HealthPlus Insurance Company

Benefit Summary ~ 3Z
Signature $2500-70% Silver PPO

This 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 or Certificate of Coverage. ***Please read*** *your Certificate of Coverage, Schedule of Benefits and any Benefit Riders for complete coverage details, benefit limitations and exclusions, and your cost sharing responsibility.*

Services	Member Responsibility In-Network (Preferred Providers) HPI (Plan) pays coinsurance % of contracted Reimbursement Rate or Allowed Amount.	Member Responsibility Out-of-Network (Non-Preferred Providers) HPI (Plan) pays coinsurance % of Allowed Amount or Reasonable and Customary Amount. **Member pays any Excess Charges**
Deductible-Deductible applies to all services except those with flat dollar copay and exceptions noted below**.**	$2,500 per member $5,000 per family	$5,000 per member $10,000 per family
Coinsurance-Member % coinsurance applies to services after deductible is met.	Member pays: 30% Plan pays: 70%	Member pays: 50% Plan pays: 50%
Out-of-Pocket Maximum-All member payments for covered services, including deductible, coinsurance, and flat dollar copays, apply to the Out-of-Pocket Maximum.	$5,000 per member $10,000 per family	$15,000 per member $30,000 per family
Immunizations and Preventive Services *Deductible does not apply to In-Network Services. See Certificate of Coverage or Schedule of Benefits for complete list of preventive services.*		
Annual preventive exam, well baby/child visits, annual gynecological exam, screenings/other preventive services	NONE	50% after deductible is met
Physician and Professional Services		
Primary care physician (General or Family Practitioner, Internist, Pediatrician, or Osteopath) Office or Home Visits for the treatment of illness or injury	$25 copay per Visit	50% after deductible is met
Specialist physician (all other specialties) Office or Home Visits for the treatment of illness or injury	$50 copay per Visit	
Chiropractor visits *(limited to combined 30 visits per benefit year combined with outpatient physical/occupational therapy)*	$25 copay per Visit	
Other physician and practitioner services	30% after deductible is met	
Emergency Health Services *In-Network deductible applies to Out-of-Network services.*		
Emergency Room Visits (Copay waived if admitted as inpatient or to observation status)	30% after deductible is met	30% after deductible is met plus any excess charges
Emergency Department Physician/Other Practitioner Services in Hospital Emergency	30% after deductible is met	30% after deductible is met
Freestanding Urgent Care Center	30% after deductible is met	30% after deductible is met plus any excess charges
Ambulance Services—medically necessary only; Prior authorization required for transport between facilities	30% after deductible is met	30% after deductible is met
Diagnostic Laboratory and Radiological Tests **Prior authorization required—See Certificate of Coverage*		
Lab Tests (except genetic and infertility tests)	$0 copay	50% after deductible is met
Professional pathology services (except preventive)	30% after deductible is met	
Diagnostic Radiological Services such as EKG and EEG Diagnostic X-rays and services to read the tests	30% after deductible is met	
*****Cardiac services such as echocardiogram *****Imaging services such as MRI, CAT scan, CT, PET scan	30% after deductible is met	
Maternity Services Provided by a Physician or Certified Midwife *See Certificate of Coverage for details*		
Pre-natal and Post-natal Office Visits ($0 copay for In-network preventive prenatal labs)	30% after deductible is met	50% after deductible is met
Delivery and Nursery Care by a Physician	30% after deductible is met	50% after deductible is met

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Hospital Care (Facility Services) ***Prior authorization required for elective services—see Certificate of Coverage**		
***Inpatient Care; semi private room rate, nursing care, supplies/services; newborn nursery and maternity care	30% after deductible is met	50% after deductible is met
*Outpatient Procedures and Surgery	30% after deductible is met	
*Outpatient /Inpatient physician and Surgical services	30% after deductible is met	
Alternatives to Hospital Care ***Prior authorization required; coverage limitations apply—see Certificate of Coverage**		
*Ambulatory Surgical Facility Services	30% after deductible is met	50% after deductible is met
***Skilled Nursing Facility (*Limit of 45 days per benefit year)*	30% after deductible is met	
***Hospice Care (*Limit of 45 days per benefit year for inpatient)*	30% after deductible is met	
***Home Health Care	30% after deductible is met	
Mental Health and Substance Abuse Services **Prior authorization required—see Certificate of Coverage*		
***Inpatient Mental Health and Substance Abuse Services (including detoxification)	30% after deductible is met	50% after deductible is met
***Partial hospitalization, intensive outpatient Mental Health, and Substance Abuse Services	30% after deductible is met	
Outpatient Mental Health and Substance Abuse Services	$25 copay per Visit	
Habilitation Services **Prior authorization required; coverage limitations apply—See Certificate of Coverage*		
***Applied Behavior Analysis Therapy to diagnose and treat Autism (Michigan residents treated in Michigan only)	30% after deductible is met	50% after deductible is met
***Physical, Occupational, and Speech Therapy as part of Autism treatment	30% after deductible is met	
Outpatient Mental Health Services to diagnose/treat Autism	$25 copay per Visit	
Short Term Rehabilitation Services *Coverage limitations apply—See Certificate of Coverage*		
Outpatient physical and occupational therapy (limit of 30 visits per benefit year combined with chiropractor visits)	30% after deductible is met	50% after deductible is met
Outpatient Speech therapy (limit of 30 visits per benefit year)	30% after deductible is met	
Prescription Drugs *Prior authorization, step therapy, mandatory specialty pharmacy and 90 supply requirements apply—See Certificate of Coverage for details. Copays shown below are 30 day supply.*		
Generic	$10 Copay	**NOT COVERED**
Formulary Brand	$80 Copay	
Non-Formulary Brand	$160 Copay	
Specialty drugs	25%; maximum $250 Copay	
90 Day Mail Order and Retail "Ask for 90" programs: 2 Copayments for 90 day supply—See Certificate of Coverage for details.		
Other Services *See Certificate of Coverage for complete list of "Other" covered services.*		
Durable Medical Equipment and Prosthetics &Orthotics	30% after deductible is met	**NOT COVERED**
Pediatric Dental Services (to age 19): exams, X-rays, fillings, extractions	$0 Copay	**NOT COVERED**
Pediatric Vision Services (to age 19); exams, glasses	$0 Copay	**NOT COVERED**
AVESIS administers the Pediatric Dental and Vision Services and provides the provider network for these services. Your Certificate of Coverage has a complete list of covered services. See your enrollment materials for information about the AVESIS Dental and Vision Networks.		