Physicians Plus
INSURANCE CORPORATION

2010 POS Schedule of Benefits
0P100V20
Co $15, ER $100, $100D+10, Ex 20

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	$250 single/$500 family
Policy Coinsurance	None	20%
Policy Maximum Out of Pocket (MOOP)	None	$2,500 single/$5,000 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
Child Office Visits *(Ages 0–17)*		
Office Visit & Well Child Exam (each visit)	$0	Deductible then 20%
Immediate/Urgent Care	$0	Deductible then 20%
*Behavioral Health (BH) & Alcohol or Other Drug Abuse (AODA)	$0	Deductible then 20%
Hearing & Vision Exam (each visit)	$15	Deductible then 20%
Allergy Testing & Injections	$0	Deductible then 20%
Chiropractic Exam	$0	Deductible then 20%
Immunizations: Age 0–6	$0	Deductible then 20%
Immunizations: Age 7–17	$0	Deductible then 20%
Adult Office Visit *(Age 18+)*		
Office Visit/(Routine Exam) (each visit)	$15	Deductible then 20%
Immediate/Urgent Care	$15	Deductible then 20%
*Behavioral Health (BH) & Alcohol or Other Drug Abuse (AODA)	$15	Deductible then 20%
Hearing Exam & Vision Exam (each visit)	$15	Deductible then 20%
Chiropractic Exams	$15	Deductible then 20%
Allergy Testing & Injections	$0	Deductible then 20%
Pre/Post-natal Maternity Care	$0	Deductible then 20%
Routine Mammograms	$0	Deductible then 20%
Emergency Services		
Emergency Room Services (copay waived if admitted)	$100	Deductible then 20%
Infertility/Conception Services		
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	Deductible then 50% of Cov. Services & Balance of Charges
Therapies: Physical, Occupational & Speech *Up to 50 combined visits.*		
0–5 visits	$15	Deductible then 20%
6 or more visits	$15	Deductible then 20%
Cardiac Rehabilitation Phase II *18 weeks up to 36 visits.*	$0	Deductible then 20%

OUTPATIENT/AMBULATORY & *INPATIENT SURGERY & SERVICES *All In-Network Services: $100 single/$200 family Benefit Deductible then 10% Coinsurance; $1,000 single/$2,000 family MOOP*	In Network, You Pay	Out of Network, You Pay
Outpatient/Ambulatory Surgery	Deductible then 10%	Deductible then 20%
Oral Surgery (Limited)	Deductible then 10%	Deductible then 20%
Semi-private Room & Board	Deductible then 10%	Deductible then 20%
*Behavioral Health (BH) & Alcohol or Other Drug Abuse (AODA)	Deductible then 10%	Deductible then 20%
Labor & Delivery	Deductible then 10%	Deductible then 20%
X-rays & Laboratory Testing	Deductible then 10%	Deductible then 20%
Medication	Deductible then 10%	Deductible then 20%
Inpatient Therapy	Deductible then 10%	Deductible then 20%
Skilled Nursing Care	Deductible then 10%	Deductible then 20%
Skilled Nursing Facility Care *100 days combined (In and Out of Network) per confinement per member.*	Deductible then 10% *100 days per confinement per member*	Deductible then 20% *30 days per confinement per member*
Hospice Care *Inpatient & Outpatient*	Deductible then 10%	Deductible then 20%
Injections	Deductible then 10%	Deductible then 20%
Colonoscopies	Deductible then 10%	Deductible then 20%
Ground Ambulance	Deductible then 10%	Deductible then 20%
Air Ambulance *$25,000 per occurrence*	Deductible then 10%	Deductible then 20%

OTHER OUTPATIENT SERVICES	In Network, You Pay	Out of Network, You Pay
Radiation Therapy	$15	Deductible then 20%
X-rays & Laboratory Testing	$0	Deductible then 20%
CT/CAT Scans	$0	Deductible then 20%
MRI, MRA & PET Scans	$0	Deductible then 20%
Sleep Studies (Facility)	$0	Deductible then 20%
Office Surgery	$0	Deductible then 20%
Temporomandibular Joint Disorder *Diagnostic procedures and non-surgical treatment limited to $1,250/member/contract year.*	See applicable type of service	See applicable type of service
*Home Health Services *Limited to 100 visits per member per contract year.*	$0	Deductible then 20%
*Home Health Therapies *Limited to 40 combined (physical, occupational and speech) home visits per contract year.*	$15	Deductible then 20%
*Medical Supplies: Including covered Diabetic Supplies, Medical Equipment & Prosthetics *Purchases over $5000 require prior authorization. Coinsurance does not apply to Policy MOOP.*	20% up to $2,000 per member per contract year; paid in full after $2,000	Deductible then 20% up to $4,000 per member/contract year; paid in full after $4,000
Insulin *30-day Supply*	$10	
Hearing Aids *(Ages 0–18) (In & Out of Network benefits are combined). One standard model hearing aid per ear replaceable every 36 months.*	20% and Balance of Charges beyond benefit limits.	Deductible then 20% and Balance of Charges beyond benefit limits.
Hearing Aids *(Age 19+) Up to $400 (In & Out of Network combined) per hearing aid per ear, replaceable every 36 months.*	Balance of Charges beyond benefit limits.	Deductible and Balance of Charges beyond benefit limits.

*TRANSPLANTS & KIDNEY DISEASE	In Network, You Pay	Out of Network, You Pay
Kidney Disease & Transplant *Up to $30,000 per member per contract year (will not duplicate Medicare coverage).*	See applicable type of service	Disease: See type of service. Transplant: In Network Only.
Other COVERED Transplants *Up to $500,000 per member per lifetime.*	See applicable type of service	In Network Benefits Only

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

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