



## Point of Service (POS) Amendment

This is an Amendment to the Physicians Plus Insurance Corporation (Physicians Plus) Medical Certificate. It is your responsibility to understand your benefits under the policy and the rules you must follow to receive those benefits.

**IMPORTANT NOTICE:** You are strongly encouraged to contact Physicians Plus before scheduling appointments or elective procedures so we can verify the participating or non-participating status of the providers involved in your care. This includes, for example, anesthesiologists, radiologists, pathologists, facilities, clinics and laboratories.

This information may help you select providers and will likely affect the level of copayment, deductible and amount of coinsurance applicable to the care you receive. The information contained in this directory may change during your plan year. Please visit Physicians Plus at [www.HealthyChoicesBigRewards.com](http://www.HealthyChoicesBigRewards.com) or call Member Service at (608) 282-8900 or (800) 545-5015 to learn more about the participating providers in your network and the implications, including financial, of receiving care from nonparticipating providers.

**TYPE OF PLAN:** You have chosen point of service (POS) health insurance coverage through Physicians Plus. This means that you generally have the choice to receive covered treatments, services and supplies from participating providers or non-participating providers. Some treatments, services and supplies that would otherwise be covered cannot be obtained from non-participating providers (TRANSPLANTS see LEVEL OF BENEFITS, below). The provider you choose will determine the level of benefits paid by Physicians Plus (see PROVIDERS, below). All policy exclusions and limitations, including deductibles, coinsurance, copayments and maximums listed in your schedule of benefits, will apply.

**PROVIDERS:** The provider that you choose to provide your care will determine your level of benefits for the treatment, service or supply. Please refer to the current Physicians Plus Provider Directory for a list of participating providers. That list is also available online at [www.pplusic.com](http://www.pplusic.com).

If you choose to use a non-participating provider, your level of benefits will be less and your out of pocket costs will be more. Please refer to your schedule of benefits. Physicians Plus does not have contracts with non-participating providers and therefore has no control over costs, billing and/or the quality of treatments, services and supplies provided by the non-participating providers.

**PRE-EXISTING BENEFIT LIMITS:** This pre-existing condition exclusion applies to services received from non-participating providers only.

Treatment, services and supplies that are received from any non-participating provider and that relate to a preexisting condition are excluded for the first 6 months after the member's enrollment date. The pre-existing condition exclusion does not apply to late enrollees.

The pre-existing condition exclusion DOES NOT apply to:

- 1) Any person who, on the enrollment date, had up to 6 consecutive months of creditable coverage without a significant break in coverage;
- 2) Pregnancy;
- 3) A dependent child who, as of the last day of the 30 day period beginning with his/her date of birth, had creditable coverage;
- 4) An adopted dependent child or dependent child placed for adoption under the age of 18 who, as of the last day of the 30-day period beginning on the date of adoption or placement for adoption, had creditable coverage; or
- 5) Genetic information, in the absence of a diagnosis of an illness related to such information.

If on the enrollment date a member has less than 6 consecutive months of creditable coverage, Physicians Plus will credit the time the member for the period that he/she had consecutive creditable coverage without a significant break in coverage (63 consecutive days).

If a member has a significant break in coverage, any days of creditable coverage that occur before the significant break in coverage will not be counted by Physicians Plus to reduce the pre-existing condition exclusion time period. Waiting periods will not count as a significant break in coverage.

## EMERGENCY MEDICAL CARE:

Emergency Medical Care means medical services provided to a member by a physician or other medical professional licensed by the state in which the care is provided in connection with an emergency medical condition.

As defined by the State Statute 632.85 "Emergency Medical Condition" means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, to lead a prudent layperson who possesses an average knowledge of health and medicine to reasonably conclude that a lack of immediate medical attention will likely result in any of the following:

- (1) Serious jeopardy to the person's health or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child;
- (2) Serious impairment to the person's bodily functions; or
- (3) Serious dysfunction of one or more of the person's body organs or parts.

Emergency medical care does not include routine health, dental or maintenance treatment, services and supplies and/or routine medical exams.

Meriter Hospital and the University of Wisconsin Hospital and Clinics are the participating hospitals in the Madison area. Meriter Hospital is the preferred participating hospital in the Madison Area. ***St. Mary's Hospital Madison is NOT a participating hospital in the Madison area.*** Please see your Provider Directory for a complete list of participating hospitals in your area.

Treatment and services provided in any hospital emergency room must meet the definition of "emergency medical condition"; see above. If services are provided in a hospital emergency room that does not meet the definition of emergency medical care, coverage for the services will be denied and you will be responsible for the payment of all charges. All benefits are determined at the time of claim.

If you require emergency medical care and you are in the Physicians Plus service area, you should go to a participating hospital emergency room for services when you can safely do so. If you cannot safely travel to a participating hospital and there is a closer non-participating hospital, you should go to that closer hospital emergency room for assistance and notify Physicians Plus within 48 hours or as soon as medically possible. If you are admitted to either a participating hospital or non-participating hospital, you and/or the hospital must notify Physicians Plus within 48 hours of the admission or as soon as medically possible.

If you are out of the Physicians Plus service area and require emergency medical care and cannot safely return to the service area to receive that care, you should go to the closest hospital emergency room and notify Physicians Plus within 48 hours or as soon as medically possible. If you are admitted to the non-participating hospital, you and/or the hospital must notify us within 48 hours or as soon as medically possible.

**LEVEL OF BENEFITS:** This plan limits the covered charges of a non-participating provider to the usual and customary charge. The usual and customary charge may be less than the billed amount. Please refer to the DEFINITIONS section of your medical certificate for more information. Any amounts that exceed the usual and customary charge are your responsibility.

Please refer to your medical certificate and schedule of benefits to identify what is otherwise covered and the level of benefits when participating and non-participating providers provide the treatment, service and/or supply.

***NOTE: All transplants require prior authorization. Treatment, services and supplies related to Transplants are NOT COVERED when a provided by a NON-PARTICIPATING PROVIDER.***

**BENEFIT REDUCTION and PRIOR AUTHORIZATION:** It is the member's responsibility to obtain prior authorization. The services listed below require PRIOR AUTHORIZATION when services are obtained from a participating and/or non-participating provider (except Transplants). If the services are NOT PRIOR AUTHORIZED the services will be covered as indicated below.

When the benefit reduction amount is indicated to be "\$500," your benefits will be reduced by \$500 or, if less, the amount of charges for the occurrence. It is the member's responsibility to pay for the reduction amount or, in the case of services indicated with no coverage, the full amount of the charges. A benefit reduction will be applied as non-covered and will be applied in conjunction with any other cost sharing required in the policy. Benefit reductions are not applied to out of pocket or benefit maximum(s).

<b>Prior Authorization is Required for the Services Listed below:</b>		
	<b>Participating Provider</b>	<b>Non Participating Provider</b>
<b>Inpatient Hospital: Admissions Care and Services</b>	<i>No Benefit reduction. Requires prior authorization.</i>	<i>\$500 Benefit Reduction applies when Prior Authorization was required but not obtained.</i>
<b>Hospice Care: Inpatient Admissions and/or Outpatient Care and Services</b>	<i>No Benefit reduction. Requires prior authorization.</i>	<i>\$500 Benefit Reduction applies when Prior Authorization was required but not obtained.</i>
<b>Skilled Nursing: Confinement (Nursing Home) Care and Services</b>	<i>No Benefit reduction. Requires prior authorization.</i>	<i>\$500 Benefit Reduction applies when Prior Authorization was required but not obtained.</i>
<b>Home Health: Care and Services including Therapies</b>	<i>No Benefit reduction. Requires prior authorization.</i>	<i>\$500 Benefit Reduction applies when Prior Authorization was required but not obtained.</i>
<b>All Transplants</b>	<i>No coverage is available with a non-participating provider. Prior Authorization is required when seeking services with a participating provider for benefits and coverage. If prior authorization is not obtained, no coverage will be provided.</i>	
<b>Durable Medical Equipment: Supplies and Prosthesis, purchases over \$5000.00</b>	<i>Prior Authorization is required for purchases over \$5000 with participating and non-participating providers. If prior authorization is not obtained, no coverage will be provided.</i>	
<b>Cochlear Implants</b>	<i>Prior Authorization is required for services with participating and non-participating providers. If prior authorization is not obtained, no coverage will be provided.</i>	
<b>Behavioral Health (BH) and/or Alcohol or Drug Abuse (AODA) Services. For Prior Authorization please contact the Behavioral Health Case Management and Consulting Services at (608) 282-8960 or (800) 683-2300</b>	<ul style="list-style-type: none"> <li>• <i>Prior Authorization is required when seeking services with a participating provider.</i></li> <li>• <i>Prior Authorization is RECOMMENDED to determine medical necessity when seeking services with a non participating provider. If prior authorization is not obtained, coverage will be provided up to the benefit maximum for medically necessary services.</i></li> </ul>	

**OTHER EXCLUSIONS AND LIMITATIONS:** All exclusions and limitations listed in the medical certificate are applicable to this POS policy. The following exclusions are *added* to the GENERAL POLICY EXCLUSIONS AND LIMITATIONS Section of your medical certificate and are NOT COVERED by this policy.

- 1) Transplant treatment, services and related supplies performed and/or provided by non-participating providers.