

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 is 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.
- The Deductible listed must be met before any medical or prescription drug services (except preventive, if applicable) will be paid by this policy. Only covered medical and prescription drug treatments, services and/or supplies apply to any applicable Policy Deductible and MOOP limit.
- Physicians Plus does not guarantee your eligibility for a Health Savings Account. Please consult an independent tax advisor for specific eligibility information.

| | |
|-------------------------------------|-------------|
| Policy Deductible | \$1,250 |
| Policy Coinsurance | 20% |
| Policy Maximum Out of Pocket (MOOP) | \$2,500 |
| Policy Lifetime Maximum | \$1,000,000 |
| Qualified Maximum Dependent Age | 18/27 DOB |

OUTPATIENT SERVICES

P — Indicates a preventive service covered by Physicians Plus up to a maximum of \$500 per member per contract year. After \$500 in charges, you pay the policy deductible and coinsurance up to the policy MOOP. This \$500 does not apply to the deductible or MOOP.

| | You Pay | We Cover |
|---|-------------------------|--------------------------|
| Child Office Visits (Ages 0–17) | | |
| Office Visit & Immediate/Urgent Care (each visit) | Deductible then 20% | 80% after Deductible |
| Well Child Exam P | Deductible then 20% | 80% after Deductible |
| *Behavioral Health (BH) & Alcohol or Other Drug Abuse (AODA) | See rider if applicable | |
| Chiropractic Exam & Hearing Exam (each visit) | Deductible then 20% | 80% after Deductible |
| Optometry/Vision Exam (Routine Vision Exam P) | Deductible then 20% | 80% after Deductible |
| Allergy Testing & Injections | Deductible then 20% | 80% after Deductible |
| Immunizations: Age 0–6 | \$0 | 100% |
| Immunizations: Age 7–17 P | Deductible then 20% | 80% after Deductible |
| Adult Office Visit (Age 18+) | | |
| Office Visit/(Routine Exam P) & Imm./Urgent Care (each visit) | Deductible then 20% | 80% after Deductible |
| Optometry/Vision Exam (Routine Vision Exam P) | Deductible then 20% | 80% after Deductible |
| *Behavioral Health (BH) & Alcohol or Other Drug Abuse (AODA) | See rider if applicable | |
| Routine Mammograms P | Deductible then 20% | 80% after Deductible |
| Pre/Post-natal Maternity Care | See rider if applicable | |
| Chiropractic Exam & Hearing Exam (each visit) | Deductible then 20% | 80% after Deductible |
| Allergy Testing & Injections | Deductible then 20% | 80% after Deductible |
| Emergency Services | | |
| Emergency Room Services (copay waived if admitted) | Deductible then 20% | 80% after Deductible |
| Air Ambulance \$25,000 per occurrence. | Deductible then 20% | 80% after Deductible |
| Ground Ambulance | Deductible then 20% | 80% after Deductible |
| Infertility/Conception Services | | |
| Diagnosis & Treatment Up to \$2,000 per member per lifetime. Coinsurance does not apply to Policy MOOP. | Deductible then 20% | \$2,000 after Deductible |
| Therapies: Physical, Occupational & Speech Up to 50 combined visits. | | |
| 0–5 visits | Deductible then 20% | 80% after Deductible |
| 6 or more visits | Deductible then 20% | 80% after Deductible |
| Cardiac Rehabilitation Phase II 18 weeks up to 36 visits. | Deductible then 20% | 80% after Deductible |

| OUTPATIENT/AMBULATORY & *INPATIENT SURGERY & SERVICES | | |
|---|-------------------------|----------------------|
| | You Pay | We Cover |
| Outpatient/Ambulatory Surgery | Deductible then 20% | 80% after Deductible |
| Semi-private Room & Board | Deductible then 20% | 80% after Deductible |
| Labor & Delivery | See rider if applicable | |
| *Behavioral Health (BH) & Alcohol or Other Drug Abuse (AODA) | See rider if applicable | |
| X-rays & Laboratory Testing | Deductible then 20% | 80% after Deductible |
| Medication | Deductible then 20% | 80% after Deductible |
| Inpatient Therapy | Deductible then 20% | 80% after Deductible |
| Skilled Nursing Care | Deductible then 20% | 80% after Deductible |
| Skilled Nursing Facility Care <i>30 days per confinement per member.</i> | Deductible then 20% | 80% after Deductible |
| Hospice Care | Deductible then 20% | 80% after Deductible |
| Injections | Deductible then 20% | 80% after Deductible |
| Colonoscopies | Deductible then 20% | 80% after Deductible |

| OTHER OUTPATIENT SERVICES | | |
|---|---|--|
| | You Pay | We Cover |
| Radiation Therapy | Deductible then 20% | 80% after Deductible |
| X-rays & Laboratory Testing | Deductible then 20% | 80% after Deductible |
| CT/CAT Scans | Deductible then 20% | 80% after Deductible |
| MRI, MRA & PET Scans | Deductible then 20% | 80% after Deductible |
| Sleep Studies (Facility) | Deductible then 20% | 80% after Deductible |
| Oral Surgery (Limited) | Deductible then 20% | 80% after Deductible |
| Office Surgery | Deductible then 20% | 80% after Deductible |
| *Hospice Care | Deductible then 20% | 80% after Deductible |
| 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 etc) | |
| *Home Health Services <i>Limited to 40 visits per member per contract year.</i> | Deductible then 20% | 80% after Deductible |
| *Home Health Therapies <i>Limited to 40 combined (physical, occupational and speech) home visits per contract year.</i> | Deductible then 20% | 80% after Deductible |
| *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> | Deductible then 20% | 80% after Deductible |
| Hearing Aids (Ages 0–18) <i>One standard model aid per ear replaceable every 36 months.</i> | Deductible then 20% and Balance of Charges | 80% after Deductible and Balance of Covered Services |
| Hearing Aids (Age 19+) <i>Up to \$400 per hearing aid, per ear, replaceable every 36 months. For hearing aids in both ears, up to \$800 replaceable every 36 months.</i> | Deductible and Balance of Charges | \$400/\$800 after Deductible |

| *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 |
| Other COVERED Transplants <i>Up to \$500,000 per member per lifetime.</i> | See applicable type of service |

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