

You are responsible for knowing the benefits and provisions of your Policy. Please read all documents carefully.

The following apply to all treatments, services and supplies:

- You and your covered dependents named on the Physicians Plus Insurance Corporation (Physicians Plus) identification (ID) card issued with the policy are covered for treatments, services and supplies as described in the policy, subject to the terms conditions and provisions of the policy.
- The benefits in this policy are subject to the following provisions: This Schedule of Benefits indicates what you pay for covered services; please consult your Medical Certificate for benefit details; services not covered, or beyond benefit maximums, are the member's responsibility and will not apply to the Policy Deductible.

	In Network	Out of Network
Policy Deductible	None	\$500 single/\$1,000 family
Policy Coinsurance	None	20%
Policy Maximum Out of Pocket (MOOP)	None	\$1,500 single/\$3,000 family
Policy Lifetime Maximum	\$2,000,000 combined (In and Out of Network)	
Qualified Maximum Dependent Age	18/27 DOB	

OUTPATIENT SERVICES

	You Pay:	Tier 1; In Network	Tier 2; In Network	Tier 3; Out of Network
Child Office Visits (Ages 0–17)				
Office Visit & Well Child Exam (each visit)		\$25	\$50	Deductible then 20%
Immediate/Urgent Care		Tier 2 Benefit Only	\$50	Deductible then 20%
*Behavioral Health (BH) & Alcohol or Other Drug Abuse (AODA)		Tier 2 Benefit Only	\$50	Deductible then 20%
Ophthalmology Exam		Tier 2 Benefit Only	\$50	Deductible then 20%
Hearing Exam		\$25	\$50	Deductible then 20%
Optometry/Vision Exams & Chiropractic Exam (each visit)		\$25	Tier 1 Benefit Only	Deductible then 20%
Allergy Testing & Injections		Covered in Full		Deductible then 20%
Immunizations: Age 0–6		Covered in Full		Deductible then 20%
Immunizations: Age 7–17		Covered in Full		Deductible then 20%
Adult Office Visit (Age 18+)				
Office Visit/Routine Exam (each visit)		\$25	\$50	Deductible then 20%
Immediate/Urgent Care		Tier 2 Benefit Only	\$50	Deductible then 20%
Hearing Exam		\$25	\$50	Deductible then 20%
Optometry/Vision Exams & Chiropractic Exam (each visit)		\$25	Tier 1 Benefit Only	Deductible then 20%
Ophthalmology Exam		Tier 2 Benefit Only	\$50	Deductible then 20%
*Behavioral Health (BH) & Alcohol or Other Drug Abuse (AODA)		Tier 2 Benefit Only	\$50	Deductible then 20%
Allergy Testing & Injections		Covered in Full		Deductible then 20%
Pre/Post Maternity Care		Covered in Full		Deductible then 20%
Routine Mammograms		Covered in Full		Deductible then 20%
Emergency Services				
Emergency Room Services		\$100		Deductible then 20%
Air Ambulance \$25,000 per occurrence.		\$500		Deductible then 20%
Ground Ambulance		\$0		Deductible then 20%
Infertility/Conception Services				
Diagnosis & Treatment Up to \$2,000 per member per lifetime. Coinsurance does not apply to Policy MOOP.		50% then Balance of Charges		Deductible then 50% of Cov. Services and Bal. of Charges
Therapies: Physical, Occupational & Speech Up to 50 combined visits.				
0–5 visits		Covered in Full		Deductible then 20%
6 or more visits		\$25		Deductible then 20%
Cardiac Rehabilitation Phase II 18 weeks up to 36 visits.		Covered in Full		Deductible then 20%

OUTPATIENT/AMBULATORY & *INPATIENT SURGERY & SERVICES Tier 1&2 Benefit Deductible: \$500 single/\$1,000 family; Benefit MOOP: \$500 single/\$1,000 family		
You Pay:	Tier 1 & 2; In Network	Tier 3; Out of Network
Outpatient/Ambulatory Surgery	Deductible	Deductible then 20%
Semi-private Room & Board	Deductible	Deductible then 20%
*Behavioral Health (BH) & Alcohol or Other Drug Abuse (AODA)	Deductible	Deductible then 20%
Labor & Delivery	Deductible	Deductible then 20%
X-rays & Laboratory Testing	Deductible	Deductible then 20%
Medication	Deductible	Deductible then 20%
Inpatient Therapy	Deductible	Deductible then 20%
Skilled Nursing Care	Deductible	Deductible then 20%
Skilled Nursing Facility Care 100 days combined (In/Out of Network) max. benefit/confinement/member.	Deductible 100 days maximum confinement per member	Deductible then 20% 30 days max. confinement per member
Hospice Care	Deductible	Deductible then 20%
Injections	Deductible	Deductible then 20%
Colonoscopies	Deductible	Deductible then 20%

OTHER OUTPATIENT SERVICES

You Pay:	Tier 1 & 2; In Network	Tier 3; Out of Network
Radiation Therapy	Covered in Full	Deductible then 20%
X-rays & Laboratory Testing	Covered in Full	Deductible then 20%
CT/CAT Scans	\$50	Deductible then 20%
PET, MRI & MRA Scans	\$50	Deductible then 20%
Sleep Studies (Facility)	\$50	Deductible then 20%
Oral Surgery (Limited)	Covered in Full	Deductible then 20%
Office Surgery	Covered in Full	Deductible then 20%
*Hospice Care	Covered in Full	Deductible then 20%
Temporomandibular Joint Disorder <i>Diagnostic procedures and non-surgical treatment limited to \$1,250/member/contract year.</i>	See applicable type of service	See applicable type of service
*Home Health Services <i>Limited to 100 visits/member/contract yr.</i>	Covered in Full	Deductible then 20%
*Home Health Therapies <i>Limited to 40 combined (physical, occupational and speech) home visits per contract year.</i>	Covered in Full	Deductible then 20%
*Medical Supplies: Including covered Diabetic Supplies, Medical Equipment & Prosthetics <i>Purchases over \$5,000 require prior authorization. Coinsurance does not apply to Policy MOOP.</i>	20% up to \$2,000 per member per contract year. Paid in full after \$2,000.	20% after Deductible up to \$4,000 per member/contract year. Paid in full after \$4,000.
Insulin 30-day supply	\$10	
Hearing Aids (Ages 0-18) <i>(In & Out of Network benefits are combined) One standard model hearing aid per ear, replaceable every 36 months.</i>	20% and Balance of Charges beyond benefit limits.	Deductible then 20% and Balance of Charges beyond benefit limits.
Hearing Aids (Age 19+) <i>Up to \$400 (In & Out of Network combined) per hearing aid per ear, replaceable every 36 months. Copayments do not apply to Policy MOOP.</i>	Deductible and Balance of Charges beyond benefit limits.	Deductible and Balance of Charges beyond benefit limits.

*TRANSPLANTS & KIDNEY DISEASE

	In Network, You Pay	Out of Network, You Pay
Kidney Disease & Transplant <i>Up to \$30,000 per member per contract year (will not duplicate Medicare coverage).</i>	See applicable type of service	Disease: See type of service. Transplant: In Network Only.
Other COVERED Transplants <i>Up to \$500,000/member/lifetime.</i>	See applicable type of service	In Network Benefit Only

* Indicates services that require written prior authorization from Physicians Plus.