

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. The Deductible applies to the Policy Maximum Out of Pocket (MOOP).
- Deductible, Coinsurance and Maximums are calculated on a calendar year basis.

	In Network	Out of Network
Policy Deductible	None	\$100 single/\$200 family
Policy Deductible (Over 65 Retirees)	None	\$200 single/\$400 family
Policy Coinsurance	None	None
Policy Maximum Out of Pocket (MOOP)	None	\$100 single/\$200 family
Policy Maximum Out of Pocket (MOOP; Over 65 Retirees)	None	\$200 single/\$400 family
Policy Lifetime Maximum	\$2,000,000 combined (In and Out of Network)	
Qualified Maximum Dependent Age	19/25 FTS EOY	

OUTPATIENT SERVICES

	In Network, You Pay	Out of Network, You Pay
Child Office Visits (Ages 0–17)		
Office Visit & Well Child Exam (each visit)	\$0	Deductible
Immediate/Urgent Care	\$0	Deductible
Hearing & Vision Exam (each visit)	\$0	Deductible
Chiropractic Exam	\$0	Deductible
Allergy Testing & Injections	\$0	Deductible
Immunizations: Age 0–6	\$0	Deductible
Immunizations: Age 7–17	\$0	Deductible
Adult Office Visit (Age 18+)		
Office Visit/(Routine Exam) (each visit)	\$0	Deductible
Immediate/Urgent Care	\$0	Deductible
Hearing & Vision Exam (each visit)	\$0	Deductible
Chiropractic Exams	\$0	Deductible
Allergy Testing & Injections	\$0	Deductible
Routine Mammograms	\$0	Deductible
Pre/Post-natal Maternity Care	\$0	Deductible
Emergency Services		
Emergency Room Services	\$0	Deductible
Air Ambulance \$25,000 per occurrence	\$0	Deductible
Ground Ambulance	\$0	Deductible
Infertility/Conception Services		
Diagnosis & Treatment <i>Up to \$2,000 per member per lifetime. Coinsurance does not apply to Policy MOOP.</i>	50% of Covered Services then Balance of Charges	Not Covered
Therapies		
Physical, Occupational & Speech <i>Up to 50 combined visits.</i>	\$0	Deductible then 20%
Cardiac Rehabilitation Phase II <i>18 weeks up to 36 visits.</i>	\$0	Deductible then 20%

OUTPATIENT/AMBULATORY & *INPATIENT SURGERY & SERVICES		
	In Network, You Pay	Out of Network, You Pay
Outpatient/Ambulatory Surgery	\$0	Deductible
Semi-private Room & Board	\$0	Deductible
Labor & Delivery	\$0	Deductible
X-rays & Lab Tests, & CT, PET, MRI and MRA Scans (each test)	\$0	Deductible
Medication	\$0	Deductible
Inpatient Therapy	\$0	Deductible
Skilled Nursing Care	\$0	Deductible
Skilled Nursing Facility Care <i>120 days combined (In and Out of Network) per confinement per member.</i>	\$0	Deductible
Hospice Care	\$0	Deductible
Injections	\$0	Deductible

OTHER OUTPATIENT SERVICES		
	In Network, You Pay	Out of Network, You Pay
Radiation Therapy	\$0	Deductible
X-rays & Laboratory Testing	\$0	Deductible
CT/CAT Scans	\$0	Deductible
PET, MRI & MRA Scans	\$0	Deductible
Oral Surgery (Limited)	\$0	Deductible
Office Surgery	\$0	Deductible
*Hospice Care	\$0	Deductible
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>	\$0	Deductible
*Home Health Therapies <i>Limited to 40 combined (physical, occupational and speech) home visits per calendar year.</i>	\$0	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%	50% after Deductible
Insulin <i>30-day Supply</i>	\$10	\$10
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. Copayments and/or Coinsurance do not apply to Policy MOOP.</i>	Balance of Charges beyond benefit limits	Not Covered

*TRANSPLANTS & KIDNEY DISEASE		
	In Network, You Pay	Out of Network, You Pay
Kidney Disease & Transplant <i>Up to \$30,000 per member per calendar 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	Deductible

*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

Note: Physicians Plus will not pay more than the benefit listed above. The maximum AODA benefit is \$6,300 combined per member per contract year. Two (2) outpatient group therapy visits equal one (1) individual visit. The number of days/visits used for AODA will be applied to any BH day/visit limits.

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