2011 HMO High-Deductible Health Plan (HSA-Compatible)
Single Plan 1RRN5000
HealthShare Plus $5,000D

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).*

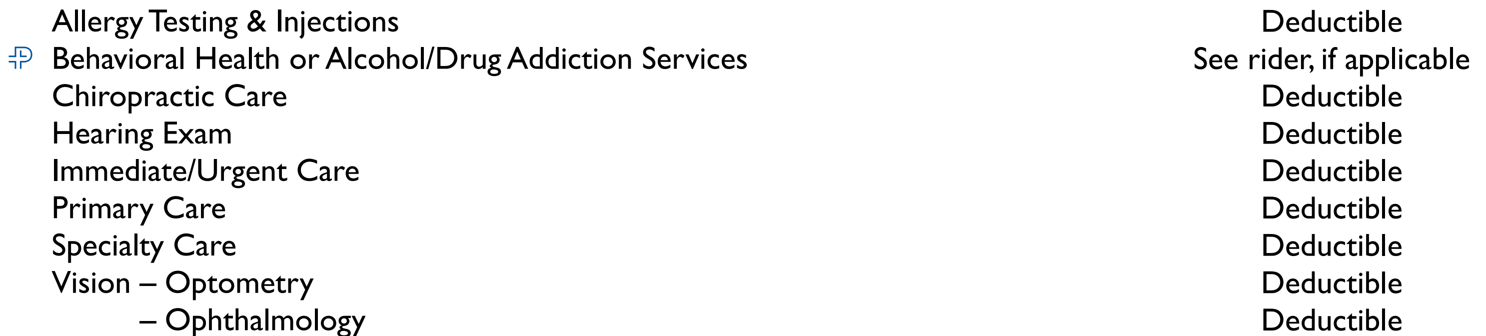
Policy Limits

Deductible	$5,000
Benefit Deductible	$0
Coinsurance	0%
Maximum Out of Pocket (MOOP)	$5,000

Preventive Care & Services

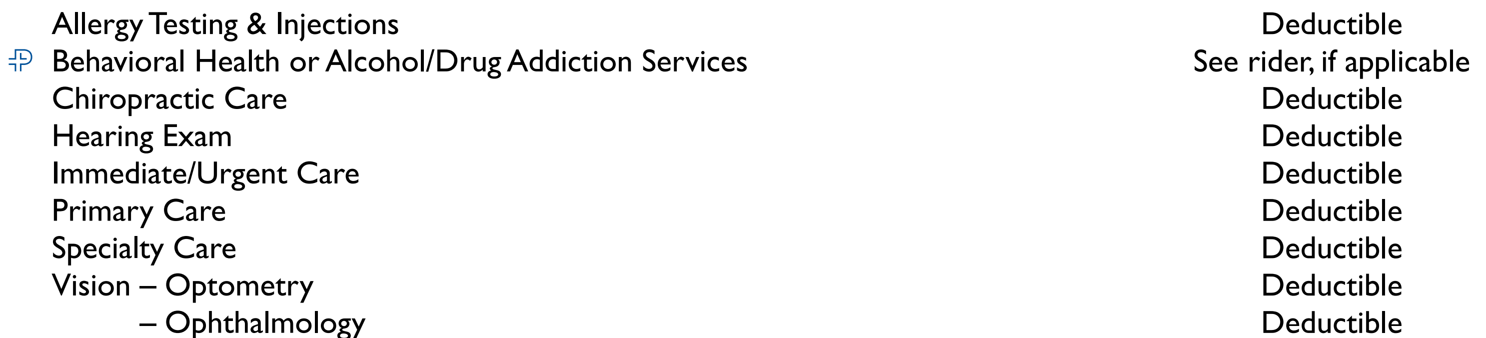
	You Pay
Age, Frequency & Procedure limits may apply. If other services are provided, cost sharing may apply (See your *Medical Certificate of Coverage* at www.pplusic.com for details).	$0

Office Visits - CHILDREN (Ages 0–17)



	You Pay
Allergy Testing & Injections	Deductible
Behavioral Health or Alcohol/Drug Addiction Services	See rider, if applicable
Chiropractic Care	Deductible
Hearing Exam	Deductible
Immediate/Urgent Care	Deductible
Primary Care	Deductible
Specialty Care	Deductible
Vision – Optometry	Deductible
– Ophthalmology	Deductible

Office Visits - ADULTS (Ages 18+)



	You Pay
Allergy Testing & Injections	Deductible
Behavioral Health or Alcohol/Drug Addiction Services	See rider, if applicable
Chiropractic Care	Deductible
Hearing Exam	Deductible
Immediate/Urgent Care	Deductible
Primary Care	Deductible
Specialty Care	Deductible
Vision – Optometry	Deductible
– Ophthalmology	Deductible

Emergency Services

	You Pay
Emergency Room	Deductible
Air Ambulance	Deductible
Ground Ambulance	Deductible

Imaging/Diagnostic Testing

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

Hospital: Inpatient & Outpatient/Ambulatory Surgery and Services

Hospital: Inpatient & Outpatient/Ambulatory Surgery and Services	You Pay
⊕ Inpatient Surgery & Services	Deductible
⊕ Hospice Care	Deductible
⊕ Behavioral Health or Alcohol/Drug Addiction Services	See rider, if applicable
⊕ Maternity Care & Services	See rider, if applicable
⊕ Skilled Nursing Facility: *30 Days*	Deductible
Outpatient/Ambulatory Surgery & Services	Deductible
⊕ Injections	Deductible
Colonoscopy	Deductible
⊕ Hospice Care	Deductible

Transplants

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

Miscellaneous Services	You Pay
⊕ Acupuncture *Up to 12 visits/calendar year. Limited to specific diagnoses.*	Deductible
⊕ 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. Rentals & purchases over $5,000 require prior authorization.*	Deductible
Hearing Aids ***Ages 0–18:*** *One aid/ear, replaceable every 36 months.*	Deductible
Ages 19+: *$400/aid, replaceable every 36 months.*	Deductible and charges over $400/aid
⊕ Home Health Services *40 combined visits/member/calendar year.*	Deductible
⊕ Home Health Therapies *40 combined visits/member/calendar year.*	Deductible
Infertility *Up to $2,000 per member/lifetime.*	Deductible
⊕ Oral Surgery (Limited)	Deductible
Radiation Therapy	Deductible
Therapies *Physical, Speech & Occupational. Policy pays up to 50 combined visits/member/calendar year.* ***Visit 0–5:***	Deductible
Visit 6+:	Deductible
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).*