

Covered Service	You Pay (Network Providers Only)	Limit (If Applicisg810 1.237 l150m

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Rehabilitative Services		
Physical Therapy	$0 for first three visits then no charge after deductible	20 visits per Benefit Year
Occupational Therapy	$0 for first three visits then no charge after deductible	20 visits per Benefit Year
Speech Therapy	No charge after deductible	
Pulmonary Rehabilitation	No charge after deductible	
Cardiac Rehabilitation Services	No charge after deductible	
Manipulation Therapy	No charge after deductible	
Post-Cochlear Implant Aural Therapy	No charge after deductible	
Other Rehabilitative Services		
Includes Chemotherapy, Dialysis, and Radiation	No charge after deductible	

Covered Service	**You Pay** (Network Providers Only)	**Limit** (If Applicable)

Dependent Information

Dependent Name	[John Doe]
Relationship to You	[104000000]
Date of Birth	[01/01/1965]
Effective Date	[01/01/2024]