

**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	\$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	18/27 DOB	

**OUTPATIENT SERVICES**

	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
Immediate/Urgent Care	\$0	Deductible
*Behavioral Health (BH) & Alcohol or Other Drug Abuse (AODA)	\$0	Deductible
Hearing & Vision Exam (each visit)	\$0	Deductible
Allergy Testing & Injections	\$0	Deductible
Chiropractic Exam	\$0	Deductible
Immunizations: Age 0–6	\$0	Deductible
Immunizations: Age 7–17	\$0	Deductible
<b>Adult Office Visit (Age 18+)</b>		
Office Visit/(Routine Exam) (each visit)	\$0	Deductible
Immediate/Urgent Care	\$0	Deductible
*Behavioral Health (BH) & Alcohol or Other Drug Abuse (AODA)	\$0	Deductible
Hearing Exam & Vision Exam (each visit)	\$0	Deductible
Chiropractic Exams	\$0	Deductible
Allergy Testing & Injections	\$0	Deductible
Pre/Post-natal Maternity Care	\$0	Deductible
Routine Mammograms	\$0	Deductible
<b>Emergency Services</b>		
Emergency Room Services (copay waived if admitted)	\$0	Deductible
Air Ambulance \$25,000 per occurrence.	\$0	Deductible
Ground Ambulance	\$0	Deductible
<b>Infertility/Conception Services</b>		
Diagnosis & Treatment Up to \$2,000 (In & Out of Network combined) per member per lifetime. Coinsurance does not apply to Policy MOOP.	50% of Covered Services then Balance of Charges	Not Covered
<b>Therapies: Physical, Occupational &amp; Speech Up to 50 combined visits.</b>		
0–5 visits	\$0	Deductible then 20%
6 or more visits	\$0	Deductible then 20%
Cardiac Rehabilitation Phase II 18 weeks up to 36 visits.	\$0	Deductible

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
*Behavioral Health (BH) & Alcohol or Other Drug Abuse (AODA)	\$0	Deductible
Labor & Delivery	\$0	Deductible
X-rays & Laboratory Testing	\$0	Deductible
Medication	\$0	Deductible
Inpatient Therapy	\$0	Deductible
Skilled Nursing Care	\$0	Deductible
Skilled Nursing Facility Care 120 days combined (In and Out of Network) per confinement per member.	\$0	Deductible
Hospice Care	\$0	Deductible
Injections	\$0	Deductible
Colonoscopies	\$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
MRI, MRA & PET Scans	\$0	Deductible
Sleep Studies (Facility)	\$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 per member per contract year.</i>	\$0	Deductible
*Home Health Therapies <i>Limited to 40 combined (physical, occupational and speech) home visits per contract year.</i>	\$0	Deductible then 20%
*Medical Supplies: Including covered Diabetic Supplies, Medical Equipment & Prosthetics <i>Purchases over \$5000 require prior authorization. Coinsurance does not apply to Policy MOOP.</i>	20%	50% after Deductible
Insulin 30-day Supply	\$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>	\$0	Not Covered
Hearing Aids (Age 19+) <i>Up to \$500 (In &amp; Out of Network combined) 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 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 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.