Physicians Plus
INSURANCE CORPORATION

2010 HMO Schedule of Benefits
0H35D500
Co $35, ER $100, $500D

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	None	None
Policy Coinsurance	None	None
Policy Maximum Out of Pocket (MOOP)	None	None
Policy Lifetime Maximum	$2,000,000	
Qualified Maximum Dependent Age	18/27 DOB	

OUTPATIENT SERVICES		
	You Pay	We Cover
Child Office Visits *(Ages 0–17)*		
Office Visit	$0	Balance of Covered Services
Well Child Exam	$0	Balance of Covered Services
*Behavioral Health (BH) & Alcohol or Other Drug Abuse (AODA)	$0	Balance of Covered Services
Immediate/Urgent Care	$0	Balance of Covered Services
Chiropractic Exam	$0	Balance of Covered Services
Hearing Exam & Vision Exam (each visit)	$35	Balance of Covered Services
Allergy Testing & Injections	$0	Balance of Covered Services
Immunizations: Age 0–6	$0	Balance of Covered Services
Immunizations: Age 7–17	$0	Balance of Covered Services
Adult Office Visit *(Age 18+)*		
Office Visit/Routine Exam	$35	Balance of Covered Services
*Behavioral Health (BH) & Alcohol or Other Drug Abuse (AODA)	$35	Balance of Covered Services
Immediate/Urgent Care	$35	Balance of Covered Services
Hearing Exam & Vision Exam (each visit)	$35	Balance of Covered Services
Chiropractic Exam	$35	Balance of Covered Services
Pre/Post-natal Maternity Care	$0	Balance of Covered Services
Allergy Testing & Injections	$0	Balance of Covered Services
Routine Mammograms	$0	Balance of Covered Services
Emergency Services		
Emergency Room Services (copay waived if admitted)	$100	Balance of Covered Services
Air Ambulance *$25,000 per occurrence.*	$500	Balance of Covered Services
Ground Ambulance	$0	Balance of Covered Services
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	$0	Balance of Covered Services
6 or more visits	$35	Balance of Covered Services
Cardiac Rehabilitation Phase II *18 weeks up to 36 visits.*	$0	Balance of Covered Services

OUTPATIENT/AMBULATORY & *INPATIENT SURGERY & SERVICES *Benefit Deductible: $500 single/$1,000 family; Benefit MOOP: $500 single/$1,000 family.*	You Pay	We Cover
Outpatient/Ambulatory Surgery	Deductible	Balance of Covered Services
Semi-private Room & Board	Deductible	Balance of Covered Services
Labor & Delivery	Deductible	Balance of Covered Services
*Behavioral Health (BH) & Alcohol or Other Drug Abuse (AODA)	Deductible	Balance of Covered Services
X-rays & Laboratory Testing	Deductible	Balance of Covered Services
Medication	Deductible	Balance of Covered Services
Inpatient Therapy	Deductible	Balance of Covered Services
Skilled Nursing Care	Deductible	Balance of Covered Services
Skilled Nursing Facility Care *100 days per confinement per member.*	Deductible	Balance of Covered Services
Hospice Care	Deductible	Balance of Covered Services
Injections	Deductible	Balance of Covered Services
Colonoscopies	Deductible	Balance of Covered Services

OTHER OUTPATIENT SERVICES	You Pay	We Cover
Radiation Therapy	$0	Balance of Covered Services
X-rays & Laboratory Testing	$0	Balance of Covered Services
CT/CAT Scans	$0	Balance of Covered Services
MRI, MRA & PET Scans	$0	Balance of Covered Services
Sleep Studies (Facility)	$0	Balance of Covered Services
Oral Surgery (Limited)	$0	Balance of Covered Services
Office Surgery	$0	Balance of Covered Services
*Hospice Care	$0	Balance of Covered Services
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 100 visits per member per contract year.*	$0	Balance of Covered Services
*Home Health Therapies *Limited to 40 combined (physical, occupational and speech) home visits per contract year.*	$0	Balance of Covered Services
*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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