HealthPlus Insurance Company

Benefit Summary ~ 55
VenturePlus $6300-100% HSA Bronze 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 covered preventive services and immunizations.	$6,300 per single contract $12,600 per family contract	$12,600 per single contract $25,200 per family contract
Coinsurance-Member % coinsurance applies to services after deductible is met.	Member pays: 0% Plan pays: 100%	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.	$6,300 per single contract $12,600 per family contract	$19,000 per single contract $38,000 per family contract
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	NONE after deductible is met	50% after deductible is met
Specialist physician (all other specialties) Office or Home Visits for the treatment of illness or injury		
Chiropractor visits *(limited to combined 30 visits per benefit year combined with outpatient physical/occupational therapy)*		
Other physician and practitioner services		
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 is met	10% after deductible is met plus any excess charges
Emergency Department Physician/Other Practitioner Services in Hospital Emergency	NONE after deductible is met	10% after deductible is met
Freestanding Urgent Care Center	NONE after deductible is met	10% after deductible is met plus any excess charges
Ambulance Services—medically necessary only; Prior authorization required for transport between facilities	NONE after deductible is met	10% after deductible is met
Diagnostic Laboratory and Radiological Tests **Prior authorization required—See Certificate of Coverage*		
Lab Tests (except genetic and infertility tests)	NONE after deductible is met	50% after deductible is met
Professional pathology services (except preventive)		
Diagnostic Radiological Services such as EKG and EEG Diagnostic X-rays and services to read the tests		
*****Cardiac services such as echocardiogram *****Imaging services such as MRI, CAT scan, CT, PET scan		
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 is met	50% after deductible is met

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Delivery and Nursery Care by a Physician		
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 is met	50% after deductible is met
*Outpatient Procedures and Surgery		
*Outpatient /Inpatient physician and Surgical services		
Alternatives to Hospital Care ***Prior authorization required; coverage limitations apply—see Certificate of Coverage***		
*Ambulatory Surgical Facility Services	NONE after deductible is met	50% after deductible is met
Skilled Nursing Facility** ***(Limit of 45 days per benefit year)		
Hospice Care** ***(Limit of 45 days per benefit year for inpatient)		
***Home Health Care**		
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 is met	50% after deductible is met
***Partial hospitalization, intensive outpatient Mental Health, and Substance Abuse Services**		
Outpatient Mental Health and Substance Abuse Services		
Habilitation Services ***Prior authorization required; coverage limitations apply—See Certificate of Coverage***		
***Applied Behavior Analysis Therapy to diagnose and treat Autism**	NONE after deductible is met	50% after deductible is met
***Physical, Occupational, and Speech Therapy as part of Autism treatment**		
Outpatient Mental Health Services to diagnose/treat Autism		
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 is met	50% after deductible is met
Outpatient Speech therapy (limit of 30 visits per benefit year)		
Prescription Drugs ***Prior authorization, step therapy, mandatory specialty pharmacy and 90 day supply requirements apply—See Certificate of Coverage for details. Copays shown below are 30 day supply.***		
Generic (Tier 1)	NONE after deductible is met	**NOT COVERED**
Formulary Brand (Tier 2)		
Non-Formulary Brand (Tier 3)		
Specialty drugs (Tier 4)		
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 is met	**NOT COVERED**
Pediatric Dental Services (to age 19): exams, X-rays, fillings, extractions	NONE after deductible is met	**NOT COVERED**
Pediatric Vision Services (to age 19); exams, glasses	NONE after deductible is 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.		