

These services must be provided by a Physicians Plus Insurance Corporation (Physicians Plus) participating provider. This Outline of Coverage is only a summary of benefits under this plan.

Policy Deductible	\$500 individual/\$1,000 family
Policy Coinsurance	As described below.
Policy Maximum Out of Pocket (MOOP)	\$500 annually, in addition to policy deductible, per member for medical supplies (including durable diabetic equipment and related supplies) and durable medical equipment.
Policy Lifetime Maximum Benefit	\$2,000,000 per member.

PREVENTIVE SERVICES

Office visits for preventive health care, including:

Adult Routine Physical Examinations	Covered in full after deductible.
Well Child Examinations (0–17 years)	Covered in full after deductible.
Immunizations	Covered in full after deductible.
Mammogram Screenings	Covered in full after deductible.

OUTPATIENT SERVICES

Adult Office Visits	Covered in full after deductible.
Child Office Visits (0–17)	Covered in full after deductible.
Adult Chiropractic Visits	Covered in full after deductible.
Child Chiropractic Visits	Covered in full after deductible.
Vision and Hearing Exams (Adult & Child)	Covered in full after deductible. One routine exam (contact lens fitting not included) per contract year.
Hearing Aids	Covered at 80% after deductible. One hearing aid per ear no more than once every three years up to a maximum payment of \$1,000 per hearing aid. Hearing aids for participants under age 18 are covered at 100% (\$1,000 limit does not apply).
Allergy Injections	Covered in full after deductible.
Routine Pre- and Post-natal Maternity Office Visits	Covered in full after deductible.
Medical Imaging and Laboratory Tests	Covered in full after deductible.
Oral Surgery	Covered in full after deductible. Limited to procedures listed in the Benefits and Services section of the “It’s Your Choice: Reference Guide” booklet.
In-Office Surgery	Covered in full after deductible.
Outpatient Surgery	*Covered in full after deductible.
Immediate/Urgent Care Services	Covered in full after deductible.
Radiation Therapy	Covered in full after deductible.

INPATIENT SERVICES

Hospitalization (Semi-private Room)	*Covered in full after deductible.
Inpatient, Physician and Nursing Care	*Covered in full after deductible.
Surgery, Anesthesia and Related Supplies	*Covered in full after deductible.
Maternity	*Covered in full after deductible.
Medical Imaging and Laboratory Tests	*Covered in full after deductible.
Special Units Care	*Covered in full after deductible.
Oxygen	*Covered in full after deductible.
Inpatient Medications	*Covered in full after deductible.

*Requires prior authorization. All benefits are paid according to terms of the Master Contract between Physicians Plus and the Group Insurance Board. Uniform Benefits, including a Schedule of Benefits, are wholly incorporated in the Master Contract. The Schedule of Benefits describes certain essential dollar or visit limits of your coverage and certain rules, if any, you must follow to obtain covered services.

EMERGENCY SERVICES	
Ambulance Service (Air/Ground)	Covered in full after deductible as is medically necessary.
Emergency Room	\$60 copayment per visit after deductible. Copayment waived if admitted as an inpatient directly from emergency room.

MENTAL HEALTH and ALCOHOL OR OTHER DRUG ABUSE (AODA) SERVICES	
Outpatient Services	Covered in full after deductible. \$1,800 maximum per member per contract year.
Transitional Services	Covered in full after deductible. \$2,700 maximum per member per contract year.
Inpatient Services	Covered in full after deductible. 30 days or \$6,300, whichever is less, per member per contract year.
Maximum Benefit	Covered in full after deductible. The maximum benefit for inpatient, outpatient and transitional services is \$7,000 per member per contract year.

The maximum is determined using the average amount paid to the providers by Physicians Plus and excludes costs associated with diagnostic testing and prescription drugs. The benefit is not subject to a copayment.

NOTE: Annual dollar and day limit maximums for mental health services are suspended.

OTHER SERVICES	
Home Care	*Covered in full after deductible. 50 visits per member/contract year. 50 additional medically necessary visits per contract year may be authorized by Physicians Plus.
Outpatient Physical, Speech and Occupational Therapy	*Covered in full after deductible up to 50 visits for all therapies combined per contract yr. Additional medically necessary visits may be available when authorized by Physicians Plus, up to a maximum of 50 additional visits per therapy per contract year.
Hospice Care	*Covered in full after deductible when the member's life expectancy is six months or less; as authorized by Physicians Plus.
Licensed Skilled Nursing Home	*Covered in full after deductible for 120 days/benefit period. Skilled care only.
Medical Supplies and Durable Medical Equipment	*Covered at 80% after deductible per purchase or rental. Out-of-pocket expense (in addition to policy deductible) will not exceed \$500 annually per member.
Accidental Dental	*Covered in full after deductible. Treatment must commence within 18 months of accident-related injury to natural teeth.
Cardiac Rehabilitation	*Covered in full after deductible for specific diagnoses.
Temporomandibular Disorder (TMD)	Covered in full after deductible. The maximum benefit for diagnostic procedures and non-surgical treatment is \$1,250/member per contract year.
Transplants	*Covered in full after deductible. Limited to transplants listed in the Benefits and Services section of the "It's Your Choice: Reference Guide" booklet; subject to a lifetime benefit of \$1,000,000 for transplants, including pre- and post-operative care.
Kidney Disease/Transplant	*Covered for inpatient and outpatient kidney disease treatment after deductible.
Cochlear Implants	*Covered at 80% after deductible when medically necessary and prior authorized by Physicians Plus. Cochlear implants for participants under age 18 are covered at 100%.

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