HealthPlus Insurance Company

Benefit Summary ~ 3Y
VenturePlus $500-80% $20/$40 Gold 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**.**	$500 per member $1,000 per family	$1,000 per member $2,000 per family
Coinsurance-Member % coinsurance applies to services after deductible is met.	Member pays: 20% Plan pays: 80%	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.	$6,600 per member $13,200 per family	$19,800 per member $39,600 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	$20 copay per Visit	50% after deductible is met
Specialist physician (all other specialties) Office or Home Visits for the treatment of illness or injury	$40 copay per Visit	
Chiropractor visits *(limited to combined 30 visits per benefit year combined with outpatient physical/occupational therapy)*	$20 copay per Visit	
Other physician and practitioner services	20% 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)	$250 Copay per Visit	$250 Copay per Visit plus any excess charges
Emergency Department Physician/Other Practitioner Services in Hospital Emergency	20% after deductible is met	20% after deductible is met
Freestanding Urgent Care Center	$75 Copay per Visit	$75 Copay per Visit plus any excess charges
Ambulance Services—medically necessary only; Prior authorization required for transport between facilities	20% after deductible is met	20% 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)	20% after deductible is met	
Diagnostic Radiological Services such as EKG and EEG Diagnostic X-rays and services to read the tests	20% after deductible is met	
*Cardiac services such as echocardiogram *Imaging services such as MRI, CAT scan, CT, PET scan	20% 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)	20% after deductible is met	50% after deductible is met
Delivery and Nursery Care by a Physician		

<table>
<tr><th>Services</th><th>Member Responsibility In-Network (Preferred Providers)
HPI (Plan) pays coinsurance % of contracted Reimbursement Rate or Allowed Amount.</th><th>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</th></tr>
<tr><td colspan="3">Hospital Care (Facility Services) *Prior authorization required for elective services—see Certificate of Coverage</td></tr>
<tr><td>*Inpatient Care; semi private room rate, nursing care, supplies/services; newborn nursery and maternity care</td><td rowspan="3">20% after deductible is met</td><td rowspan="3">50% after deductible is met</td></tr>
<tr><td>*Outpatient Procedures and Surgery</td></tr>
<tr><td>*Outpatient /Inpatient physician and Surgical services</td></tr>
<tr><td colspan="3">Alternatives to Hospital Care *Prior authorization required; coverage limitations apply—see Certificate of Coverage</td></tr>
<tr><td>*Ambulatory Surgical Facility Services</td><td rowspan="4">20% after deductible is met</td><td rowspan="4">50% after deductible is met</td></tr>
<tr><td>*Skilled Nursing Facility (Limit of 45 days per benefit year)</td></tr>
<tr><td>*Hospice Care (Limit of 45 days per benefit year for inpatient)</td></tr>
<tr><td>*Home Health Care</td></tr>
<tr><td colspan="3">Mental Health and Substance Abuse Services *Prior authorization required—see Certificate of Coverage</td></tr>
<tr><td>*Inpatient Mental Health and Substance Abuse Services (including detoxification)</td><td>20% after deductible is met</td><td rowspan="3">50% after deductible is met</td></tr>
<tr><td>*Partial hospitalization, intensive outpatient Mental Health, and Substance Abuse Services</td><td>20% after deductible is met</td></tr>
<tr><td>Outpatient Mental Health and Substance Abuse Services</td><td>$20 Copay per Visit</td></tr>
<tr><td colspan="3">Habilitation Services *Prior authorization required; coverage limitations apply—See Certificate of Coverage</td></tr>
<tr><td>*Applied Behavior Analysis Therapy to diagnose and treat Autism</td><td>20% after deductible is met</td><td rowspan="3">50% after deductible is met</td></tr>
<tr><td>*Physical, Occupational, and Speech Therapy as part of Autism treatment</td><td>20% after deductible is met</td></tr>
<tr><td>Outpatient Mental Health Services to diagnose/treat Autism</td><td>$20 Copay per Visit</td></tr>
<tr><td colspan="3">Short Term Rehabilitation Services Coverage limitations apply—See Certificate of Coverage</td></tr>
<tr><td>Outpatient physical and occupational therapy (limit of 30 visits per benefit year combined with chiropractor visits)</td><td rowspan="2">20% after deductible is met</td><td rowspan="2">50% after deductible is met</td></tr>
<tr><td>Outpatient Speech therapy (limit of 30 visits per benefit year)</td></tr>
<tr><td colspan="3">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.</td></tr>
<tr><td>Generic (Tier 1)</td><td>$10 Copay</td><td rowspan="4">NOT COVERED</td></tr>
<tr><td>Formulary Brand (Tier 2)</td><td>$40 Copay</td></tr>
<tr><td>Non-Formulary Brand (Tier 3)</td><td>$80 Copay</td></tr>
<tr><td>Specialty drugs (Tier 4)</td><td>25%; maximum $250 Copay</td></tr>
<tr><td colspan="3">90 Day Mail Order and Retail “Ask for 90” programs: 2 Copayments for 90 day supply—See Certificate of Coverage for details.</td></tr>
<tr><td colspan="3">Other Services See Certificate of Coverage for complete list of “Other” covered services.</td></tr>
<tr><td>Durable Medical Equipment and Prosthetics &Orthotics</td><td>20% after deductible is met</td><td>NOT COVERED</td></tr>
<tr><td>Pediatric Dental Services (to age 19): cleanings, X-rays</td><td>$20 Copay</td><td>NOT COVERED</td></tr>
<tr><td>Pediatric Vision Services (to age 19); eye exam</td><td>$20 Copay</td><td>NOT COVERED</td></tr>
<tr><td colspan="3">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.</td></tr>
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