

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.
- The Deductible listed must be met before any medical or prescription drug services (except preventive, if applicable) will be paid by this policy. Only covered medical and prescription drug treatments, services and/or supplies apply to any applicable Policy Deductible and MOOP limit.
- Physicians Plus does not guarantee your eligibility for a Health Savings Account. Please consult an independent tax advisor for specific eligibility information.

| | In Network | Out of Network |
|--|--|----------------|
| Policy Deductible [Medical & Prescription Drug (RX)] | \$1,250 | \$5,000 |
| Policy Coinsurance | 20% | 40% |
| Policy Maximum Out of Pocket (MOOP)[Medical & RX] | \$2,500 | \$10,000 |
| 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 when provided by In Network providers 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 20% | Deductible then 40% |
| Well Child Exam P | Deductible then 20% | Deductible then 40% |
| *Behavioral Health (BH) & Alcohol or Other Drug Abuse (AODA) | Deductible then 20% | Deductible then 40% |
| Chiropractic Exam & Hearing Exam (each visit) | Deductible then 20% | Deductible then 40% |
| Optometry/Vision Exam (Routine Vision Exam P) | Deductible then 20% | Deductible then 40% |
| Allergy Testing & Injections | Deductible then 20% | Deductible then 40% |
| Immunizations: Age 0–6 | \$0 | Deductible then 40% |
| Immunizations: Age 7–17 P | Deductible then 20% | Deductible then 40% |
| Adult Office Visit (Age 18+) | | |
| Office Visit/(Routine Exam P) & Imm./Urgent Care (each visit) | Deductible then 20% | Deductible then 40% |
| Optometry/Vision Exam (Routine Vision Exam P) | Deductible then 20% | Deductible then 40% |
| *Behavioral Health (BH) & Alcohol or Other Drug Abuse (AODA) | Deductible then 20% | Deductible then 40% |
| Routine Mammograms P & Pre/Post Maternity Care (each visit) | Deductible then 20% | Deductible then 40% |
| Chiropractic Exam & Hearing Exam (each visit) | Deductible then 20% | Deductible then 40% |
| Allergy Testing & Injections | Deductible then 20% | Deductible then 40% |
| Prescription Drugs | | |
| Formulary Prescription Drugs Only | Deductible then 20% | Deductible then 40% |
| Emergency Services | | |
| Emergency Room Services (copay waived if admitted) | Deductible then 20% | Deductible then 40% |
| Air Ambulance \$25,000 per occurrence. | Deductible then 20% | Deductible then 40% |
| Ground Ambulance | Deductible then 20% | Deductible then 40% |
| Infertility/Conception Services | | |
| Diagnosis & Treatment Up to \$2,000 per member per lifetime. Coinsurance does not apply to Policy MOOP. | Deductible then 20% | Deductible then 40% |
| Therapies: Physical, Occupational & Speech Up to 50 combined visits. | | |
| 0–5 visits | Deductible then 20% | Deductible then 40% |
| 6 or more visits | Deductible then 20% | Deductible then 40% |
| Cardiac Rehabilitation Phase II 18 weeks up to 36 visits. | Deductible then 20% | Deductible then 40% |

| OUTPATIENT/AMBULATORY & *INPATIENT SURGERY & SERVICES | | |
|---|---------------------|-------------------------|
| | In Network, You Pay | Out of Network, You Pay |
| Outpatient/Ambulatory Surgery | Deductible then 20% | Deductible then 40% |
| Semi-private Room & Board | Deductible then 20% | Deductible then 40% |
| *Behavioral Health (BH) & Alcohol or Other Drug Abuse (AODA) | Deductible then 20% | Deductible then 40% |
| Labor & Delivery | Deductible then 20% | Deductible then 40% |
| X-rays & Laboratory Testing | Deductible then 20% | Deductible then 40% |
| Medication | Deductible then 20% | Deductible then 40% |
| Inpatient Therapy | Deductible then 20% | Deductible then 40% |
| Skilled Nursing Care | Deductible then 20% | Deductible then 40% |
| Skilled Nursing Facility Care 30 days combined (In and Out of Network) per confinement per member. | Deductible then 20% | Deductible then 40% |
| Hospice Care | Deductible then 20% | Deductible then 40% |
| Injections | Deductible then 20% | Deductible then 40% |
| Colonoscopies | Deductible then 20% | Deductible then 40% |

| OTHER OUTPATIENT SERVICES | | |
|---|---|---|
| | In Network, You Pay | Out of Network, You Pay |
| Radiation Therapy | Deductible then 20% | Deductible then 40% |
| X-rays & Laboratory Testing | Deductible then 20% | Deductible then 40% |
| CT/CAT Scans | Deductible then 20% | Deductible then 40% |
| MRI, MRA & PET Scans | Deductible then 20% | Deductible then 40% |
| Sleep Studies (Facility) | Deductible then 20% | Deductible then 40% |
| Oral Surgery (Limited) | Deductible then 20% | Deductible then 40% |
| Office Surgery | Deductible then 20% | Deductible then 40% |
| *Hospice Care | Deductible then 20% | Deductible then 40% |
| Temporomandibular Joint Disorder <i>Diagnostic procedures and non-surgical treatment limited to \$1,250/member/contract year.</i> | Deductible then 20% | Deductible then 40% |
| *Home Health Services <i>Limited to 40 visits per member per contract year.</i> | Deductible then 20% | Deductible then 40% |
| *Home Health Therapies <i>Limited to 40 combined (physical, occupational and speech) home visits per contract year.</i> | Deductible then 20% | Deductible then 40% |
| *Medical Supplies: Including covered Diabetic Supplies, Medical Equipment & Prosthetics <i>Purchases over \$5000 require prior authorization.</i> | Deductible then 20% | Deductible then 40% |
| 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> | Deductible then 20% and Balance of Charges beyond benefit limits. | Deductible then 40% 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.