HealthPlus Insurance Company

Benefit Summary ~ 5Z
Signature Catastrophic PPO
(*Eligibility Criteria Apply)

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 covered preventive services and immunizations.	$6,350 per member $12,700 per family	Not Applicable
Coinsurance-Member % coinsurance applies to services after deductible is met.	Member pays: 0% Plan pays: 100%	Not Applicable
Out-of-Pocket Maximum-All member payments for covered services, including deductible, coinsurance, and flat dollar copays, apply to the Out-of-Pocket Maximum.	$6,350 per member $12,700 per family	Not Applicable
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	**NOT COVERED**
Physician and Professional Services *Deductible does not apply to 3 primary care physician visits per benefit year*		
Primary care physician (General or Family Practitioner, Internist, Pediatrician, or Osteopath) Office or Home Visits for the treatment of illness or injury	$25 copay for 3 visits per benefit year. Additional visits: NONE after deductible met.	**NOT COVERED**
Specialist physician (all other specialties) Office or Home Visits for the treatment of illness or injury	NONE after deductible met	
Chiropractor visits *(limited to combined 30 visits per benefit year combined with outpatient physical/occupational therapy)*	NONE after deductible met	
Other physician and practitioner services	NONE after deductible 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)	NONE after deductible met	NONE after deductible is met except any excess charges
Emergency Department Physician/Other Practitioner Services in Hospital Emergency	NONE after deductible met	NONE after deductible met
Freestanding Urgent Care Center	NONE after deductible met	NONE after deductible met except any excess charges
Ambulance Services—medically necessary only; Prior authorization required for transport between facilities	NONE after deductible met	NONE after deductible met
Diagnostic Laboratory and Radiological Tests **Prior authorization required—See Certificate of Coverage*		
Lab Tests (except genetic and infertility tests)	NONE after deductible met	**NOT COVERED**
Professional pathology services (except preventive)	NONE after deductible met	
Diagnostic Radiological Services such as EKG and EEG Diagnostic X-rays and services to read the tests	NONE after deductible met	
*****Cardiac services such as echocardiogram *****Imaging services such as MRI, CAT scan, CT, PET scan	NONE after deductible 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)	NONE after deductible met	**NOT COVERED**
Delivery and Nursery Care by a Physician	NONE after deductible met	**NOT COVERED**

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**
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	NONE after deductible met	**NOT COVERED**
*Outpatient Procedures and Surgery	NONE after deductible met	
*Outpatient /Inpatient physician and Surgical services	NONE after deductible met	
Alternatives to Hospital Care ***Prior authorization required; coverage limitations apply—see Certificate of Coverage**		
*Ambulatory Surgical Facility Services	NONE after deductible met	**NOT COVERED**
***Skilled Nursing Facility (*Limit of 45 days per benefit year)*	NONE after deductible met	
***Hospice Care *(Limit of 45 days per benefit year for inpatient)*	NONE after deductible met	
***Home Health Care	NONE after deductible met	
Mental Health and Substance Abuse Services **Prior authorization required—see Certificate of Coverage*		
***Inpatient Mental Health and Substance Abuse Services (including detoxification)	NONE after deductible met	**NOT COVERED**
***Partial hospitalization, intensive outpatient Mental Health, and Substance Abuse Services	NONE after deductible met	
Outpatient Mental Health and Substance Abuse Services	NONE after deductible met	
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)	NONE after deductible met	**NOT COVERED**
***Physical, Occupational, and Speech Therapy as part of Autism treatment	NONE after deductible met	
Outpatient Mental Health Services to diagnose/treat Autism	NONE after deductible met	
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)	NONE after deductible met	**NOT COVERED**
Outpatient Speech therapy (limit of 30 visits per benefit year)	NONE after deductible 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	NONE after deductible met	**NOT COVERED**
Formulary Brand	NONE after deductible met	
Non-Formulary Brand	NONE after deductible met	
Specialty drugs	NONE after deductible met	
90 Day Mail Order and Retail "Ask for 90" programs are available. 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	NONE after deductible met	**NOT COVERED**
Pediatric Dental Services (to age 19): exams, X-rays, fillings, extractions	NONE after deductible met	**NOT COVERED**
Pediatric Vision Services (to age 19); exams, glasses	NONE after deductible met	**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.		

***Catastrophic Plan Eligibility Rules effective 1/1/2014.**
Source: Federal Register/Vol. 78, No. 39/Wednesday, February 27, 2013 pages 13423-13424
The two categories of individuals eligible to enroll in catastrophic plans:

1. The first category includes individuals who are younger than age 30 before the beginning of the plan year
2. The second category includes individuals who have been certified as exempt from the individual responsibility payment because they cannot afford minimum essential coverage or because they are eligible for a hardship exemption.
   - Only the Exchange may issue certificates of exemption based on hardship
   - Individuals granted a certificate of exemption by the Exchange may use it to establish eligibility to purchase a catastrophic plan outside of the exchange.
   - Each individual enrolled in a catastrophic family plan must fall into at least one of the two categories above.