

**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   | \$2,500 single/\$5,000 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                                   |
|---|----------|-----------------------------|---------------------|--|
| <b>Child Office Visits (Ages 0–17)</b>  |          |                             |                     |  |
| Office Visit & Well Child Exam (each visit)   |          | \$20                        | \$40                | Deductible then 20%                                      |
| Immediate/Urgent Care   |          | Tier 2 Benefit Only         | \$40                | 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%                                      |
| *Behavioral Health (BH) & Alcohol or Other Drug Abuse (AODA)  |          | Tier 2 Benefit Only         | \$40                | Deductible then 20%                                      |
| Ophthalmology Exam  |          | Tier 2 Benefit Only         | \$40                | Deductible then 20%                                      |
| Hearing Exam  |          | \$20                        | \$40                | Deductible then 20%                                      |
| Optometry/Vision Exams & Chiropractic Exam (each visit)   |          | \$20                        | Tier 1 Benefit Only | Deductible then 20%                                      |
| <b>Adult Office Visit (Age 18+)</b>   |          |                             |                     |  |
| Office Visit/Routine Exam (each visit)  |          | \$20                        | \$40                | Deductible then 20%                                      |
| Immediate/Urgent Care   |          | Tier 2 Benefit Only         | \$40                | Deductible then 20%                                      |
| Hearing Exam  |          | \$20                        | \$40                | Deductible then 20%                                      |
| Chiropractic & Optometry/Vision Exam (each visit)   |          | \$20                        | Tier 1 Benefit Only | Deductible then 20%                                      |
| Ophthalmology Exam  |          | Tier 2 Benefit Only         | \$40                | Deductible then 20%                                      |
| *Behavioral Health (BH) & Alcohol or Other Drug Abuse (AODA)  |          | Tier 2 Benefit Only         | \$40                | 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%                                      |
| <b>Emergency Services</b>   |          |                             |                     |  |
| Emergency Room Services   |          | \$100                       |                     | Deductible then 20%                                      |
| Air Ambulance \$25,000 per occurrence.  |          | \$500                       |                     | Deductible then 20%                                      |
| Ground Ambulance  |          | \$0                         |                     | Deductible then 20%                                      |
| <b>Infertility/Conception Services</b>  |          |                             |                     |  |
| 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 |
| <b>Therapies: Physical, Occupational &amp; Speech Up to 50 combined visits.</b>                         |          |                             |                     |  |
| 0–5 visits  |          | Covered in Full             |                     | Deductible then 20%                                      |
| 6 or more visits  |          | \$20                        |                     | Deductible then 20%                                      |
| Cardiac Rehabilitation Phase II 18 weeks up to 36 visits.   |          | Covered in Full             |                     | Deductible then 20%                                      |

**OUTPATIENT/AMBULATORY & \*INPATIENT SURGERY & SERVICES**

| You Pay:  | Tier 1 & 2; In Network   | Tier 3; Out of Network   |
|---|--|--|
| Outpatient/Ambulatory Surgery   | Covered in Full  | Deductible then 20%  |
| Semi-private Room & Board   | Covered in Full  | Deductible then 20%  |
| *Behavioral Health (BH) & Alcohol or Other Drug Abuse (AODA)  | Covered in Full  | Deductible then 20%  |
| Labor & Delivery  | Covered in Full  | Deductible then 20%  |
| X-rays & Laboratory Testing   | Covered in Full  | Deductible then 20%  |
| Medication  | Covered in Full  | Deductible then 20%  |
| Inpatient Therapy   | Covered in Full  | Deductible then 20%  |
| Skilled Nursing Care  | Covered in Full  | Deductible then 20%  |
| Skilled Nursing Facility Care <i>100 days combined (In/Out of Network) max. benefit/confinement/member.</i> | Covered in Full <i>100 days maximum confinement per member</i> | Deductible then 20% <i>30 days max. confinement per member</i> |
| Hospice Care  | Covered in Full  | Deductible then 20%  |
| Injections  | Covered in Full  | Deductible then 20%  |
| Colonoscopies   | Covered in Full  | 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 <i>30-day supply</i>  | \$10  |  |
| Hearing Aids (Ages 0–18) <i>(In &amp; 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 &amp; Out of Network combined) per hearing aid per ear, replaceable every 36 months.</i>  | 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.