2011 Individual HMO HealthShare Complete
1RHY3551
Co $35, Cos 20, ER $100, $500D, Dx $100

Physicians Plus

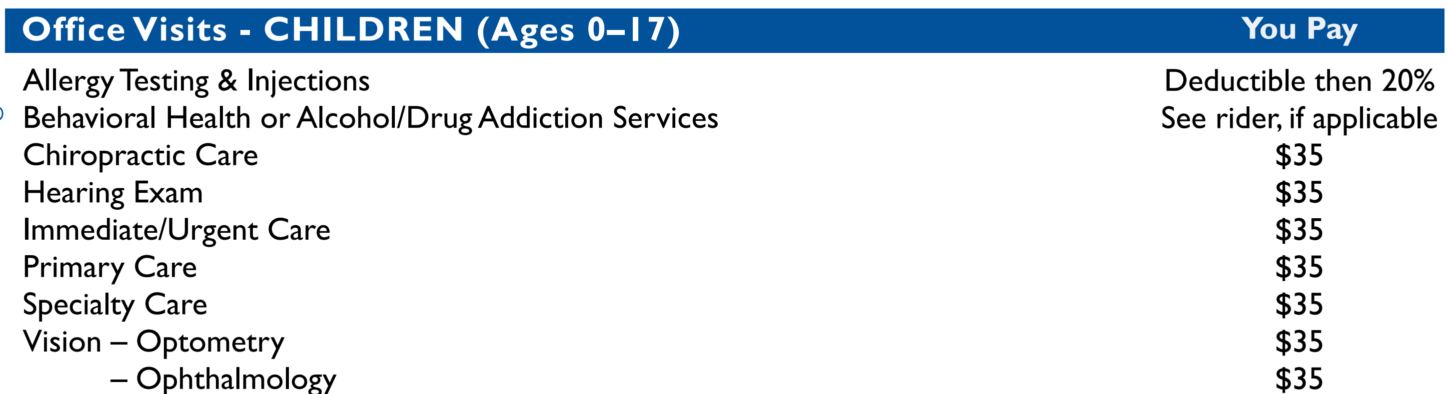
SUMMARY OF BENEFITS

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**.

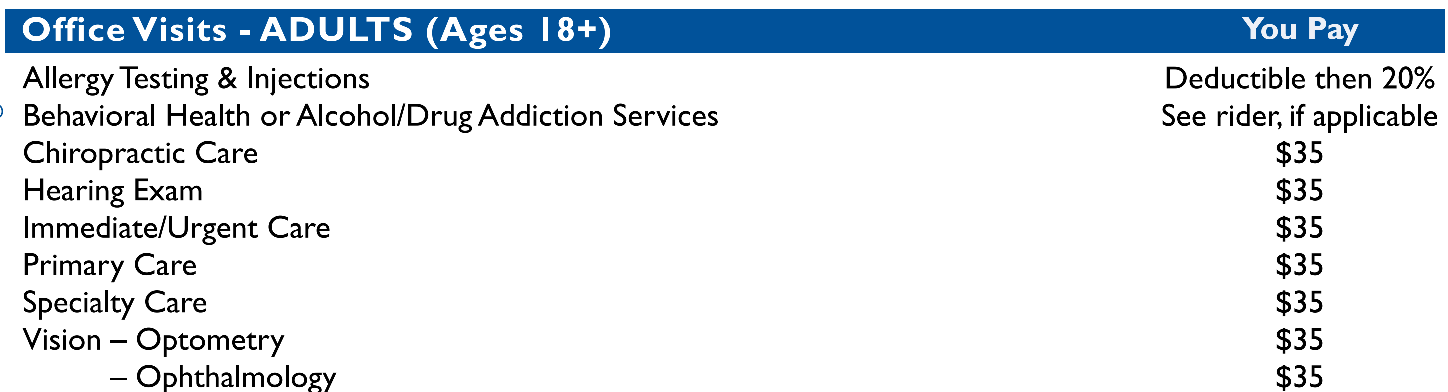
= **REQUIRES PRIOR AUTHORIZATION** *(Approval by Physicians Plus BEFORE services are obtained).*

Policy Limits	Single	Family
Deductible	$500	$1,000
Benefit Deductible	$0	$0
Coinsurance	20%	20%
Maximum Out of Pocket (MOOP)	$1,500	$3,000

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	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



Office Visits - ADULTS (Ages 18+)	You Pay
Allergy Testing & Injections	Deductible then 20%
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	Deductible then 20%
Ground Ambulance	Deductible then 20%

Imaging/Diagnostic Testing *(the "You Pay" amount applies to each scan)*	You Pay
CT/CAT Scans, MRI, MRA & PET Scans	$100
Diagnostic Testing	Deductible then 20%
Sleep Study: Home	Deductible then 20%
Facility	$100
Virtual Colonoscopy	$100

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	See rider, if applicable
⅌ Maternity Care & Services	See rider, if applicable
⅌ 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 $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 *40 combined visits/member/calendar year.*	Deductible then 20%
⅌ Home Health Therapies *40 combined visits/member/calendar year.*	Deductible then 20%
Infertility* *Up to $2,000 per member/lifetime.*	50%
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*

⅌ = **Requires Prior Authorization** *(Approval by Physicians Plus BEFORE services are obtained).*

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