


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	\$0	\$0
Benefit Deductible	\$500	\$1,000
Coinsurance	0%	0%
Maximum Out of Pocket (MOOP)	\$0	\$0

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

Office Visits - CHILDREN (Ages 0–17)	You Pay
Allergy Testing & Injections	\$0
 Behavioral Health or Alcohol/Drug Addiction Services	See rider, if applicable
Chiropractic Care	\$0
Hearing Exam	\$35
Immediate/Urgent Care	\$0
Primary Care	\$0
Specialty Care	\$0
Vision – Optometry	\$35
– Ophthalmology	\$35

Office Visits - ADULTS (Ages 18+)	You Pay
Allergy Testing & Injections	\$0
 Behavioral Health or Alcohol/Drug Addiction Services	See rider, if applicable
Chiropractic Care	\$35
Hearing Exam	\$35
Immediate/Urgent Care	\$35
Primary Care	\$35
Specialty Care	\$35
Vision – Optometry	\$35
– Ophthalmology	\$35

Emergency Services	You Pay
Emergency Room	\$100
Air Ambulance	\$500
Ground Ambulance	\$0

Imaging/Diagnostic Testing

(the "You Pay" amount applies to each scan)

	You Pay
CT/CAT Scans, MRI, MRA & PET Scans	\$0
Diagnostic Testing	\$0
Sleep Study: Home	\$0
Facility	\$0
Virtual Colonoscopy	\$0

Hospital: Inpatient & Outpatient/Ambulatory Surgery and Services

Benefit Deductible: \$500 single/\$1,000 family;

Benefit MOOP: \$500 single/\$1,000 family.

	You Pay
<ul style="list-style-type: none"> ⌘ Inpatient Surgery & Services <ul style="list-style-type: none"> ⌘ Hospice Care ⌘ Behavioral Health or Alcohol/Drug Addiction Services ⌘ Maternity Care & Services ⌘ Skilled Nursing Facility: 100 Days 	Deductible Deductible See rider, if applicable See rider, if applicable Deductible
<ul style="list-style-type: none"> ⌘ Outpatient/Ambulatory Surgery & Services <ul style="list-style-type: none"> ⌘ Injections Colonoscopy ⌘ Hospice Care 	Deductible Deductible Deductible \$0

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 \$750,000/member/lifetime.	See type of service

Miscellaneous Services

	You Pay
⌘ Acupuncture Up to 12 visits/calendar year. Limited to specific diagnoses.	\$35
⌘ 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) Includes diabetic supplies & prosthetics. Coinsurance does not apply to POLICY MOOP. Rentals & purchases over \$5,000 require prior authorization.	20% up to \$2,000/member/calendar year
Hearing Aids* Ages 0–18: One aid/ear, replaceable every 36 months.	20%
Ages 19+: \$400/aid, replaceable every 36 months.	Charges over \$400/aid
⌘ Home Health Services 100 combined visits/member/calendar year.	\$0
⌘ Home Health Therapies 40 combined visits/member/calendar year.	\$0
Infertility* Up to \$2,000 per member/lifetime.	50%
Insulin	\$10 per 30-day supply
⌘ Oral Surgery (Limited)	\$0
Radiation Therapy	\$0
Therapies Physical, Speech & Occupational. Policy pays up to 50 combined visits/member/calendar year.	Visit 0–5: \$0 Visit 6+: \$35
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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