 3. For mental diseases or illness, which, according to generally accepted professional standards, are not usually amenable to favorable modification.
- L. Vocational rehabilitation.
 - M. Personal comfort or convenience items such as television and telephone services.
 - N. Orthopedic or other corrective footwear, unless attached to a prescribed hip, knee, and/or ankle-foot orthopedic brace.
 - O. Sex transformation surgery and all expenses in connection with such surgery.
 - P. Reversal of a voluntary sterilization and all infertility services are specifically excluded, including but not limited to: In Vitro Fertilization and associated services; Gamete Intro Fallopian Transfer and associated services; Zygote Intro Fallopian Transfer and associated services; Donor Artificial Insemination and all associated costs, including sperm bank services; pre-embryo cyro-preservation techniques and associated services; infertility services if one of the partners has previously undergone surgical sterilization or if one of the partners is menopausal or post-menopausal; all services related to surrogate parenting arrangements of any kind.
 - Q. Surgery and any other services for the purposes of weight reduction or control, except when specifically approved by HPM for severely obese Subscribers with high-risk comorbidities.
 - R. Wigs, prosthetic hair, hair transplants, or other procedures or supplies to enhance hair growth.
 - S. Care rendered while in police custody, unless authorized by the Subscriber's Primary Care Physician.
 - T. Court ordered tests, reports, or treatment.
 - U. Services or products provided by Convalescent Homes, Homes for the Aged, or Adult Foster Care Facilities.
 - V. Nonprescription drugs (or their Prescription Drug equivalents), dietary and other supplements, articles, and supplies provided on an outpatient basis, and not specifically identified as Covered Services by this Benefit Rider. HPM may elect to cover and include certain over-the-counter nonprescription drugs in the HPM Formulary based on recommendations made by HPM's Pharmacy and Therapeutics Committee.
 - W. Ancillary services provided as an adjunct to services for which benefits are not provided under this Benefit Rider.
 - X. Skilled Nursing Services provided on a twenty-four (24) hour basis in the home.
 - Y. Coverage for treatment which is necessary because of the Subscriber's commission of, or attempt to commit a felony, or because the Subscriber was engaged in an illegal occupation.
 - Z. Private duty nursing services, except when Medically Necessary.
 - AA. Routine foot care including, but not limited to, hygienic care, treatment of corns, calluses, or toenails.
 - BB. Charges associated with hypnosis or acupuncture services.
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- CC. Services, products, or supplies that are illegal.
 - DD. Charges for the completion of claim forms, interest on late payments, or charges for failure to keep scheduled appointments.
 - EE. Medical expenses incurred by a Subscriber who donates an organ or tissue to a non-Subscriber. Medical expenses incurred by a non-Subscriber who donates an organ or tissue to a Subscriber will only be covered if the non-Subscriber does not have coverage for these services.
 - FF. Services that are provided by individuals who are not licensed/certified under the Michigan Public Health Code (or other similar code/statute of any other state or governmental unit) or services which are beyond the treating individual's licensing.
 - GG. Charges for transportation and/or lodging which may be required to receive Covered Services.
 - HH. Premarital exams or classes.
 - II. Homemaker services.
 - JJ. Meals delivered to the Subscriber's home.
 - KK. Non-medical ancillary services and long-term rehabilitative services for the treatment of alcoholism or drug abuse, including rehabilitation services in a specialized inpatient or residential facility.
 - LL. Any services that are not specifically provided herein or otherwise covered under the Medicare Program.
 - MM. Services for any injury or illness resulting from war, declared or undeclared, or an act of war, or service in the armed forces of any country, to the extent coverage of such injury or illness is provided through any governmental plan or program. An act of terrorism will not be considered an act of war, declared or undeclared.
 - NN. Services provided to the Subscriber by: the Subscriber, immediate family member(s) of the Subscriber, or individuals that have the same legal residence as the Subscriber.
 - OO. Prescription Drugs for treatment of sexual or erectile dysfunction, unless used to treat a condition other than sexual or erectile dysfunction, for which the drug has been approved by the Food and Drug Administration (FDA), are excluded from Medicare Part D coverage effective January 1, 2007 and are not a covered benefit under this HealthPlus Senior plan.
 - PP. Naturopath services.
 - QQ. Radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services.

HealthPlus Senior Option 3 Benefit Rider • Material ID – H2354_0805; CMS Approved 08/13/07