Physicians Plus
INSURANCE CORPORATION

2010 HMO Two-Tier Schedule of Benefits
0H20HY1C
HealthShareComplete Co $20/40, C/A, ER $100, $1,000D, Dx $100

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.

	Single Policy	Family Policy
Policy Deductible	$1,000	$2,000
Policy Coinsurance	20%	20%
Policy Maximum Out of Pocket (MOOP)	$2,000	$4,000
Policy Lifetime Maximum	$2,000,000	
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.

	Tier 1; You Pay	Tier 2; You Pay	We Cover
Child Office Visits *(Ages 0–17)*			
Office Visit	$20	$40	Balance of Covered Services
Well Child Exam **P**	$20	$40	Balance of Covered Services
*Behavioral Health (BH) & Alcohol or Other Drug Abuse (AODA)	Tier 2 Benefit only	$40	Balance of Covered Services
Immediate/Urgent Care & Ophthalmology (each visit)	Tier 2 Benefit only	$40	Balance of Covered Services
Chiropractic & Optometry Exam (Routine Vision Exam **P**)	$20	Tier 1 Benefit only	Balance of Covered Services
Hearing Exam	$20	$40	Balance of Covered Services
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**) & Hearing Exam (each visit)	$20	$40	Balance of Covered Services
Optometry Exam (Routine Vision Exam **P**)	$20	Tier 1 Benefit only	Balance of Covered Services
*Behavioral Health (BH) & Alcohol or Other Drug Abuse (AODA)	Tier 2 Benefit only	$40	Balance of Covered Services
Immediate/Urgent Care & Ophthalmology (each visit)	Tier 2 Benefit only	$40	Balance of Covered Services
Chiropractic Exam	$20	Tier 1 Benefit only	Balance of Covered Services
Pre/Post-natal Maternity Care	Deductible then 20%		80% after Deductible
Allergy Testing & Injections	Deductible then 20%		80% after Deductible
Routine Mammograms **P**	Deductible then 20%		80% after Deductible
Emergency Services			
Emergency Room Services (copay waived if admitted)	$100		Balance of Covered Services
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.*	Balance of Charges		50% of Covered Services
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	Deductible then 20%	80% after Deductible
*Behavioral Health (BH) & Alcohol or Other Drug Abuse (AODA)	Deductible then 20%	80% after Deductible
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 *30 days per confinement per member.*	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	$100	Balance of Covered Services
MRI, MRA & PET Scans	$100	Balance of Covered Services
Sleep Studies (Facility)	$100	Balance of Covered Services
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 *Diagnostic procedures and non-surgical treatment limited to $1,250/member/contract year.*	See the applicable type of service (i.e. Office Vist, Surgery etc)	
*Home Health Services *Limited to 40 visits per member per contract year.*	Deductible then 20%	80% after Deductible
*Home Health Therapies *Limited to 40 combined (physical, occupational and speech) home visits per contract year.*	Deductible then 20%	80% after Deductible
*Medical Supplies: Including covered Diabetic Supplies, Medical Equipment & Prosthetics *Purchases over $5,000 require prior authorization. Coinsurance does not apply to Policy MOOP.*	20% up to $2,000 per member per contract year	Balance of Covered Services
Insulin *30-day supply*	$10	Balance of Covered Services
Hearing Aids *(Ages 0–18) One standard model aid per ear replaceable every 36 months. Coinsurance does not apply to Policy MOOP.*	20% and Balance of Charges	80% of Covered Services
Hearing Aids *(Age 19+) 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.*	Balance of Charges	Balance of Covered Services

*TRANSPLANTS & KIDNEY DISEASE

	You Pay
Kidney Disease & Transplant *Up to $30,000 per member per contract year (will not duplicate Medicare coverage).*	See applicable type of service
Other COVERED Transplants *Up to $500,000 per member per lifetime.*	See applicable type of service

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

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