

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	\$2,500 single/\$5,000 family	\$3,500 single/\$7,000 family
Policy Coinsurance	10%	30%
Policy Maximum Out of Pocket (MOOP)	\$3,000 single/\$6,000 family	\$5,000 single/\$10,000 family
Policy Lifetime Maximum	\$2,000,000 combined (In and Out of Network)	
Qualified Maximum Dependent Age	18/27 DOB	

OUTPATIENT SERVICES

P — Indicates a preventive service covered by Physicians Plus up to a maximum of \$500 per member per contract year. After \$500 in charges, you pay the policy deductible and coinsurance up to the policy MOOP. This \$500 does not apply to the deductible or MOOP.

	In Network, You Pay	Out of Network, You Pay
Child Office Visits (Ages 0–17)		
Office Visit & Immediate/Urgent Care (each visit)	Deductible then 10%	Deductible then 30%
Well Child Exam P	Deductible then 10%	Deductible then 30%
Hearing & Vision Exam (Routine Vision Exam P)	Deductible then 10%	Deductible then 30%
Chiropractic Exam	Deductible then 10%	Deductible then 30%
*Behavioral Health (BH) & Alcohol or Other Drug Abuse (AODA)	Deductible then 10%	Deductible then 30%
Allergy Testing & Injections	Deductible then 10%	Deductible then 30%
Immunizations: Age 0–6	\$0	Deductible then 30%
Immunizations: Age 7–17 P	Deductible then 10%	Deductible then 30%
Adult Office Visit (Age 18+)		
Office Visit/(Routine Exam) (each visit) (Routine Vision Exam P)	Deductible then 10%	Deductible then 30%
Immediate/Urgent Care	Deductible then 10%	Deductible then 30%
Hearing Exam & Vision Exam (each visit)	Deductible then 10%	Deductible then 30%
Chiropractic Exam	Deductible then 10%	Deductible then 30%
*Behavioral Health (BH) & Alcohol or Other Drug Abuse (AODA)	Deductible then 10%	Deductible then 30%
Allergy Testing & Injections	Deductible then 10%	Deductible then 30%
Pre/Post-natal Maternity Care	Deductible then 10%	Deductible then 30%
Routine Mammograms P	Deductible then 10%	Deductible then 30%
Emergency Services		
Emergency Room Services (copay waived if admitted)	Deductible then 10%	Deductible then 30%
Air Ambulance \$25,000 per occurrence.	Deductible then 10%	Deductible then 30%
Ground Ambulance	Deductible then 10%	Deductible then 30%
Infertility/Conception Services		
Diagnosis & Treatment Up to \$2,000 (In & Out of Network combined) per member per lifetime. Coinsurance does not apply to Policy MOOP.	50% of Covered Services then Balance of Charges	Deductible then 50% of Cov. Services & Balance of Charges
Therapies: Physical, Occupational & Speech Up to 50 combined visits.		
0–5 visits	Deductible then 10%	Deductible then 30%
6 or more visits	Deductible then 10%	Deductible then 30%
Cardiac Rehabilitation Phase II 18 weeks up to 36 visits.	Deductible then 10%	Deductible then 30%

OUTPATIENT/AMBULATORY & *INPATIENT SURGERY & SERVICES		
	In Network, You Pay	Out of Network, You Pay
Outpatient/Ambulatory Surgery	Deductible then 10%	Deductible then 30%
Semi-private Room & Board	Deductible then 10%	Deductible then 30%
*Behavioral Health (BH) & Alcohol or Other Drug Abuse (AODA)	Deductible then 10%	Deductible then 30%
Labor & Delivery	Deductible then 10%	Deductible then 30%
X-rays & Laboratory Testing	Deductible then 10%	Deductible then 30%
Medication	Deductible then 10%	Deductible then 30%
Inpatient Therapy	Deductible then 10%	Deductible then 30%
Skilled Nursing Care	Deductible then 10%	Deductible then 30%
Skilled Nursing Facility Care <i>100 days combined (In and Out of Network) per confinement per member.</i>	Deductible then 10% <i>100 days per confinement per member</i>	Deductible then 30% <i>30 days per confinement per member</i>
Hospice Care	Deductible then 10%	Deductible then 30%
Injections	Deductible then 10%	Deductible then 30%
Colonoscopies	Deductible then 10%	Deductible then 30%

OTHER OUTPATIENT SERVICES		
	In Network, You Pay	Out of Network, You Pay
Radiation Therapy	Deductible then 10%	Deductible then 30%
X-rays & Laboratory Testing	Deductible then 10%	Deductible then 30%
CT/CAT Scans	Deductible then 10%	Deductible then 30%
MRI, MRA & PET Scans	Deductible then 10%	Deductible then 30%
Sleep Studies (Facility)	Deductible then 10%	Deductible then 30%
Oral Surgery (Limited)	Deductible then 10%	Deductible then 30%
Office Surgery	Deductible then 10%	Deductible then 30%
*Hospice Care	Deductible then 10%	Deductible then 30%
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 per member per contract year.</i>	Deductible then 10%	Deductible then 30%
*Home Health Therapies <i>Limited to 40 combined (physical, occupational and speech) home visits per contract year.</i>	Deductible then 10%	Deductible then 30%
*Medical Supplies: Including covered Diabetic Supplies, Medical Equipment & Prosthetics <i>Purchases over \$5,000 require prior authorization.</i>	20% up to \$2,000 per member per contract year; paid in full after \$2,000	Deductible then 30% up to \$4,000 per member/contract year; paid in full after \$4,000
Insulin <i>30-day supply</i>	\$10	\$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>	Deductible then 10% and Balance of Charges beyond benefit limits.	Deductible then 30% 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.</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 per member per lifetime.</i>	See applicable type of service	In Network Benefits Only

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