

**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 is 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.

	Single Policy	Family Policy
Policy Deductible	None	None
Policy Coinsurance	None	None
Policy Maximum Out of Pocket (MOOP)	None	None
Policy Lifetime Maximum	\$2,000,000	
Qualified Maximum Dependent Age	18/27 DOB	

**Two-Tier Plans** Tier 1 services generally have the lowest copays and include all general practitioners, internists, family medicine doctors, pediatricians, geriatricians, obstetricians, gynecologists, optometrists and chiropractors. Tier 2 services generally include specialists and services such as immediate care.

OUTPATIENT SERVICES		
	Tier 1; You Pay	Tier 2; You Pay
<b>Child Office Visits (Ages 0–17)</b>		
Office Visit & Well Child Exam (each visit)	\$35	\$70
Immediate/Urgent Care	Tier 2 Benefit Only	\$70
Hearing Exam	\$35	\$70
Optometry/Vision Exam & Chiropractic Exam (each visit)	\$35	Tier 1 Benefit Only
Ophthalmology Exam	Tier 2 Benefit Only	\$70
*Behavioral Health (BH) & Alcohol or Other Drug Abuse (AODA)	Tier 2 Benefit Only	\$70
Allergy Testing & Injections	Covered in Full	
Immunizations: Age 0–17	Covered in Full	
<b>Adult Office Visit (Age 18+)</b>		
Office Visit/Routine Exam & Hearing Exam (each visit)	\$35	\$70
Optometry/Vision Exam & Chiropractic Exam (each visit)	\$35	Tier 1 Benefit Only
Immediate/Urgent Care & Ophthalmology Exam (each visit)	Tier 2 Benefit Only	\$70
*Behavioral Health (BH) & Alcohol or Other Drug Abuse (AODA)	Tier 2 Benefit Only	\$70
Pre/Post-natal Maternity Care	Covered in Full	
Routine Mammograms	Covered in Full	
Allergy Testing & Injections	Covered in Full	
<b>Emergency Services</b>		
Emergency Room Services (copay waived if admitted)	\$100	
Air Ambulance \$25,000 per occurrence.	\$500	
Ground Ambulance	\$0	
<b>Infertility/Conception Services</b>		
Diagnosis & Treatment Up to \$2,000 per member per lifetime. Coinsurance does not apply to Policy MOOP.	50% of Covered Services	
<b>Therapies: Physical, Occupational &amp; Speech Up to 50 combined visits.</b>		
0–5 visits	Covered in Full	
6 or more visits	\$35	
Cardiac Rehabilitation Phase II 18 weeks up to 36 visits.	Covered in Full	

OUTPATIENT/AMBULATORY & *INPATIENT SURGERY & SERVICES <i>Benefit Deductible: \$500 single/\$1,000 family</i>	
	Tier 1 & 2; You Pay
Outpatient/Ambulatory Surgery	Deductible
Semi-private Room & Board	Deductible
Labor & Delivery	Deductible
*Behavioral Health (BH) & Alcohol or Other Drug Abuse (AODA)	Deductible
X-rays & Laboratory Testing	Deductible
Medication	Deductible
Inpatient Therapy	Deductible
Skilled Nursing Care	Deductible
Skilled Nursing Facility Care <i>100 days per confinement per member.</i>	Deductible
Hospice Care	Deductible
Injections	Deductible
Colonoscopies	Deductible

OTHER OUTPATIENT SERVICES	
	Tier 1 & 2; You Pay
Radiation Therapy	Covered in Full
X-rays & Laboratory Testing	Covered in Full
CT/CAT Scans	\$50
MRI, MRA & PET Scans	\$50
Sleep Studies (Facility)	\$50
Oral Surgery (Limited)	Covered in Full
Office Surgery	Covered in Full
*Hospice Care	Covered in Full
Temporomandibular Joint Disorder <i>Diagnostic procedures and non-surgical treatment limited to \$1,250/member/contract year.</i>	See the applicable type of service (i.e. Office Vist, Surgery etc)
*Home Health Services <i>Limited to 100 visits per member per contract year.</i>	Covered in Full
*Home Health Therapies <i>Limited to 40 combined (physical, occupational and speech) home visits per contract year.</i>	Covered in Full
*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
Insulin <i>30-day supply</i>	\$10
Hearing Aids (Ages 0–18) <i>One standard model aid per ear replaceable every 36 months. Coinsurance does not apply to Policy MOOP.</i>	20% and Balance of Charges
Hearing Aids (Age 19+) <i>Up to \$400 per hearing aid, per ear, replaceable every 36 months. For hearing aids in both ears, up to \$800 replaceable every 36 months.</i>	Balance of Charges

*TRANSPLANTS & KIDNEY DISEASE	
	Tier 1 & 2; 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
Other COVERED Transplants <i>Up to \$500,000 per member per lifetime.</i>	See applicable type of service

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