



*The Plus makes all the difference.*

### Schedule of Benefits

Custom PPO Plan for Schools (Plan Code 5P)

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

• Chiropractic:	YES	Rider Name: CH0038XT
• Hearing Aid:	YES	Rider Name: HEAR50
• Home Health Private Duty Nurse:	YES	Rider Name: PRVDTY50
• Prescription Drugs:	YES	Rider Name: 6Q10

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

- **Yes:** See **FAMILY CONTINUATION RIDER FM** 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 and Out-of-Pocket Maximums*, are shown on the attached **DEDUCTIBLE RIDER**; *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.*)

For Covered Services 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. Deductibles, Out-of-Pocket Maximums and service limits are based on the **benefit year** shown on the welcome letter at the front of the Benefit Guide. The chart on the following pages indicates which services are subject to the Out-of-Network 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 for imaging services, you will 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)
<b>Deductible</b> Deductible applies to Out-of-Pocket Maximum	See Deductible/Out-of-Pocket Maximum Rider	See Deductible/Out-of-Pocket Maximum Rider
<b>Coinsurance</b>	Member pays: 0% Plan pays: 100% of HPI reimbursement rate	Member pays: 20% of Allowed Amount plus any Excess Charges billed by provider Plan pays: 80% of Allowed Amount
<b>Out-of-Pocket Maximum</b> The following do not apply to Deductible or the Out-of-Pocket Maximum: flat dollar Copayments, % Coinsurance for specialty injectables, Penalty payments, payments for Excess Charges, payments for Non-Covered Services, payments for Covered Services without proper Prior Authorizations, and flat dollar or percent Copayments for any optional services covered by Rider only.	See Deductible/Out-of-Pocket Maximum Rider  After the Member or Family Out-of-Pocket Maximum is reached, HPI will pay 100% of HPI reimbursement rate for Covered In-Network services and 100% of Allowed Amount for Out of Network 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.	See Deductible/Out-of-Pocket Maximum Rider;
<b>Lifetime Maximum Benefits</b>	Each Transplant Type has a \$1,000,000 per Member limit.	
<b>IMMUNIZATIONS and PREVENTIVE SERVICES</b> <i>Deductible does not apply to In-Network services listed unless noted below</i>		
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 and age range in Member Handbook)	Immunizations Covered at 100% Office Visit Copay may apply	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
Adult Immunizations: • Influenza vaccine (annually) • Pneumonia vaccine (at age 65 or if Medically Necessary) • Tetanus/Diphtheria	Immunizations Covered at 100% Office Visit Copay may apply	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
Other Immunizations (if not specifically excluded from coverage)	Covered at 100% after Deductible is met	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
Adult Routine Health Maintenance Exam <i>one per benefit year</i>	Covered at 100%; office visit copay waived	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
Adult Well-Woman Gynecological Exam <i>one per benefit year</i>	Covered at 100%; office visit copay waived	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
Well-Baby and Well Child Care Visits: <i>6 Visits per benefit year through age 23 months.</i> <i>2 Visits per benefit year ages 24 through 47 months</i> <i>1 Visit per benefit year ages 4 –17 years</i>	Covered at 100%; office visit copays waived	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
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>	Labs Covered at 100% Office Visit Copay may apply if additional services provided	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
Chlamydia Screening — <i>available for women age 16-25; one per benefit year</i>	Labs Covered at 100% Office Visit Copay may apply	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
Cervical Cancer screening Pap Smear — <i>1 per benefit year for women age 18 or older</i>	Labs and Pathology Services Covered at 100%. Office Visit Copay may apply	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
Breast Cancer Screening Mammogram — <i>baseline for women ages 35 - 40; one per benefit year for women age 40 or older</i>	Mammogram Covered at 100% Office Visit Copay may apply	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges

Item	Member Responsibility In-Network (Preferred Providers)	Member Responsibility Out-of-Network (Non-Preferred Providers)
<b>IMMUNIZATIONS and PREVENTIVE SERVICES CONT.</b>		
Colorectal Cancer screening beginning at 50: <ul style="list-style-type: none"> <li>• Fecal occult blood Test (<i>one per benefit year</i>)</li> <li>• Sigmoidoscopy (<i>one per benefit year</i>) OR</li> <li>• Double contrast barium enema (<i>one every 5 years</i>) OR</li> <li>• Colonoscopy (<i>one every 10 years</i>)</li> </ul>	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
Cholesterol Screening beginning at age 20; <i>one every 5 years</i>	Labs Covered at 100% Office Visit Copay may apply	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
Diabetes Screening beginning at age 45; <i>one every 3 years</i>	Labs Covered at 100% Office Visit Copay may apply	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
Prostate Cancer Screening; Routine PSA test beginning at age 45; <i>one per benefit year for men</i>	Labs Covered at 100% Office Visit Copay may apply	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
<b>PHYSICIAN and PROFESSIONAL SERVICES</b> <i>Deductible does not apply to office or home visits by physician</i>		
Office and Home Visits for illness or injury or by Primary Care Physicians (General or Family Practitioner, Internist, Pediatrician, or Osteopath)	\$5 Copay per Visit	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
Specialist Office or Home Visit for illness or injury (all other physician specialties)	\$5 Copay per Visit	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
Inpatient or Outpatient Visits and/or Consultations	Member pays \$0 after Deductible is met	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
Surgical Services and Anesthesiology Services provided by a Physician or Specialist Physician	Member pays \$0 after Deductible is met	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
All other Physician services provided for diagnosis or treatment of illness or injury including those associated with Emergency Health Services.	Member pays \$0 after Deductible is met	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
All other professional Practitioner services including those associated with Emergency Health Services	Member pays \$0 after Deductible is met	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
<b>EMERGENCY HEALTH SERVICES</b> <i>Deductible does not apply to hospital emergency room or urgent care visits.</i>		
Emergency Department Visits <i>Hospital ER Copay waived if Member is admitted to the hospital</i>	\$15 Copay per Visit	Member pays In-Network Copay plus any Excess Charges
Emergency Department Physician/Other Practitioner Services in Hospital Emergency Department, including follow-up care after emergency has ended	Member pays \$0	Member pays \$0
Freestanding Emergency Center or Urgent Care Center Visits	\$5 Copay per Visit	Member pays In-Network Copay plus any Excess Charges
Ambulance Services—Medically Necessary services	Member pays \$0	Member pays \$0

Item	Member Responsibility In-Network (Preferred Providers)	Member Responsibility Out-of-Network (Non-Preferred Providers)
<b>LABORATORY AND DIAGNOSTIC SERVICES</b> <i>*Imaging services such as MRI, CAT scan, and PET scans 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. <b>Without proper Prior Authorizations, imaging services are not covered and Member is responsible for total cost.</b></i>		
Laboratory and Pathology Tests including those related to pregnancy	Quest Labs: \$0 Copay , no Deductible All other Preferred Providers: Member pays \$0 after Deductible is met	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
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	Member pays \$0 after Deductible is met	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
*Imaging services, including but not limited to: MRI, CAT scan, CT, CTA, MRA, PET scan and nuclear cardiac studies and virtual studies such as virtual colonoscopy	Member pays \$0 after Deductible is met	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
<b>MATERNITY SERVICES PROVIDED BY A PHYSICIAN or CERTIFIED MIDWIFE</b> <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	Physician Visits Covered at 100%. Office Visit Copay may apply for first Visit	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
*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
<b>*HOSPITAL CARE/AMBULATORY SURGICAL FACILITY</b> <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. <b>A Copayment penalty of \$500</b> 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 <b>Copayment penalty of up to \$500</b> 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.	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 ( <i>See section VII of Certificate of Coverage or website or call Customer Service for list of outpatient procedures that require Prior Authorization</i> )	Member pays \$0 after Deductible is met	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
*Ambulatory Surgical Facility	Member pays \$0 after Deductible is met	HPI covers 100% of Allowed Amount. Member responsible for any Excess Charges
*Surgical services, including supplies, anesthesia and professional services	Member pays \$0 after Deductible is met	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
<b>*ALTERNATIVES TO HOSPITAL CARE</b> <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 ( <i>Limited to 120 days per benefit year. Prior Authorization required</i> )	Member pays \$0 after Deductible is met	HPI covers 100% of Allowed Amount. Member responsible for any Excess Charges
*Hospice Care-- <i>Inpatient care requires Prior Authorization. Residential or home Care up to 180 days; no Prior Authorization required</i> Includes Bereavement Counseling for family members of deceased who was in hospice – counseling can be for family unit –up to 18 sessions per benefit year.	Member pays \$0 after Deductible is met	HPI covers 100% of Allowed Amount. Member responsible for any Excess Charges

Item	Member Responsibility In-Network (Preferred Providers)	Member Responsibility Out-of-Network (Non-Preferred Providers)
<b>*ALTERNATIVES TO HOSPITAL CARE CONT.</b>		
*Home Health Care-- <i>No Prior Authorization required for first 30 visits. Prior Authorization required for additional Visits</i>	Member pays \$0 after Deductible is met	HPI covers 100% of Allowed Amount. Member responsible for any Excess Charges
<b>*ORGAN AND TISSUE TRANSPLANT</b> <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> )	Member pays \$0 after Deductible is met <b>Maximum benefit; Up to \$1 million maximum per transplant type per lifetime of Member</b>	<b>Not Covered</b>
*Organ or Tissue Donor Services	Member pays \$0 after Deductible is met	<b>Not Covered</b>
*Reasonable and necessary costs of Transportation, meals, lodging for person(s) eligible to accompany the transplant patient up to maximum of \$10,000. These costs are included in the lifetime \$1 million maximum per transplant type per member		
<b>*MENTAL HEALTH SERVICES</b> <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> )	Member pays \$0 after Deductible is met	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
*Outpatient Mental Health Services ( <i>Prior authorization required after 50 Visits</i> )	Primary Care Physician Office Visit copay applies	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
*Inpatient Substance Abuse 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
*Substance Abuse Services; Intensive Outpatient/Intermediate Care, including Day Treatment /Partial Hospitalization Programs ( <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
* Outpatient Substance Abuse Services ( <i>Prior authorization required after 50 Visits</i> )	Primary Care Physician Office Visit copay applies	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
<b>OTHER SERVICES</b> <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, Occupational Therapy and Vision Therapy (by qualified orthoptist) <i>Physical, Speech, Occupational and Vision 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  Except at Freestanding Physical Therapy facility; HPI covers 100% of Allowed Amount; member responsible for 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>	Member pays \$0 after Deductible is met	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
*Outpatient Pulmonary Rehabilitation Services; Prior Authorization required <i>Maximum benefit of 12 weeks per lifetime of Member</i>	Member pays \$0 after Deductible is met	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
*Durable Medical Equipment (includes urological and ostomy supplies and diabetic management supplies if the Member does not have Prescription Drug Coverage). <i>Prior Auth required for items \$3000 and over and some specific items—see website for list</i>	Member pays \$0 after Deductible is met	HPI covers 100% of Allowed Amount. Member responsible for any Excess Charges

Item	Member Responsibility In-Network (Preferred Providers)	Member Responsibility Out-of-Network (Non-Preferred Providers)
<b>OTHER SERVICES CONT.</b>		
*Prosthetic Devices and Orthotic Appliances  <i>Prior Authorization required</i>	Member pays \$0 after Deductible is met	HPI covers 100% of Allowed Amount. Member responsible for any Excess Charges
Family Planning Services: <ul style="list-style-type: none"> <li>• Voluntary adult sterilization (reversal of voluntary sterilization is not a covered service)</li> <li>• Insertion and removal of contraceptive devices</li> <li>• Contraceptive injections</li> <li>• Termination of pregnancy in accordance with locally accepted medical practices</li> </ul>	Member pays \$0 after Deductible is met	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
*Medically-indicated genetic testing and counseling per generally accepted medical practice	Member pays \$0 after Deductible is met	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
*Infertility Services: diagnosis, counseling and treatment of infertility when Medically Necessary; Prior Authorization required <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>	Member pays \$0 after Deductible is met	Not Covered
Therapeutic Services and/or Procedures including Radiation Therapy, Inhalation Therapy and Chemotherapy and Dialysis services	Member pays \$0 after Deductible is met	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
Outpatient Diabetes Self-Management Training Program (conducted in group setting whenever available)	Member pays \$0 after Deductible is met	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
Allergy Injections	Covered at 100% --Deductible does not apply Office Visit Copay may apply	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
Allergy Testing and Services <i>See sections 8.17 (A) and IX of Certificate of Coverage for exclusions</i>	Member pays \$0 after Deductible is met	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
Vision Care for: 1) Medical conditions and diagnosis related to vision loss  2) One pair of glasses post cataract surgery  3) One retinal eye exam per benefit year for diabetics  <b><i>Routine eye exams and glasses/contact lenses are not covered</i></b>	1) Member pays \$0 after Deductible is met  2) Member pays \$0 after Deductible is met. Maximum benefit is \$250 per benefit year  3) Member pays \$0 after Deductible is met	1) Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges  2) Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges. Maximum benefit is \$250 per benefit year  3) Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
Pain Management Services including coverage for evaluation and treatment of intractable pain	Member pays \$0 after Deductible is met	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
*Specialty Injectable Medications ( <i>such as growth hormone, injectable drugs for rheumatoid arthritis and multiple sclerosis</i> ) that are injected or infused at Physician's office or outpatient facility.	Injectables Covered at 100%--Deductible does not apply Office Visit Copay may apply	Member pays 20% of Allowed Amount plus any Excess Charges Deductible does not apply. Member coinsurance payment does not apply to out of pocket max.

Item	Member Responsibility In-Network (Preferred Providers)	Member Responsibility Out-of-Network (Non-Preferred Providers)
<b>OTHER SERVICES CONT.</b>		
Dietician Services/Nutritional Counseling; <i>Limited to a maximum of 2 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
Medical Weight Loss Services (by qualified physician for treatment of morbid obesity) <i>Limited to \$625 per 36 month period</i>	Member pays \$0 after Deductible is met	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
Bariatric Surgery for treatment of morbid obesity with co-morbidities Requires prior authorization and must meet criteria	Member pays \$0 after Deductible is met	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
Other Covered Services not specified on this document <i>(See Certificate of Coverage Section 8.17 for complete list of "other services" and Prior Authorization requirements)</i>	Member pays \$0 after Deductible is met	Member pays 20% of Allowed Amount after Deductible is met plus any Excess Charges
<b>SERVICES COVERED BY OPTIONAL RIDER</b> <i>You have coverage for these services if the applicable Rider is included with your Schedule of Benefits and Certificate of Coverage</i>		
Chiropractic Services	See Rider for coverage details	See Rider for coverage details
Hearing Testing and Hearing Aid	See Rider for coverage details	See Rider for coverage details
Home Health Private Duty Nursing	See Rider for coverage details	See Rider for coverage details
Prescription Drugs –See list of RX Riders	See Rider for coverage details	See Rider for coverage details

**HealthPlus Insurance Company**  
**DEDUCTIBLE RIDER D0X1A**  
*(Attach this Rider to your Certificate)*



*The Plus makes all the difference.*

**THIS DEDUCTIBLE RIDER MUST BE READ TOGETHER WITH THE HEALTHPLUS INSURANCE COMPANY CERTIFICATE OF COVERAGE AND SCHEDULE OF BENEFITS**

Annual Medical Deductible shall mean the amount a Member must pay for Covered Services in a benefit year before HPI will begin paying for those Covered Services in that benefit year.

“Out-of-Pocket Maximum” shall mean the maximum amount for which a Member will be responsible on Covered Services rendered during a benefit year and the maximum amount for which all Members under one Certificate of Coverage will be responsible on Covered Services rendered during a benefit year.

The following expenses do not count toward the Annual Medical Deductible or reaching the Out-of-Pocket Maximum and Members shall continue to be responsible for the following expenses during the remainder of the benefit year after the Out-of-Pocket maximum has been reached:

- Fixed dollar Copayments
- Coinsurance payments for covered Specialty Injectable Medications provided in a Physician’s office
- Penalty payments and payments for Covered Services without proper Prior Authorization
- Expenses for Non-Covered Services
- Fixed dollar Copayments or percent Coinsurance payments for any optional services covered by Rider only including, but not limited to: Prescription Drugs, Hearing Aid services and private duty nursing services.
- Expenses for Excess Charges

<b>In- Network (Preferred Providers)</b>	<b>Deductible:</b> \$0 per Member /\$0 per family
	<b>Out-of-Pocket Maximum:</b> \$0 per Member /\$0 per family

<b>Out-of-Network (Non-Preferred Providers)</b>	<b>Deductible:</b> \$250 per Member /\$500 per family
	<b>Out-of-Pocket Maximum:</b> \$2,000 per Member /\$4,000 per family

**HealthPlus Insurance Company**  
**RIDER CH0038XT**  
**(Attach this Rider to your Certificate)**



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**THIS CHIROPRACTIC SERVICES RIDER MUST BE READ TOGETHER WITH THE HEALTHPLUS INSURANCE COMPANY CERTIFICATE OF COVERAGE AND SCHEDULE OF BENEFITS**

Section I below specifies Covered Services and applicable Copayments/Coinsurance. Section II below specifies the Limitations of and Exclusions from Covered Services.

**SECTION I  
COVERED SERVICES**

The services and benefits described in this Section I are offered in accordance with HealthPlus Insurance Company's (HPI) policies and procedures for benefit administration. Only services that are Medically Necessary according to generally accepted standards of practice as determined by HPI or its designee are Covered Services under this Rider.

Subject to the Limitations and Exclusions of Section II, Covered Services include:

**1.1 CHIROPRACTIC SERVICES**

Coverage for office Visits, manipulative treatment, manual and mechanical traction, application of hot or cold packs, therapeutic exercise (to develop strength, endurance, range of motion and flexibility), ~~\_\_\_\_\_~~ and selected X-rays of the spine, hip, and pelvis. Other treatments and X-rays are not covered. Coverage is limited to thirty-eight (38) Visits per benefit year.

<b>In Network Copayment/Coinsurance</b>	None.
<b>Out of Network Copayment/Coinsurance</b>	20% of Allowed Amount plus any Excess Charges billed by Provider

**SECTION II  
BENEFIT LIMITATIONS AND EXCLUSIONS**

**2.1 LIMITATIONS**

The Covered Services set forth in Section I of this Rider shall be limited by any applicable Limitation stated in the Certificate of Coverage or Schedule of Benefits.

**2.2 EXCLUSIONS**

Services not specifically identified by this Rider are not Covered Services, including, but not limited to any applicable Exclusion stated in the Certificate of Coverage or Schedule of Benefits.

**HealthPlus Insurance Company**  
**RIDER HEAR50%**  
*(Attach this Rider to your Certificate)*



**THIS HEARING AID RIDER MUST BE READ TOGETHER WITH THE HEALTHPLUS INSURANCE COMPANY CERTIFICATE OF COVERAGE AND SCHEDULE OF BENEFITS**

Section I below specifies Covered Services and applicable Coinsurance. Section II below specifies the Limitations of and Exclusions from Covered Services.

**SECTION I  
COVERED SERVICES**

The services and benefits described in this Section I are offered in accordance with HealthPlus Insurance Company's (HPI) policies and procedures for benefit administration. Only services that are Medically Necessary according to generally accepted standards of practice as determined by HPI or its designee are Covered Services under this Rider.

Subject to the Limitations and Exclusions of Section II, Covered Services include:

**1.1 HEARING AID COVERAGE**

Coverage for hearing testing, Hearing Aids, and adjustments to Hearing Aids. No coverage for Hearing Aid batteries. Benefit limit of one thousand dollars (\$1000) per benefit year. Coinsurance paid by a Member does not apply towards the Member's Out-of-Pocket Maximum. A Member is not required to meet his/her Deductible before services are covered under this Rider.

<b>In Network Coinsurance</b>	50% Coinsurance for all Claims.
<b>Out of Network Coinsurance</b>	50% Coinsurance for all Claims plus any Excess Charges.

**SECTION II  
BENEFIT LIMITATIONS AND EXCLUSIONS**

**2.1 LIMITATIONS**

The Covered Services set forth in Section I of this Rider shall be limited by any applicable Limitation stated in the Certificate of Coverage or Schedule of Benefits.

**2.2 EXCLUSIONS**

The following are excluded from Coverage: Hearing Aids ordered prior to the Effective Date of Coverage under the Certificate of Coverage, replacement and/or repair of Hearing Aids because of loss or misuse, and Hearing Aid batteries.

Coverage for services not specifically identified by this Rider are not Covered Services, including, but not limited to any applicable Exclusion stated in the Certificate of Coverage or Schedule of Benefits.

**THIS PRIVATE DUTY HOME HEALTH NURSING RIDER MUST BE READ TOGETHER WITH THE HEALTHPLUS INSURANCE COMPANY CERTIFICATE OF COVERAGE AND SCHEDULE OF BENEFITS**

Section I below specifies Covered Services and applicable Coinsurance. Section II below specifies the Limitations of and Exclusions from Covered Services.

**SECTION I  
COVERED SERVICES**

The services and benefits described in this Section I are offered in accordance with HealthPlus Insurance Company's (HPI) policies and procedures for benefit administration. Only services that are Medically Necessary according to generally accepted standards of practice as determined by HPI or its designee are Covered Services under this Rider.

Subject to the Limitations and Exclusions of Section II, Covered Services include:

**1.1 PRIVATE DUTY HOME HEALTH NURSING COVERAGE**

Coverage for private duty home health Skilled Nursing Care only if provided by licensed In Network Providers for up to eight (8) hours per day, thirty (30) days per benefit year, and if all of the following criteria are met:

- A. Member has obtained Prior Authorization from HPI;
- B. Member is confined to home;
- C. Private duty home health Skilled Nursing Care is Medically Necessary; and
- D. Private duty home health Skilled Nursing Care is a medically safe alternative to an inpatient stay in a Skilled Nursing Facility or Hospital.

No Coverage for: Custodial-type care, such as feeding, bathing, cleaning, cooking, or other non-skilled chores; or care provided by a person who ordinarily resides in the Member's home or is a family member of the Member or his/her spouse.

Coinsurance paid by a Member does not apply towards the Member's Out-of-Pocket Maximum. A Member is not required to meet his/her Deductible before services are covered under this Rider.

<b>In Network Coinsurance</b>	50% Coinsurance for all Claims.
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**SECTION II  
BENEFIT LIMITATIONS AND EXCLUSIONS**

**2.1 LIMITATIONS**

The Covered Services set forth in Section I of this Rider shall be limited by any applicable Limitation stated in the Certificate of Coverage or Schedule of Benefits. Coverage is limited to up to eight (8) hours per day, thirty (30) days per benefit year, provided all other requirements provided in Section 1.1 are met.

**2.2 EXCLUSIONS**

The following are excluded from Coverage: custodial-type care, such as feeding, bathing, cleaning, cooking, or other non-skilled chores; or care provided by a person who ordinarily resides in the Member's home or is a family member of the Member or his/her spouse.

Coverage for services not specifically identified by this Rider are not Covered Services, including, but not limited to any applicable Exclusion stated in the Certificate of Coverage or Schedule of Benefits.

**THIS PRESCRIPTION DRUG RIDER MUST BE READ TOGETHER WITH THE HEALTHPLUS INSURANCE COMPANY CERTIFICATE OF COVERAGE AND SCHEDULE OF BENEFITS**

Section I below specifies Covered Services and applicable Copayments and Coinsurance. Section II below specifies the Limitations of and Exclusions from Covered Services.

**SECTION I  
 COVERED SERVICES**

The services and benefits described in this Section I are offered in accordance with HealthPlus Insurance Company's (HPI) policies and procedures for benefit administration. Only services that are Medically Necessary according to generally accepted standards of practice as determined by HPI or its designee are Covered Services under this Rider. Copayment, Coinsurance and Excess Charges paid by Member do not apply towards Member's Deductible or Out-of-Pocket Maximum.

Subject to the Limitations and Exclusions of Section II, Covered Services include:

**1.1 PRESCRIPTION DRUGS**

Benefits for Prescription Drugs and certain over-the-counter nonprescription drugs in the HPI formulary, when prescribed by a Physician, Dentist, or Provider, including:

<b>Preferred Pharmacy Copayment and Coinsurance</b>	Generic	\$10/Prescription
	Brand	\$10/Prescription
	Fertility Prescription Drugs	\$10/Prescription
<b>Non-Preferred Pharmacy Copayment and Coinsurance</b>	Generic	\$10/Prescription plus Excess Charges
	Brand	\$10/Prescription plus Excess Charges
	Fertility Prescription Drugs	\$10/Prescription plus Excess Charges

Coverage under this Section 1.1 will include: (A) Federal Food and Drug Administration (FDA) approved drugs used for off-label purposes and the reasonable cost of supplies medically necessary to administer the drug in accordance with Section 3406q of the Insurance Code, (B) FDA approved drugs used in antineoplastic therapy in accordance with Section 3406e of the Insurance Code, and (C) a ninety (90) day supply of select Prescription Drugs filled through the designated mail order provider or retail by a participating In-Network Pharmacy through the "Ask for 90 Program". No Coverage for ninety (90) day supply of Prescription Drugs filled through a Non-Preferred mail Pharmacy or by a Non-Preferred retail Pharmacy through the "Ask for 90 Program".

<b>"Ask for 90" Program at participating Preferred Pharmacies or through Express Scripts (mail order)</b>	Generic	\$10 Copayment per 90 day supply
	Brand	\$10 Copayment per 90 day supply
	Fertility Prescription Drugs	Not Covered

## 2.2 EXCLUSIONS

Coverage for services and products not specifically identified by this Rider are not Covered Services, including, but not limited to:

- A. Nonprescription drugs (or their Prescription Drug equivalents), dietary and other supplements, including, but not limited to food supplements and medical foods, articles, and supplies provided on an outpatient basis, and not specifically identified as Health Care Benefits by the Certificate of Coverage, Schedule of Benefits, or this Rider. HPI may elect to cover and include certain over-the-counter nonprescription drugs on the HPI formulary based on recommendations made by our Pharmacy and Therapeutics Committee.
- B. Any other applicable Exclusion stated in the Certificate of Coverage and Schedule of Benefits.

**THIS RIDER MUST BE READ TOGETHER WITH THE HEALTHPLUS INSURANCE COMPANY CERTIFICATE OF COVERAGE, THE ASSOCIATED SCHEDULE OF BENEFITS AND ANY OTHER APPLICABLE RIDERS.**

The following sections of the HealthPlus Insurance Company Certificate of Coverage are amended:

## **SECTION II – DEFINITIONS**

Section 2.43 is deleted and restated in its entirety as follows:

“Intermediate Care” means, as it applies to mental health and substance abuse services, the use of a full or partial residential therapy setting (also known as Day Treatment or partial hospitalization programs), or intensive outpatient programs and shall include generally accepted therapeutic techniques and other therapeutic and ancillary services.

Section 2.72 is deleted and restated in its entirety as follows:

“Residential Mental Health Treatment” means non-Medically Necessary, primarily custodial treatment provided in a facility that provides services twenty-four (24) hours a day.

A new Section 2.72a is added as follows:

“Residential Substance Abuse Treatment” means treatment in a medically supervised residential setting where patients spend the night and are involved in a structured treatment program at least eight (8) hours per day, five (5) days per week.

## **SECTION VII – PRIOR AUTHORIZATION FOR BENEFITS**

Section 7.4D is amended to read Mental Health and Substance Abuse Services.

Section 7.4D is amended to add the following:

2. Outpatient Mental Health Services: Prior Authorization from HPI or its designee is required to determine the need for additional Visits beyond fifty (50). Call the Behavioral Health telephone number on the back of the HPI ID card for Prior Authorization. If Prior Authorization is not obtained, any Visits beyond fifty (50) will be denied and will not be considered Covered Services.
3. Outpatient Substance Abuse Services: Prior Authorization from HPI or its designee is required to determine the need for additional Visits beyond fifty (50). Call the Behavioral Health Telephone number on the back of the HPI ID card for Prior Authorization. If Prior Authorization is not obtained, any Visits beyond fifty (50) will be denied and will not be considered Covered Services.

- B. Residential Substance Abuse Treatment.
- C. Intermediate Care, including Day Treatment Substance Abuse Programs/partial hospitalization programs and intensive outpatient programs.

Prior Authorization from HPI or its designee is required for all substance abuse admissions, including inpatient detoxification, Residential Substance Abuse Treatment and Intermediate Care.

- D. Outpatient substance abuse Visits.

Prior Authorization from HPI or its designee is required for outpatient mental health Visits beyond fifty (50).

### **SECTION IX – LIMITATIONS AND EXCLUSIONS**

Section 9.1.A. COVERAGE LIMITATIONS, Benefit maximums, is amended to delete all references to substance abuse and mental health treatment.

Section 9.3 QQQ is deleted and restated in its entirety as follows:

- Residential Mental Health Treatment

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**HealthPlus Insurance Company**  
**FAMILY CONTINUATION RIDER FM**  
**(Attach this Rider to your Certificate)**



**WHEN ATTACHED TO THE HEALTHPLUS INSURANCE COMPANY CERTIFICATE OF COVERAGE, THIS RIDER WILL DO THE FOLLOWING:**

Delete Section 3.2 B. pertaining to Dependents and replace it with the following:

- An unmarried Child of the Subscriber or the Subscriber's Spouse until the end of the year in which he/she reaches nineteen (19) years of age.
- Additional Coverage for a Dependent Child is available through the end of the year in which he/she reaches twenty-five (25) years of age. See your employer to determine if there are any additional eligibility and/or contribution requirements for this Coverage.
- Additional Coverage for an unmarried Dependent Child beyond the end of the calendar year in which he/she reaches twenty-five (25) years of age if such Dependent Child remains continuously covered under this Plan after reaching twenty-five (25) years of age, and is a full-time student. If such a student takes a leave of absence from school due to illness or injury, his/her Coverage under this Plan will continue for up to twelve (12) months from the last day of attendance in school, provided that the Dependent student's Physician certifies in writing to HPI that the leave of absence from school is Medically Necessary.

See your employer for "full-time student" criteria and any certification and/or other eligibility requirements.

HPI reserves the right to periodically require satisfactory proof of a Child's status as a Dependent of the Subscriber or the Subscriber's Spouse. HPI also reserves the right to periodically require continued medical certification from a Dependent student's Physician for Dependent students over twenty-five (25) years of age on a medical leave of absence from school, as provided above.