

**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	\$2,000 single/\$4,000 family
Policy Coinsurance	None	30%
Policy Maximum Out of Pocket (MOOP)	None	\$5,000 single/\$10,000 family
Policy Lifetime Maximum	\$2,000,000 combined (In and Out of Network)	
Qualified Maximum Dependent Age	18/27 DOB	

<b>OUTPATIENT SERVICES</b>		
	In Network, You Pay	Out of Network, You Pay
<b>Child Office Visits (Ages 0–17)</b>		
Office Visit & Well Child Exam (each visit)	\$0	Deductible then 30%
Immediate/Urgent Care	\$0	Deductible then 30%
*Behavioral Health (BH) & Alcohol or Other Drug Abuse (AODA)	\$0	Deductible then 30%
Hearing & Vision Exam (each visit)	\$35	Deductible then 30%
Allergy Testing & Injections	\$0	Deductible then 30%
Chiropractic Exam	\$0	Deductible then 30%
Immunizations: Age 0–6	\$0	Deductible then 30%
Immunizations: Age 7–17	\$0	Deductible then 30%
<b>Adult Office Visit (Age 18+)</b>		
Office Visit/(Routine Exam) (each visit)	\$35	Deductible then 30%
Immediate/Urgent Care	\$35	Deductible then 30%
*Behavioral Health (BH) & Alcohol or Other Drug Abuse (AODA)	\$35	Deductible then 30%
Hearing Exam & Vision Exam (each visit)	\$35	Deductible then 30%
Chiropractic Exams	\$35	Deductible then 30%
Allergy Testing & Injections	\$0	Deductible then 30%
Pre/Post-natal Maternity Care	\$0	Deductible then 30%
Routine Mammograms	\$0	Deductible then 30%
<b>Emergency Services</b>		
Emergency Room Services (copay waived if admitted)	\$100	Deductible then 30%
<b>Infertility/Conception Services</b>		
Diagnosis & Treatment <i>Up to \$2,000 (In &amp; Out of Network combined) per member per lifetime. Coinsurance does not apply to Policy MOOP.</i>	50% of Covered Services then Balance of Charges	Deductible then 50% of Cov. Services & Balance of Charges
<b>Therapies: Physical, Occupational &amp; Speech <i>Up to 50 combined visits.</i></b>		
0–5 visits	\$35	Deductible then 30%
6 or more visits	\$35	Deductible then 30%
Cardiac Rehabilitation Phase II <i>18 weeks up to 36 visits.</i>	\$0	Deductible then 30%

OUTPATIENT/AMBULATORY & *INPATIENT SURGERY & SERVICES All In-Network Services: \$1,000 single/\$2,000 family Benefit Deductible then 10% Coinsurance; \$2,000 single/\$4,000 family MOOP		
	In Network, You Pay	Out of Network, You Pay
Outpatient/Ambulatory Surgery	Deductible then 10%	Deductible then 30%
Oral Surgery (Limited)	Deductible then 10%	Deductible then 30%
Semi-private Room & Board	Deductible then 10%	Deductible then 30%
*Behavioral Health (BH) & Alcohol or Other Drug Abuse (AODA)	Deductible then 10%	Deductible then 30%
Labor & Delivery	Deductible then 10%	Deductible then 30%
X-rays & Laboratory Testing	Deductible then 10%	Deductible then 30%
Medication	Deductible then 10%	Deductible then 30%
Inpatient Therapy	Deductible then 10%	Deductible then 30%
Skilled Nursing Care	Deductible then 10%	Deductible then 30%
Skilled Nursing Facility Care 100 days combined (In and Out of Network) per confinement per member.	Deductible then 10% 100 days per confinement per member	Deductible then 30% 30 days per confinement per member
Hospice Care Inpatient & Outpatient	Deductible then 10%	Deductible then 30%
Injections	Deductible then 10%	Deductible then 30%
Colonoscopies	Deductible then 10%	Deductible then 30%
Ground Ambulance	Deductible then 10%	Deductible then 30%
Air Ambulance \$25,000 per occurrence	Deductible then 10%	Deductible then 30%

OTHER OUTPATIENT SERVICES		
	In Network, You Pay	Out of Network, You Pay
Radiation Therapy	\$35	Deductible then 30%
X-rays & Laboratory Testing	\$0	Deductible then 30%
CT/CAT Scans	\$0	Deductible then 30%
MRI, MRA & PET Scans	\$0	Deductible then 30%
Sleep Studies (Facility)	\$0	Deductible then 30%
Office Surgery	\$0	Deductible then 30%
Temporomandibular Joint Disorder Diagnostic procedures and non-surgical treatment limited to \$1,250/member/contract year.	See applicable type of service	See applicable type of service
*Home Health Services Limited to 100 visits per member per contract year.	\$0	Deductible then 30%
*Home Health Therapies Limited to 40 combined (physical, occupational and speech) home visits per contract year.	\$35	Deductible then 30%
*Medical Supplies: Including covered Diabetic Supplies, Medical Equipment & Prosthetics Purchases over \$5000 require prior authorization. Coinsurance does not apply to Policy MOOP.	20% up to \$2,000 per member per contract year; paid in full after \$2,000	Deductible then 30% up to \$4,000 per member/contract year; paid in full after \$4,000
Insulin 30-day Supply	\$10	
Hearing Aids (Ages 0–18) (In & Out of Network benefits are combined). One standard model hearing aid per ear replaceable every 36 months.	20% and Balance of Charges beyond benefit limits.	Deductible then 30% and Balance of Charges beyond benefit limits.
Hearing Aids (Age 19+) Up to \$400 (In & Out of Network combined) per hearing aid per ear, replaceable every 36 months.	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 Up to \$30,000 per member per contract year (will not duplicate Medicare coverage).	See applicable type of service	Disease: See type of service. Transplant: In Network Only.
Other COVERED Transplants Up to \$500,000 per member per lifetime.	See applicable type of service	In Network Benefits Only

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