



Schedule of Benefits

Custom PPO Plan # LT (WRAP Plan)

Optional Riders: *If YES, you have coverage for the services indicated. See attached Rider for coverage details.*

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|-----------------------------------|------------|-----------------------------|
| • Chiropractic: | YES | Rider Name: CIH38XTM |
| • Hearing Aid: | YES | Rider Name: HEARHR35 |
| • Home Health Private Duty Nurse: | YES | Rider Name: PRIVHRA |
| • Prescription Drugs: | YES | Rider Name: AZ10201X |

Family Continuation Rider: *(See section 3.2 of Certificate of Coverage for complete Dependent Child coverage details).*

- See Rider **FS** for Dependent Child coverage details.

General Information

Read this Schedule of Benefits along with the Certificate of Coverage and any optional Riders for complete information about your coverage. Words in *italics* below are defined in the Certificate of Coverage.

This *Schedule of Benefits* explains Member financial responsibility for HealthPlus Insurance Company (HPI) *Preferred Provider Organization (PPO)* health care benefits. *Deductibles, Out-of-Pocket Maximum, Coinsurance and Copayments for Covered Services* are shown for both *In-Network* and *Out-of-Network Covered Services* on the chart following this general information page. The *In-Network Deductible, Coinsurance, and Out-of-Pocket Maximum* apply when you receive *Covered Services* from *HealthPlus Preferred Providers*. The *Out-of-Network Deductible, Coinsurance, and Out-of-Pocket Maximum* apply when you receive services from *Non-Preferred Providers*. *(Note: When the cost of a Covered Service from a Non-Preferred Provider is more than the HealthPlus Allowed Amount for that service, it is called an Excess Charge; Members are always responsible for Excess Charges billed by Non-Preferred Providers.)*

If *Covered Services* are subject to the *Deductible*, you are responsible for paying the *Deductible* before HealthPlus Insurance will start to pay benefits for those *Covered Services*. After the *Deductible* is met, you are responsible for the Member percent *Coinsurance* until the *Out-of-Pocket-Maximum* is met. When a Member meets the “Member” *Deductible*, *Coinsurance* will apply to *Covered Services* for that Member. Two or more Members of a family must meet a “Family” *Deductible*; *Coinsurance* will then apply to *Covered Services* for all Members of the Family. The chart on the following pages indicates which services are subject to the *Deductible*.

The *Deductible* does not apply to certain **In-Network** services including *Preventive Services, Physician Office and Home Visits, Outpatient Mental Health and Substance Abuse Visits, Emergency Room and Urgent Care Services*. It also does not apply to services available by *Rider* including *Chiropractic Visits, Prescription Drugs, Hearing Aid Services, and Private Duty Home Health Nursing Services*. The Member is always responsible for *Copayments* for these services and the *Copayments* do not apply to the *Out-of-Pocket Maximum*.

You are responsible for obtaining required *Prior Authorizations* from HealthPlus or its designee for specific Covered Services. The back of your ID card lists phone numbers to call for *Prior Authorization*. An asterisk (*) on the following chart indicates which *Covered Services* require *Prior Authorization*. **If you do not obtain the required *Prior Authorization*, you may be responsible for the entire cost of the service.** *Medically Necessary Hospital inpatient and outpatient Covered Services* that require *Prior Authorization* but for which no *Prior Authorization* was obtained will include up to a **\$500 penalty** to be paid by you. *Penalty charges* do not apply to the *Deductible* or the *Out-of-Pocket Maximum*. **See section VII of your Certificate of Coverage for *Prior Authorization requirements*.**

For complete details on service limits and/or exclusions, see **sections VIII and IX of the Certificate of Coverage.**

Item	Member Responsibility In-Network (Preferred Providers)		Member Responsibility Out-of-Network (Non-Preferred Providers)
Deductible Deductible applies to Out-of-Pocket Maximum	Employer Pays: \$1,250 per Member/ \$2,500 per Family	Member Pays: \$0	\$250 per Member/\$500 per Family
Coinsurance	Member pays: 0% Plan pays: 100%		Member pays: 20% of Allowed Amount plus any Excess Charges billed by provider Plan pays: 80% of Allowed Amount
Out-of-Pocket Maximum The following do not apply to Deductible or the Out-of-Pocket Maximum: expenses for services that are not covered benefits; penalty expenses for services provide without proper prior authorization; expenses for services denied/not covered because no prior authorization; expenses for services beyond benefit maximums; expenses for excess charges; any flat dollar copayments	Employer Pays: \$1,250 per Member/ \$2,500 per Family	Member Pays: \$0	\$2,000 per Member/\$4,000 per Family
After the Member or Family Out-of-Pocket Maximum is reached, HPI will pay for all Covered Services for the Member and/or Family. Payments that do not apply to the Deductible and/or the Out-of-Pocket Maximum will remain the responsibility of the Member.			
Lifetime Maximum Benefits	No lifetime dollar limits		
IMMUNIZATIONS and PREVENTIVE SERVICES For additional preventive services and immunizations with no member Copay, see www.healthplus.org. Copays or deductible/coinsurance apply to all services, including preventive services, provided in a Hospital Emergency Room, Urgent Care Facility or as part of a hospital inpatient stay. Immunizations are covered at 100% at all locations.			
Childhood Immunizations through age 18 for prevention of diphtheria, tetanus, pertussis, polio, measles, mumps and rubella, chickenpox, hemophilus influenza type b, hepatitis B, pneumonia, bacterial meningitis, influenza. (See list of covered immunizations and recommended dose/ age range in at www.healthplus.org , or in Member Handbook)	Immunizations Covered at 100% Office Visit Copay may apply		
Adult Immunizations: <ul style="list-style-type: none"> • Influenza vaccine (annually) • Pneumonia vaccine (at age 65 or if Medically Necessary) • Tetanus/Diphtheria 			
Other Immunizations (if not specifically excluded from coverage)	Covered at 100% after Deductible is met		
Adult Routine Health Maintenance Exam <i>one per benefit year</i>			
Adult Well-Woman Gynecological Exam <i>one per benefit year</i>			Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
Well-Baby and Well Child Care Visits: <i>7 Visits per benefit year through age 12 months.</i> <i>6 Visits per benefit year ages 13- 23 months</i> <i>3 Visits per benefit year ages 24 -47 months</i> <i>1 Visit per benefit year ages 4 through 17 yrs</i>	Covered at 100%; Office Visit Copay applies to any additional visits		
Childhood Screenings: Lead testing — <i>infants/early childhood</i> Urinalysis— <i>once at age 5 and once between age 11-17</i> Hemoglobin/Hemocrit— <i>one before age 1; once between age 11-17</i>	Covered at 100% Office Visit Copay may apply		
Cervical Cancer screening Pap Smear — <i>1 per benefit year for women age 18 or older</i>			
Breast Cancer Screening Mammogram — <i>baseline for women ages 35 - 40; one per benefit year for women age 40 or older</i>			

Item	Member Responsibility In-Network (Preferred Providers)	Member Responsibility Out-of-Network (Non-Preferred Providers)
IMMUNIZATIONS and PREVENTIVE SERVICES (Continued)		
Colorectal Cancer screening beginning at 50: <ul style="list-style-type: none"> • Fecal occult blood Test (<i>one per benefit year</i>) • Sigmoidoscopy (<i>one every 5 years</i>) OR • Double contrast barium enema (<i>one every 5 years</i>) OR • Colonoscopy (<i>one every 10 years</i>) Cholesterol Screening; <i>one per benefit year</i> Diabetes Screening; <i>one per benefit year</i> Prostate Cancer Screening; Routine PSA test beginning at age 45; <i>one per benefit year for men</i>	Labs and tests Covered at 100% Office Visit Copay may apply	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
PHYSICIAN and PROFESSIONAL SERVICES		
Office and Home Visits for illness or injury or by Primary Care Physicians (General or Family Practitioner, Internist, Pediatrician, or Osteopath)	Member pays \$0 after Deductible is met	
Specialist Office or Home Visit for illness or injury (all other physician specialties)	Member pays \$0 after Deductible is met	
Inpatient or Outpatient Visits and/or Consultations		
Surgical Services and Anesthesiology Services provided by a Physician or Specialist Physician Note to Members: <ul style="list-style-type: none"> • Laparoscopic surgery is a covered benefit • Additional charges for robotic assisted laparoscopic surgery will not be covered All other Physician/I Practitioner covered services for diagnosis or treatment of illness or injury.	Member pays \$0 after Deductible is met	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
EMERGENCY HEALTH SERVICES		
Emergency Room Visits (<i>Hospital ER Copay waived if Member is admitted to the hospital or admitted to observation</i>)	Member pays \$0 after deductible is met	Employer pays In-Network Deductible; Member may be responsible for any Excess Charges
Emergency Department Physician/Other Practitioner Services in Hospital Emergency Department, including follow-up care after emergency has ended	Member pays \$0 after Deductible is met	In-Network Deductible and Coinsurance apply
Urgent Care Center Visits	Member pays \$0 after Deductible is met	Employer pays In-Network Deductible; Member may be responsible for any Excess Charges
Ambulance Services	Member pays \$0 after Deductible is met	In-Network Deductible and Coinsurance apply

Item	Member Responsibility In-Network (Preferred Providers)	Member Responsibility Out-of-Network (Non-Preferred Providers)
*LABORATORY AND DIAGNOSTIC SERVICES <i>*Imaging services such as MRI, CAT scan, CT, CTA, MRA and PET scans, nuclear cardiac studies and virtual colonoscopy require Prior Authorization from HPI or its designee; please see Certificate of Coverage for details. Refer to back of ID card for telephone number to call for Prior Authorization of these services. Without proper Prior Authorizations, imaging services are not covered and Member is responsible for total cost.</i>		
Laboratory and Pathology Tests including those related to pregnancy	Member pays \$0 Copay (Deductible does not apply to outpatient preferred provider laboratory services)	
Diagnostic Radiological Services such as EKG, EEG, Diagnostic X-rays, and other medically acceptable diagnostic procedures including such services due to a pregnancy; and any professional services when required to read/administer specific tests <i>*Imaging services, including but not limited to: MRI, CAT, CT, CTA, MRA, PET scan; nuclear cardiac studies ;and studies such as virtual colonoscopy</i>	Member pays \$0 after Deductible is met	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
*MATERNITY SERVICES PROVIDED BY A PHYSICIAN or CERTIFIED MIDWIFE <i>Certified Midwife covered if he/she provides services under the supervision of a Physician. No coverage for home births.</i>		
Pre-natal and Post-natal Office Visits	Member pays \$0 after Deductible is met	
*Delivery and Nursery Care by a Physician	Member pays \$0 after Deductible is met	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
HOSPITAL AND AMBULATORY SURGICAL FACILITY CARE <i> All elective hospitalizations require Prior Authorization from HPI or its designee. Emergency hospitalizations require authorization within 24 hours of admission. Telephone numbers for authorizations can be found on the back of the ID card. A Copayment penalty of \$500 will be applied when proper authorizations are not obtained for inpatient services even if services are Medically Necessary. Selected outpatient procedures and surgeries also require Prior Authorization; a Copayment penalty of up to \$500 will be applied to these services when proper authorizations are not obtained. See section VII of Certificate of Coverage for details on Prior Authorization requirements and section 8.6 for Hospital coverage details.</i>		
*Inpatient Care (unlimited days) including newborn nursery care, Semi Private Room rate and related facility charges.		
Hospital Observation		
*Ambulatory Surgical Facility	Member pays \$0 after Deductible is met	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
*Outpatient Procedures and Surgery (See section VII of Certificate of Coverage or website or call Customer Service for list of outpatient procedures that require Prior Authorization)		
*ALTERNATIVES TO HOSPITAL CARE <i>Prior Authorization and Limitations apply; see Section VII of Certificate of Coverage section for more details on Prior Authorization. See Section 8.7 for coverage details.</i>		
*Skilled Nursing Facility (Limited to 120 days per benefit year. Prior Authorization required)		
*Hospice Care--Inpatient care requires Prior Authorization. Residential or home Care up to 180 days; no Prior Authorization required	Member pays \$0 after Deductible is met	Member pays \$0 after In-Network Deductible is met when arranged through a HealthPlus approved provider.
*Home Health Care-- No Prior Authorization required for first 30 visits. Prior Authorization required for additional Visits		

Item	Member Responsibility In-Network (Preferred Providers)	Member Responsibility Out-of-Network (Non-Preferred Providers)
*ORGAN AND TISSUE TRANSPLANT <i>*Prior Authorization required for evaluation for transplant, transplant and any donor services. See section 8.8 of Certificate of Coverage for coverage details.</i>		
*Organ, Skin and Cornea Transplant <i>(In approved Organ Transplant Facility Only)</i> *Specific Organ or Tissue Donor Services	Member pays \$0 after Deductible is met	Member pays \$0 after In-Network Deductible is met when arranged through a HealthPlus approved provider.
*MENTAL HEALTH SERVICES <i>All services except Outpatient Mental Health and Outpatient Substance Abuse Services require Prior Authorization. See sections 8.9 and 8.10 of the Certificate of Coverage for coverage details.</i>		
*Inpatient Mental Health Services <i>(Limited to Medically Necessary treatment)</i>	Member pays \$0 after Deductible is met	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
*Mental Health Services; Intensive Outpatient/ Intermediate Care, including Day Treatment/Partial Hospitalization Programs <i>(Limited to Medically Necessary treatment)</i>		
Outpatient Mental Health Services <i>(Limited to Medically Necessary treatment)</i>		
*Inpatient Substance Abuse Services <i>(Limited to Medically Necessary treatment)</i>	Member pays \$0 after Deductible is met	
*Substance Abuse Services; Intensive Outpatient/Intermediate Care, including Day Treatment /Partial Hospitalization Programs <i>(Limited to Medically Necessary treatment)</i>		
Outpatient Substance Abuse Services <i>(Limited to Medically Necessary treatment)</i>		
OTHER SERVICES <i>Some services in this section require Prior Authorization; others have specific limits and exclusions; see Sections 8.11 through 8.17 of the Certificate of Coverage for coverage details.</i>		
Short Term Outpatient Physical, Speech and Occupational Therapy <i>(Physical, Speech and Occupational Therapy limited to 120 combined visits per benefit year)</i>	Member pays \$0 after Deductible is met	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
Outpatient Cardiac Rehabilitation <i>(Limited to Stage 2: Outpatient hospital or physician directed clinic; 3 sessions per week for 6 weeks, (18 sessions). No coverage for Stage 3 or Stage 4 rehabilitation programs)</i>		
*Outpatient Pulmonary Rehabilitation Services; Prior Authorization required <i>(Maximum benefit of 12 weeks per lifetime of Member)</i>		

Item	Member Responsibility In-Network (Preferred Providers)	Member Responsibility Out-of-Network (Non-Preferred Providers)
OTHER SERVICES (Continued)		
<p>*Durable Medical Equipment <i>(Includes urological and ostomy supplies and diabetic management supplies if the Member does not have Prescription Drug Coverage).</i></p> <p><i>Prior Authorization required for items \$3000 and over and specific items under \$3000--- see Prior Authorization list in section 6 of Certificate of Coverage or HealthPlus website at www.healthplus.org.</i></p>	Member pays \$0 after Deductible is met	Member pays \$0 after In-Network Deductible is met when arranged through a HealthPlus approved provider.
<p>*Prosthetic Devices and Orthotic Appliances</p> <p><i>Prior Authorization required</i></p>	Member pays \$0 after Deductible is met	Not Covered <i>(except for Medically Necessary breast prosthesis following mastectomy; Deductible applies; Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges)</i>
<p>Family Planning Services:</p> <ul style="list-style-type: none"> • Voluntary adult sterilization (reversal of voluntary sterilization is not a covered service) • Insertion and removal of contraceptive devices • Contraceptive injections • Termination of pregnancy in accordance with locally accepted medical practices 	Member pays \$0 after Deductible is met	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
<p>*Medically-indicated genetic testing and counseling per generally accepted medical practice</p>		
<p>*Infertility Services: diagnosis, counseling and treatment of infertility when Medically Necessary; Prior Authorization required</p> <p><i>(Limited to 4 artificial insemination attempts per lifetime. See Section 9.3 (Z) of the Certificate of Coverage for services that are excluded from coverage)</i></p>	50% Coinsurance after Deductible	Not Covered
<p>Therapeutic Services and/or Procedures including Radiation Therapy, Inhalation Therapy, Chemotherapy and Dialysis</p>	Member pays \$0 after Deductible is met	
<p>Outpatient Diabetes Self-Management Training Program (conducted in group setting whenever available)</p>		Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
<p>Allergy Injections</p>	Member pays \$0 after Deductible met	
<p>Allergy Testing and Services <i>See sections 8.17 (A) and IX of Certificate of Coverage for exclusions</i></p>	Member pays \$0 after Deductible is met	

Item	Member Responsibility In-Network (Preferred Providers)	Member Responsibility Out-of-Network (Non-Preferred Providers)
OTHER SERVICES (Continued)		
Vision Care for: 1) Medical conditions and diagnosis related to vision loss 2) One pair of glasses post cataract surgery (Maximum benefit is \$250 per benefit year) 3) One retinal eye exam per benefit year for diabetics Routine eye exams and glasses/contact lenses are not covered	Member pays \$0 after Deductible is met Note to Members: <ul style="list-style-type: none"> • HealthPlus Insurance covers monofocal lenses as a replacement for the natural lens removed during cataract surgery. • Multifocal lenses can also be used as a replacement for the damaged natural lenses if you will pay the difference in cost and follow-up care. • Check with your provider about which lens is best for your situation and to determine the difference in cost 	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges Note to members shown in column to the left does apply to Out of network services. Member costs will be higher if using an Out of Network Provider.
Pain Management Services including coverage for evaluation and treatment of intractable pain	Member pays \$0 after Deductible is met	
*Specialty Injectable Medications (such as growth hormone, injectable drugs for rheumatoid arthritis and multiple sclerosis) that are injected or infused at Physician's office or outpatient facility.	Member pays \$0 (reminder—deductible does not apply to these services)	
Dietician Services/Nutritional Counseling; (Limited to a maximum of 6 visits per benefit year)		Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
Other Covered Services not specified on this document (See Certificate of Coverage Section 8.17 for complete list of "other services" and Prior Authorization requirements)	Member pays \$0 after Deductible is met	
Coverage when traveling outside the US—Emergency or urgent care coverage only—see Certificate of Coverage for details	<ul style="list-style-type: none"> • In-Network Deductible and Coinsurance will apply to any covered services • Member must request reimbursement after payment for covered services. 	
SERVICES COVERED BY OPTIONAL RIDER		
<i>You have coverage for these services if the applicable Rider is included with your Schedule of Benefits and Certificate of Coverage</i>		
Chiropractic Manipulative Treatment	See Rider for coverage details	See Rider for coverage details
Hearing Testing and Hearing Aid		
Home Health Private Duty Nursing		
Prescription Drugs		