

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 and/or Maximums.
- The applicable Policy Deductible listed must be met before any services (except preventive, if applicable) will be paid by this policy. Policy Deductible and Coinsurance apply to the Policy Maximum Out of Pocket (MOOP).
- Deductible, Coinsurance and Maximums are calculated on a contract year basis.

	Single Policy	Family Policy
Policy Deductible	None	None
Policy Coinsurance	None	None
Policy Maximum Out of Pocket (MOOP)	None	None
Policy Lifetime Maximum	No Limit	
Qualified Maximum Dependent Age	19/25 FTS EOY	

OUTPATIENT SERVICES		
	You Pay	We Cover
Child Office Visits (Ages 0–17)		
Office Visit	\$0	Balance of Covered Services
Immediate/Urgent Care	\$0	Balance of Covered Services
Hearing Exam & Vision Exam (each visit)	\$0	Balance of Covered Services
Chiropractic Exam	\$0	Balance of Covered Services
Well Child Exam	\$0	Balance of Covered Services
Allergy Testing & Injections	\$0	Balance of Covered Services
Immunizations: Age 0–6	\$0	Balance of Covered Services
Immunizations: Age 7–17	\$0	Balance of Covered Services
Adult Office Visit (Age 18+)		
Office Visit/Routine Exam	\$0	Balance of Covered Services
Immediate/Urgent Care	\$0	Balance of Covered Services
Hearing Exam & Vision Exam (each visit)	\$0	Balance of Covered Services
Chiropractic Exam	\$0	Balance of Covered Services
Allergy Testing & Injections	\$0	Balance of Covered Services
Routine Mammograms	\$0	Balance of Covered Services
Pre/Post-natal Maternity Care	\$0	Balance of Covered Services
Emergency Services		
Emergency Room Services	\$25	Balance of Covered Services
Air Ambulance \$25,000 per occurrence.	\$0	Balance of Covered Services
Ground Ambulance	\$0	Balance of Covered Services
Infertility/Conception Services		
Diagnosis & Treatment <i>Up to \$2000 per member per lifetime. Coinsurance does not apply to Policy MOOP.</i>	Balance of Charges	50% of Covered Services
Therapies		
Physical, Occupational & Speech <i>Up to 50 combined visits.</i>	\$0	Balance of Covered Services
Cardiac Rehabilitation Phase II <i>18 weeks up to 36 visits.</i>	\$0	Balance of Covered Services

OUTPATIENT/AMBULATORY & *INPATIENT SURGERY & SERVICES		
	You Pay	We Cover
Outpatient/Ambulatory Surgery	\$0	Balance of Covered Services
Semi-private Room & Board	\$0	Balance of Covered Services
Labor & Delivery	\$0	Balance of Covered Services
X-rays & Laboratory Testing	\$0	Balance of Covered Services
Medication	\$0	Balance of Covered Services
Inpatient Therapy	\$0	Balance of Covered Services
Skilled Nursing Care	\$0	Balance of Covered Services
Skilled Nursing Facility Care <i>100 days per confinement per member.</i>	\$0	Balance of Covered Services
Hospice Care	\$0	Balance of Covered Services
Injections	\$0	Balance of Covered Services

OTHER OUTPATIENT SERVICES		
	You Pay	We Cover
Radiation Therapy	\$0	Balance of Covered Services
X-rays & Laboratory Testing	\$0	Balance of Covered Services
CT/CAT Scans	\$0	Balance of Covered Services
MRI, MRA & PET Scans	\$0	Balance of Covered Services
Oral Surgery (Limited)	\$0	Balance of Covered Services
Office Surgery	\$0	Balance of Covered Services
*Hospice Care	\$0	Balance of Covered Services
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 visit, surgery, hospitalization)	
*Home Health Services <i>Limited to 100 visits per member per contract year.</i>	\$0	Balance of Covered Services
*Home Health Therapies <i>Limited to 40 combined (physical, occupational and speech) home visits per contract year.</i>	\$0	Balance of Covered Services
*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%	Balance of Covered Services
Insulin <i>30-day supply</i>	\$10	Balance of Covered Services
Hearing Aids <i>Up to \$500 per hearing aid per ear, replaceable every 36 months. For hearing aids in both ears, up to \$1,000 replaceable every 36 months.</i>	Balance of Charges	Balance of Covered Services

*TRANSPLANTS & KIDNEY DISEASE	
	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 (i.e. office visit, surgery, hospitalization)
Other COVERED Transplants <i>Up to \$500,000 per member per lifetime.</i>	See applicable type of service (i.e. office visit, surgery, hospitalization)

*BEHAVIORAL HEALTH (BH) & ALCOHOL OR OTHER DRUG ABUSE (AODA)		
	BH; We Cover	AODA; We Cover
Inpatient Services	Up to 12 days	12 days up to \$6,300 combined
Transitional Services	Up to 18 days	18 days up to \$6,300 combined
Outpatient Services	Up to 20 visits	20 visits up to \$6,300 combined
<i>Note: Physicians Plus will not pay more than the benefit listed above. Two (2) group therapy visits equal one (1) individual visit. The maximum AODA benefit is \$6,300 for all services combined per member per contract year. The number of days/visits used for AODA will be applied to any BH day/visit limits.</i>		

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

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