



# Comprehensive Plus

## Medical Plan Schedule of Benefits 2021

**Annual Deductible**

\$100 per person / \$300 maximum per family

**Stop Loss**

\$2,000 per person / \$6,000 per family (per calendar year, includes deductibles & copayments)

**Lifetime Maximum**

Unlimited

Benefit	Coinsurance/Copayment	
	Participating	Non-Participating
<b>Hospital and Facility Services</b>		
Ambulatory Surgical Center (ASC)	20%	20%
Hospital Ancillary Services	20%	20%
Hospital Room and Board	20%	20%
Outpatient Facility	20%	20%
Skilled Nursing Facility	20%	20%
<b>Emergency Services</b>		
Emergency Room	20%	20%
Physician Visits	\$15	\$15
Online and Telephonic Care via HMAA's HiDoc Service	None	Not Covered
<b>Physician Services</b>		
Physician Visits	\$15	\$15
Hospital Visits	\$15	\$15
Immunizations (standard, including travel)	None	None
Telehealth Services	\$15	Not Covered
<b>Testing, Laboratory and Radiology</b>		
Allergy Testing	20%*	20%*
Allergy Treatment Materials	\$5	\$5
Diagnostic Testing	20%	20%
Laboratory and Pathology — Inpatient	20%	20%
Outpatient	None	None
Radiology	20%	20%
<b>Chemotherapy and Radiation Therapy</b>		
Chemotherapy — Infusion/Injections	20%*	20%*
Radiation Therapy — Inpatient	20%*	20%*
Outpatient	20%	20%
<b>Other Medical Services and Supplies</b>		
Acupuncture, Chiropractic, Massage, & Naturopathic Services	20%	20%
Ambulance (air)	20%*	20%*
Ambulance (ground)	20%	20%
Blood and Blood Products	20%*	20%*
Dialysis and Supplies	20%*	20%*
Durable Medical Equipment and Supplies	20%*	20%*
Evaluations for Hearing Aids	20%*	20%*
Growth Hormone Therapy	20%	20%
Home IV Therapy	20%	20%
Inhalation Therapy	20%	20%
Injections	20%*	20%*
Medical Foods	20%	20%
Orthotics and External Prosthetics	20%*	20%*
Vision and Hearing Appliances	20%*	20%*

\* = Annual Deductible Applies | % = Coinsurance (Percentage based on eligible charge) | \$ = Copayment (Fixed dollar amount)

Benefit	Coinsurance/Copayment	
	Participating	Non-Participating
<b>Rehabilitation Therapy</b>		
Physical and Occupational Therapy		
Inpatient	20%	20%
Outpatient	20%*	20%*
Speech Therapy Services		
Inpatient	20%	20%
Outpatient	20%*	20%*
<b>Special Benefits – Disease Management and Preventive Services</b>		
Disease Management	None	Not Covered
Preventive Services — Laboratory	None	None
Preventive Services — Physical Exam	None	None
Screening and Preventive Counseling	None	None
<b>Special Benefits for Children</b>		
Newborn Care	10%	10%
Well Child Care Immunizations	None	None
Well Child Care Laboratory Tests	None	None
Well Child Care Physician Office Visits	None	None
<b>Special Benefits for Men</b>		
Prostate Specific Antigen Test (screening)	None	None
<b>Special Benefits for Women</b>		
Breast Pump	None	None
Chlamydia Screening	None	None
Contraceptive Implants (generic)	None	None
Contraceptive Injectables (generic)	None	None
Contraceptive IUD (generic)	None	None
In Vitro Fertilization	20%*	20%*
Mammography (screening)	None	None
Maternity Care	10%	10%
Pap Smears (screening)	None	None
Tubal Ligation	None	None
Well Woman Exam	None	None
<b>Special Benefits for Homebound, Terminal, or Long-Term Care</b>		
Home Health Care	20%	20%
Hospice Services	None	None
<b>Behavioral Health – Mental Health and Substance Abuse</b>		
Hospital and Facility Services	20%	20%
Physician Services		
Inpatient	None	None
Outpatient	\$15	\$15
Psychological Testing	20%	20%
<b>Special Offers</b>		
Employee Assistance Program (EAP)	Up to 6 fully-covered visits to assist subscribers with personal or family issues	
Health and Wellness Programs	A variety of solutions for healthy living including Active&Fit®, Flu Prevention, Colorectal Cancer Screening, Baby & Me (our free maternity incentive program), and more	
Member Plus Discount Program	Discounted prices and special offers from HMAA member groups and other participating merchants	

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**Note:** Reimbursement is based on a percentage of HMAA's eligible charges, not the billed charges. Eligible charges may be based on a procedure fee schedule, a percentage of billed charges, per day (per diem) fees, per case fees, per treatment fees, or other methods. This document is intended to provide a condensed explanation of benefits. Please refer to the Description of Coverage (DOC) for details. In the case of a discrepancy between this document and the language contained within the DOC, the latter will take precedence.