2012 HMO
2RPW2520
Copay $25/$50, C/A, ER $250, $2,500D

Physicians Plus

SUMMARY OF BENEFITS

Please read applicable Policy documents carefully. You are responsible for knowing the benefits and provisions of your Policy. This is a SUMMARY of your benefits with Physicians Plus. Please consult your Policy, Amendments, Riders and Medical Certificate of Coverage for complete benefit and coverage details. Not all medical services are covered benefits, and all covered services must be medically necessary. To review benefits, services and claims, sign up for **GO-TO™** at **pplusic.com**.

= **REQUIRES PRIOR AUTHORIZATION** *(Approval by Physicians Plus BEFORE services are obtained).*

Policy Limits	Single	Family
Deductible	$2,500	$5,000
Coinsurance	20%	20%
Maximum Out of Pocket (MOOP) *Includes Deductible and Coinsurance. Does not include Copayments.*	$5,000	$10,000

Preventive Care & Services	You Pay
Age, Frequency & Procedure limits may apply. If other services are provided, cost sharing may apply (See your *Medical Certificate of Coverage* at www.pplusic.com for details).	$0

Office Visits - CHILDREN (Ages 0–17)	You Pay
Allergy Testing & Injections	Deductible then 20%
Behavioral Health or Alcohol/Drug Addiction Services	Only available through purchase of separate policy rider
Chiropractic Care	$25
Hearing Exam	$25
Immediate/Urgent Care	$50
Primary Care	$25
Specialty Care	$50
Vision – Optometry	$25
– Ophthalmology	$25
Lab and Radiological Services provided, as well as any treatment room and facility charges, in either a primary care office setting, specialty care office setting or urgent care facility.	Deductible then 20%

Office Visits - ADULTS (Ages 18+)	You Pay
Allergy Testing & Injections	Deductible then 20%
Behavioral Health or Alcohol/Drug Addiction Services	Only available through purchase of separate policy rider
Chiropractic Care	$25
Hearing Exam	$25
Immediate/Urgent Care	$50
Primary Care	$25
Specialty Care	$50
Vision – Optometry	$25
– Ophthalmology	$25
Lab and Radiological Services provided, as well as any treatment room and facility charges, in either a primary care office setting, specialty care office setting or urgent care facility.	Deductible then 20%

Emergency Services	You Pay
Emergency Room *(Copay waived if admitted to hospital)*	$250 copay then Deductible then 20%
Air Ambulance	Deductible then 20%
Ground Ambulance	Deductible then 20%

Imaging/Diagnostic Testing *(the "You Pay" amount applies to each scan)*	You Pay
High-tech Radiology *(i.e. CT/CAT Scans, MRI, MRA & PET Scans)*	Deductible then 20%
Diagnostic Testing	Deductible then 20%
Sleep Study: Home	Deductible then 20%
Facility	Deductible then 20%
Virtual Colonoscopy	Deductible then 20%

Hospital: Inpatient & Outpatient/ Ambulatory Surgery and Services	You Pay
Inpatient Surgery & Services	Deductible then 20%
Hospice Care	Deductible then 20%
Behavioral Health or Alcohol/Drug Addiction Services	Only available through purchase of separate policy rider
Maternity Care & Services	Only available through purchase of separate policy rider
Skilled Nursing Facility: *30 Days*	Deductible then 20%
Outpatient/Ambulatory Surgery & Services	Deductible then 20%
Injections	Deductible then 20%
Colonoscopy	Deductible then 20%
Hospice Care	Deductible then 20%

Transplants	You Pay
Kidney Disease & Transplant: *Policy pays up to $30,000/member /calendar year (this policy will not duplicate Medicare Benefits).*	See type of service
Other Covered Transplants: *Policy pays up to $1,250,000/member /lifetime.*	See type of service

Miscellaneous Services		You Pay
Autism Services *Limit does not apply for large employers. The applicable service cost sharing will apply. Intensive (Policy pays up to $50,000); Non-Intensive (Policy pays up to $25,000).*		See type of service
Durable Medical Equipment (DME) *Including diabetic supplies. Rentals & purchases over $750 and all limb prosthetics require prior authorization. Coinsurance does not apply to POLICY MOOP.*		20% up to $2,000/ member/calendar year
Hearing Aids*	***Ages 0–18:*** *One aid/ear, replaceable every 36 months.*	Deductible then 20%
	Ages 19+: *$400/aid, replaceable every 36 months.*	Charges over $400/aid
Home Health Services *40 combined visits/member/calendar year.*		Deductible then 20%
Home Health Therapies *40 combined visits/member/calendar year.*		Deductible then 20%
Insulin		$10 per 30-day supply
Oral Surgery (Limited)		Deductible then 20%
Radiation Therapy		Deductible then 20%
Therapies *Physical, Speech & Occupational. Policy pays up to 50 combined visits/member/calendar year.*	***Visit 0–5:***	Deductible then 20%
	Visit 6+:	Deductible then 20%
TMJ/TMD *Limited to $1,250/calendar year for Non-Surgical Services.*		See type of service

** Coinsurance does not apply to MOOP*

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