Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
Physicians Plus Insurance Corporation: 2018 HMO
Medical Code: JHCMGREG Rx: CL3513M6850TM

Coverage Period: Beginning on or after 01/01/2018
Coverage for: Member/Family | **Plan Type:** HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.pplusic.com or call 1-800-545-5015. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-545-5015 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical and Pharmacy: $6,850 Member / $13,700 Family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See http://directory.pplusic.com/ or call 1-800-545-5015 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes. Out-of-network specialists require prior written referral approval from the plan.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge; deductible does not apply	Not Covered	None
	Specialist visit	No charge; deductible does not apply	Not Covered	None
	Preventive care/screening/ Immunization	No charge; deductible does not apply	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge; deductible does not apply	Not Covered	Genetic testing requires Prior Authorization
	Imaging (CT/PET scans, MRIs)	No charge; deductible does not apply	Not Covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.pplusic.com/ members/pharmacy.	Preferred Generic drugs (Tier 1)	$5 copay/ prescription; deductible does not apply	Not Covered	Most medications available for three-month supply; some limited to less depending upon formulary status.
	Preferred Brand and Select Generic drugs (Tier 2)	$15 copay/ prescription; deductible does not apply	Not Covered	Most medications available for three-month supply; some limited to less depending upon formulary status.
	Non-Preferred Brands and Generic drugs (Tier 3)	$35 copay/ prescription; deductible does not apply	Not Covered	Most medications available for three-month supply; some limited to less depending upon formulary status.
	Specialty Brands and Generic drugs (Tier 4)	$15 copay/ prescription; deductible does not apply	Not Covered	May require prior authorization. Requires filling within the Specialty Pharmacy Network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge; deductible does not apply	Not Covered	Coverage is limited to medically necessary services.
	Physician/surgeon fees	No charge; deductible does not apply	Not Covered	Coverage is limited to medically necessary services.
If you need immediate medical attention	Emergency room care	$60 copay per visit; deductible does not apply	$60 copay per visit; deductible does not apply	Coverage is limited to emergency care.

* For more information about limitations and exceptions, see the plan or policy document at www.pplusic.com or call **1-800-545-5015**.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Emergency medical transportation	No charge; deductible does not apply	No charge; deductible does not apply	Coverage is limited to emergency care.
	Urgent care	No charge; deductible does not apply	Not covered	Urgent Care services received outside of the Physicians Plus service area covered per In-Network benefits.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge; deductible does not apply	Not covered	Prior authorization required.
	Physician/surgeon fees	No charge; deductible does not apply	Not covered	Prior authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge; deductible does not apply	Not covered	For provider and benefit information, call (608) 417-4709.
	Inpatient services	No charge; deductible does not apply	Not covered	Prior authorization required.
If you are pregnant	Office visits	No charge; deductible does not apply	Not covered	None
	Childbirth/delivery professional services	No charge; deductible does not apply	Not covered	None
	Childbirth/delivery facility services	No charge; deductible does not apply	Not covered	None
If you need help recovering or have other special health needs	Home health care	No charge; deductible does not apply	Not covered	Coverage is limited to 50 combined visits annually. Prior authorization required.
	Rehabilitation services	No charge; deductible does not apply	Not covered	Policy pays up to 60 habilitation and 60 rehabilitation therapy visits annually. Plan may approve 50 more visits per year. Prior authorization required for home therapy visits.
	Habilitation services	No charge; deductible does not apply	Not covered	
	Skilled nursing care	No charge; deductible does not apply	Not covered	Coverage is limited to 120 days per confinement. Prior authorization required.
	Durable medical equipment	20% coinsurance; deductible does not apply	Not covered	DME coinsurance maximum $500 annually. Prior authorization required for items over $750.
	Hospice services	No charge; deductible does not apply	Not covered	Prior authorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge; deductible does not apply	Not covered	Limited to one routine exam annually. Other exams covered as medically necessary. Contact lens fittings not covered.
	Children's glasses	Basic model: No charge; deductible does not apply	Not covered	One basic model covered annually for children up to age 18.
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Dental Care (Child)
- Glasses, Lenses and Frames - Adult
- Infertility Treatment
- Long Term Care
- Non-Emergency care when traveling outside the United States
- Private Duty Nursing
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic Care
- Hearing Aids (Limited)
- Routine Eye care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.healthcare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Physicians Plus Insurance Corporation at 608-282-8900 or 1-800-545-5015. If coverage is a group plan fully insured, or non-federal governmental group health plan or a church plan you may also contact the Wisconsin Office of the Commissioner of Insurance at 608-266-0103 or 1-800-236-8517 or www.oci.wi.gov. You may also contact U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 608-282-8900 (1-800-545-5015)
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 608-282-8900 (1-800-545-5015)
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 608-282-8900 (1-800-545-5015)
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 608-282-8900 (1-800-545-5015)

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$0**
- **Specialist copay** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$60**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$0**
- **Specialist copay** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$760**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$0**
- **Specialist copay** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **20%**

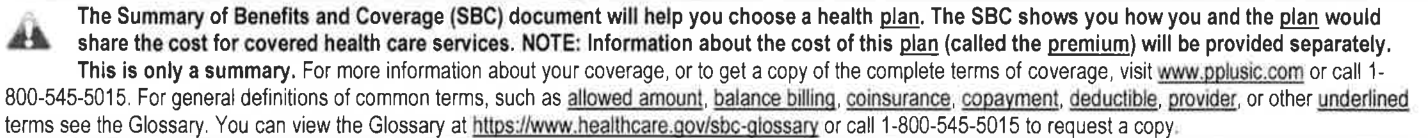
This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$40
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$40**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.



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Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $0 Out-of-Network: $500 Member / $1,000 Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network Medical and Pharmacy: $6,850 Member / $13,700 Family. Out-of-Network: $13,700 Member / $27,400 Family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See http://directory.pplusic.com/ or call 1-800-545-5015 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge; deductible does not apply	20% coinsurance	None
	Specialist visit	No charge; deductible does not apply	20% coinsurance	None
	Preventive care/screening/ Immunization	No charge; deductible does not apply	20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge; deductible does not apply	20% coinsurance	Genetic testing requires Prior Authorization
	Imaging (CT/PET scans, MRIs)	No charge; deductible does not apply	20% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.pplusic.com/ members/pharmacy.	Preferred Generic drugs (Tier 1)	$5 copay/ prescription; deductible does not apply	Not Covered	Most medications available for three-month supply; some limited to less depending upon formulary status.
	Preferred Brand and Select Generic drugs (Tier 2)	$15 copay/ prescription; deductible does not apply	Not Covered	Most medications available for three-month supply; some limited to less depending upon formulary status.
	Non-Preferred Brands and Generic drugs (Tier 3)	$35 copay/ prescription; deductible does not apply	Not Covered	Most medications available for three-month supply; some limited to less depending upon formulary status.
	Specialty Brands and Generic drugs (Tier 4)	$15 copay/ prescription; deductible does not apply	Not Covered	May require prior authorization. Requires filling within the Specialty Pharmacy Network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge; deductible does not apply	20% coinsurance	Coverage is limited to medically necessary services.
	Physician/surgeon fees	No charge; deductible does not apply	20% coinsurance	Coverage is limited to medically necessary services.
If you need immediate medical attention	Emergency room care	$60 copay per visit; deductible does not apply	$60 copay per visit; deductible does not apply	Coverage is limited to emergency care.

* For more information about limitations and exceptions, see the plan or policy document at www.pplusic.com or call **1-800-545-5015**.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Emergency medical transportation	No charge; deductible does not apply	No charge; deductible does not apply	Coverage is limited to emergency care.
	Urgent care	No charge; deductible does not apply	20% coinsurance	Urgent Care services received outside of the Physicians Plus service area covered per In-Network benefits.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge; deductible does not apply	20% coinsurance	Prior authorization required.
	Physician/surgeon fees	No charge; deductible does not apply	20% coinsurance	Prior authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge; deductible does not apply	20% coinsurance	For provider and benefit information, call (608) 417-4709.
	Inpatient services	No charge; deductible does not apply	20% coinsurance	Prior authorization required.
If you are pregnant	Office visits	No charge; deductible does not apply	20% coinsurance	None
	Childbirth/delivery professional services	No charge; deductible does not apply	20% coinsurance	None
	Childbirth/delivery facility services	No charge; deductible does not apply	20% coinsurance	None
If you need help recovering or have other special health needs	Home health care	No charge; deductible does not apply	20% coinsurance	Coverage is limited to 50 combined visits annually. Prior authorization required.
	Rehabilitation services	No charge; deductible does not apply	20% coinsurance	Policy pays up to 60 habilitation and 60 rehabilitation therapy visits annually. Plan may approve 50 more visits per year. Prior authorization required for home therapy visits.
	Habilitation services	No charge; deductible does not apply	20% coinsurance	
	Skilled nursing care	No charge; deductible does not apply	20% coinsurance	Coverage is limited to 120 days per confinement. Prior authorization required.
	Durable medical equipment	20% coinsurance; deductible does not apply	20% coinsurance	In-Network DME coinsurance maximum $500 annually. Out-of-Network DME coinsurance maximum $4,000 annually. Prior authorization required for items over $750.
	Hospice services	No charge; deductible does not apply	20% coinsurance	Prior authorization required.

* For more information about limitations and exceptions, see the plan or policy document at www.pplusic.com or call **1-800-545-5015**.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge; deductible does not apply	20% coinsurance	Limited to one routine exam annually. Other exams covered as medically necessary. Contact lens fittings not covered.
	Children's glasses	Basic model: No charge; deductible does not apply	Not covered	One basic model covered annually for children up to age 18.
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Dental Care (Child)
- Glasses, Lenses and Frames - Adult
- Infertility Treatment
- Long Term Care
- Non-Emergency care when traveling outside the United States
- Private Duty Nursing
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic Care
- Hearing Aids (Limited)
- Routine Eye care

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Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.healthcare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Physicians Plus Insurance Corporation at 608-282-8900 or 1-800-545-5015. If coverage is a group plan fully insured, or non-federal governmental group health plan or a church plan you may also contact the Wisconsin Office of the Commissioner of Insurance at 608-266-0103 or 1-800-236-8517 or www.oci.wi.gov. You may also contact U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 608-282-8900 (1-800-545-5015)

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$0**
- **Specialist copay** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$60**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$0**
- **Specialist copay** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$760**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$0**
- **Specialist copay** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$40
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$40**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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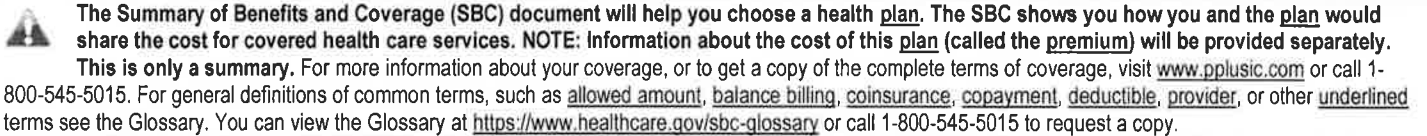
Medical Code: JAPCMGREG Rx: CL3513M6850TM

Coverage Period: Beginning on or after 01/01/2018
Coverage for: Member/Family | **Plan Type:** PPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.pplusic.com or call 1-800-545-5015. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-545-5015 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $0 Out-of-Network: $500 Member / $1,000 Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network Medical and Pharmacy: $6,850 Member / $13,700 Family. Out-of-Network: $13,700 Member / $27,400 Family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See http://directory.pplusic.com/ or call 1-800-545-5015 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge; deductible does not apply	20% coinsurance	None
	Specialist visit	No charge; deductible does not apply	20% coinsurance	None
	Preventive care/screening/ Immunization	No charge; deductible does not apply	20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge; deductible does not apply	20% coinsurance	Genetic testing requires Prior Authorization
	Imaging (CT/PET scans, MRIs)	No charge; deductible does not apply	20% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.pplusic.com/ members/pharmacy.	Preferred Generic drugs (Tier 1)	$5 copay/ prescription; deductible does not apply	Not Covered	Most medications available for three-month supply; some limited to less depending upon formulary status.
	Preferred Brand and Select Generic drugs (Tier 2)	$15 copay/ prescription; deductible does not apply	Not Covered	Most medications available for three-month supply; some limited to less depending upon formulary status.
	Non-Preferred Brands and Generic drugs (Tier 3)	$35 copay/ prescription; deductible does not apply	Not Covered	Most medications available for three-month supply; some limited to less depending upon formulary status.
	Specialty Brands and Generic drugs (Tier 4)	$15 copay/ prescription; deductible does not apply	Not Covered	May require prior authorization. Requires filling within the Specialty Pharmacy Network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge; deductible does not apply	20% coinsurance	Coverage is limited to medically necessary services.
	Physician/surgeon fees	No charge; deductible does not apply	20% coinsurance	Coverage is limited to medically necessary services.
If you need immediate medical attention	Emergency room care	$60 copay per visit; deductible does not apply	$60 copay per visit; deductible does not apply	Coverage is limited to emergency care.

* For more information about limitations and exceptions, see the plan or policy document at www.pplusic.com or call **1-800-545-5015**.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Emergency medical transportation	No charge; deductible does not apply	No charge; deductible does not apply	Coverage is limited to emergency care.
	Urgent care	No charge; deductible does not apply	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge; deductible does not apply	20% coinsurance	Prior authorization required.
	Physician/surgeon fees	No charge; deductible does not apply	20% coinsurance	Prior authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge; deductible does not apply	20% coinsurance	For provider and benefit information, call (608) 417-4709.
	Inpatient services	No charge; deductible does not apply	20% coinsurance	Prior authorization required.
If you are pregnant	Office visits	No charge; deductible does not apply	20% coinsurance	None
	Childbirth/delivery professional services	No charge; deductible does not apply	20% coinsurance	None
	Childbirth/delivery facility services	No charge; deductible does not apply	20% coinsurance	None
If you need help recovering or have other special health needs	Home health care	No charge; deductible does not apply	20% coinsurance	Coverage is limited to 50 combined visits annually. Prior authorization required.
	Rehabilitation services	No charge; deductible does not apply	20% coinsurance	Policy pays up to 60 habilitation and 60 rehabilitation therapy visits annually. Plan may approve 50 more visits per year. Prior authorization required for home therapy visits.
	Habilitation services	No charge; deductible does not apply	20% coinsurance	
	Skilled nursing care	No charge; deductible does not apply	20% coinsurance	Coverage is limited to 120 days per confinement. Prior authorization required.
	Durable medical equipment	20% coinsurance; deductible does not apply	20% coinsurance	In-Network DME coinsurance maximum $500 annually. Out-of-Network DME coinsurance maximum $4,000 annually. Prior authorization required for items over $750.
	Hospice services	No charge; deductible does not apply	20% coinsurance	Prior authorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge; deductible does not apply	20% coinsurance	Limited to one routine exam annually. Other exams covered as medically necessary. Contact lens fittings not covered.
	Children's glasses	Basic model: No charge; deductible does not apply	Not covered	One basic model covered annually for children up to age 18.
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Dental Care (Child)
- Glasses, Lenses and Frames - Adult
- Infertility Treatment
- Long Term Care
- Non-Emergency care when traveling outside the United States
- Private Duty Nursing
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic Care
- Hearing Aids (Limited)
- Routine Eye care

* For more information about limitations and exceptions, see the plan or policy document at www.pplusic.com or call **1-800-545-5015**.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.healthcare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Physicians Plus Insurance Corporation at 608-282-8900 or 1-800-545-5015. If coverage is a group plan fully insured, or non-federal governmental group health plan or a church plan you may also contact the Wisconsin Office of the Commissioner of Insurance at 608-266-0103 or 1-800-236-8517 or www.oci.wi.gov. You may also contact U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 608-282-8900 (1-800-545-5015)
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 608-282-8900 (1-800-545-5015)
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 608-282-8900 (1-800-545-5015)
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 608-282-8900 (1-800-545-5015)

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at www.pplusic.com or call **1-800-545-5015**.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$0**
- **Specialist copay** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$60**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$0**
- **Specialist copay** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$760**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$0**
- **Specialist copay** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$40
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$40**

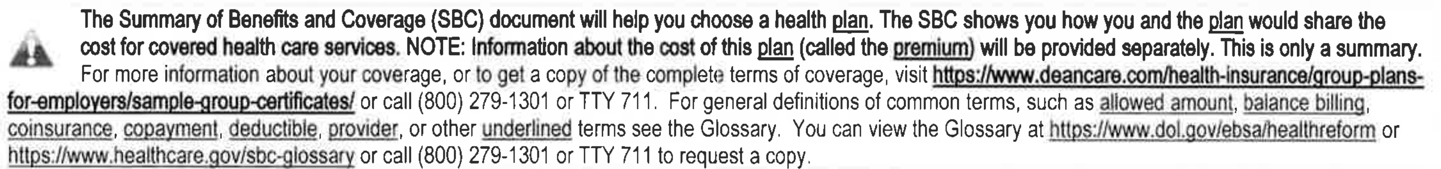
The plan would be responsible for the other costs of these EXAMPLE covered services.

HMO03985 / PHA01707

Coverage Period: 01/01/2018 - 12/31/2018

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

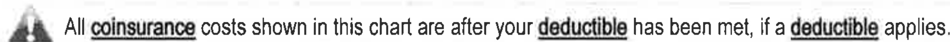
Coverage for: Individual/Family | **Plan Type:** HMO



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit **https://www.deancare.com/health-insurance/group-plans-for-employers/sample-group-certificates/** or call (800) 279-1301 or TTY 711. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.dol.gov/ebsa/healthreform or https://www.healthcare.gov/sbc-glossary or call (800) 279-1301 or TTY 711 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$6600 individual / $13200 family. Included in the out-of-pocket limit is a deductible and coinsurance limit, which for covered services is $0 individual / $0 family.	The out-of-pocket limit is the most you could pay in a year for covered services. The deductible and coinsurance limit does not include copayments. Once the deductible and coinsurance limit is met, the plan pays 100% of allowed amounts, not including copayments; the members pay copayments until they reach the total out-of-pocket limit. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balanced-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See http://www.deancare.com/find-a-doc/ or call 1-800-279-1301 or TTY 711 for a list of network providers	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.



Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$0 copay/visit	Not covered	No coverage for Chiropractic maintenance or long-term therapy.
	Specialist visit	$0 copay/visit	Not covered	Infertility services are covered at 100% up to $2,000 policy life time maximum.
	Preventive care/screening/ immunization	$0 copay/visit	Not covered	Services under the ACA guidelines will be covered as preventive. Services may have a limit on number of visits and/or specific age requirements. For additional information please see the Preventive Services section in your Member Certificate. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance after deductible	Not covered	None
	Imaging (CT/PET scans, MRIs)	$50 copay/visit	Not covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.deancare.com/pharmacy	Preferred generic drugs (Tier 1)	$5 copay / prescription (retail)	Not covered (retail and mail order)	For mail order maintenance prescriptions, a 90-day supply (Tiers 1 & 2) for 2 copays; 90-day supply (Tier 3) for 3 copays.
	Non-preferred generic, Preferred brand drugs (Tier 2)	$15 copay / prescription (retail)	Not covered (retail and mail order)	
	Non-preferred generic, Non-preferred brand drugs (Tier 3)	$35 copay / prescription (retail)	Not covered (retail and mail order)	
	Specialty drugs	50% coinsurance after deductible for infertility drugs/prescription (retail)	Not covered (retail and mail order)	Tobacco cessation products will be covered with a $0 copay if member enrolls in the Quit for Life program. Failure to enroll in Quit for Life will result in not covered Tobacco cessation products.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance after deductible	Not covered	None

* For more information about limitations and exceptions, see the plan or policy document at https://www.deancare.com/health-insurance/group-plans-for-employers/sample-group-certificates/.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Physician/surgeon fees	0% coinsurance after deductible	Not covered	
If you need immediate medical attention	Emergency room care	$60 copay/visit	$60 copay/visit	Initial emergency services are covered with out-of-network providers. Copay is waived if admitted for observation or inpatient.
	Emergency medical transportation	0% coinsurance after deductible	0% coinsurance after deductible	None
	Urgent care	$0 copay/visit	$0 copay/visit	Initial urgent care services are covered with out-of-network providers.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance after deductible	Not covered	None
	Physician/surgeon fees	0% coinsurance after deductible	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$0 copay/outpatient visit 0% coinsurance after deductible for day treatment services	Not covered	None
	Inpatient services	0% coinsurance after deductible	Not covered	None
If you are pregnant	Office visits	$0 copay/visit	Not covered	Home or intentional out of hospital deliveries are not covered. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% coinsurance after deductible	Not covered	
	Childbirth/delivery facility services	0% coinsurance after deductible	Not covered	
If you need help recovering or have other special health needs	Home health care	0% coinsurance after deductible	Not covered	60 visits/contract period.
	Rehabilitation services	Rehabilitation Services: 0% coinsurance after deductible PT/OT/ST: $0 copay/therapy/day	Not covered	Rehabilitation care - 90 days/contract period PT/OT/ST - 60 visits/contract period Services for custodial care are a policy exclusion.

* For more information about limitations and exceptions, see the plan or policy document at https://www.deancare.com/health-insurance/group-plans-for-employers/sample-group-certificates/.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	$0 copay/therapy/day	Not covered	Habilitative therapies - 60 visits/contract period. Services for custodial care are a policy exclusion.
	Skilled nursing care	0% coinsurance after deductible	Not covered	30 days/confinement.
	Durable medical equipment	20% coinsurance up to $2,000 limit	Not covered	Durable medical equipment coinsurance is not subject to the contract period out of pocket maximum.
	Hospice services	0% coinsurance after deductible	Not covered	None
If your child needs dental or eye care	Children's eye exam	$0 copay/visit	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic services including surgery
- Dental care (Adult)
- Glasses
- Long-term care
- Non-emergency care when travelling outside the U.S.
- Private-duty nursing
- Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric Surgery after written approval and completion of Weight Management program.
- Chiropractic care
- Hearing aids
- Infertility treatment
- Routine eye care
- Weight Loss Programs as part of our Comprehensive Weight Management Program

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Wisconsin Office of the Commissioner of Insurance at (800) 236-8517 or http://oci.wi.gov/ or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al: (800) 279-1301 or TTY 711.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa: (800) 279-1301 or TTY 711.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码: (800) 279-1301 or TTY 711.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne': (800) 279-1301 or TTY 711.

——To see examples of how this plan might cover costs for a sample medical situation, see the next section.——

* For more information about limitations and exceptions, see the plan or policy document at https://www.deancare.com/health-insurance/group-plans-for-employers/sample-group-certificates/.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$0**
Specialist copayment	**$0**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$20
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$80**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$0**
Specialist copayment	**$0**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$420**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$0**
Specialist copayment	**$0**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)s*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,900

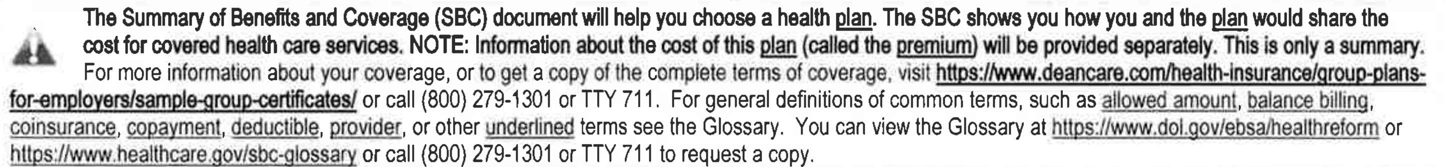
In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$0**

The plan would be responsible for the other costs of these EXAMPLE covered services.

POS03334 / PHA01708 | Coverage Period: 01/01/2018 - 12/31/2018

Summary of Benefits and Coverage: What this Plan Covers & What it Costs | **Coverage for:** Individual/Family | **Plan Type:** POS



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit **https://www.deancare.com/health-insurance/group-plans-for-employers/sample-group-certificates/** or call (800) 279-1301 or TTY 711. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.dol.gov/ebsa/healthreform or https://www.healthcare.gov/sbc-glossary or call (800) 279-1301 or TTY 711 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0/individual network $0/family network $250/individual out-of-network $500/family out-of-network	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $6600 individual / $13200 family; for out-of-network providers $13200 individual / $26400 family. Included in the out-of-pocket limit for covered network services is a deductible and coinsurance limit, which for covered network services is $0 individual / $0 family. There is a deductible and coinsurance limit for covered out-of-network services, which is $750 individual / $1500 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balanced-billing charges, penalties for failure to obtain pre-authorization, and	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

	health care this plan doesn't cover.	
Will you pay less if you use a network provider?	Yes. See http://www.deancare.com/find-a-doc/ or call 1-800-279-1301 or TTY 711 for a list of network providers	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$0 copay/visit	20% coinsurance after deductible	No coverage for Chiropractic maintenance or long-term therapy.
	Specialist visit	$0 copay/visit	20% coinsurance after deductible	Infertility services are covered at 100% up to $2,000 policy life time maximum.
	Preventive care/screening/ immunization	$0 copay/visit	20% coinsurance after deductible	Services under the ACA guidelines will be covered as preventive. Services may have a limit on number of visits and/or specific age requirements. For additional information please see the Preventive Services section in your Member Certificate. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance after deductible	20% coinsurance after deductible	Certain covered diagnostic tests and/or imaging may require written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Imaging (CT/PET scans, MRIs)	$50 copay/visit	20% coinsurance after deductible	

* For more information about limitations and exceptions, see the plan or policy document at https://www.deancare.com/health-insurance/group-plans-for-employers/sample-group-certificates/.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.deancare.com/pharmacy	Preferred generic drugs (Tier 1)	$5 copay / prescription (retail)	50% coinsurance / prescription (retail)	For mail order maintenance prescriptions, a 90-day supply (Tiers 1 & 2) for 2 copays; 90-day supply (Tier 3) for 3 copays.
	Non-preferred generic, Preferred brand drugs (Tier 2)	$15 copay / prescription (retail)	50% coinsurance / prescription (retail)	
	Non-preferred generic, Non-preferred brand drugs (Tier 3)	$35 copay / prescription (retail)	Not covered (retail and mail order)	
	Specialty drugs	50% coinsurance after deductible for infertility drugs/prescription (retail)	Not covered (retail and mail order)	Tobacco cessation products will be covered with a $0 copay if member enrolls in the Quit for Life program. Failure to enroll in Quit for Life will result in not covered Tobacco cessation products.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance after deductible	20% coinsurance after deductible	Outpatient hospital services require a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Physician/surgeon fees	0% coinsurance after deductible	20% coinsurance after deductible	
If you need immediate medical attention	Emergency room care	$60 copay/visit	$60 copay/visit	Copay is waived if admitted for observation or inpatient.
	Emergency medical transportation	0% coinsurance after deductible	0% coinsurance after in-network deductible	None
	Urgent care	$0 copay/visit	$0 copay/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance after deductible	20% coinsurance after deductible	Inpatient hospital services require a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Physician/surgeon fees	0% coinsurance after deductible	20% coinsurance after deductible	

* For more information about limitations and exceptions, see the plan or policy document at https://www.deancare.com/health-insurance/group-plans-for-employers/sample-group-certificates/.

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	 Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$0 copay/outpatient visit 0% coinsurance after deductible for day treatment services	20% coinsurance after deductible	Outpatient mental health services require a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Inpatient services	0% coinsurance after deductible	20% coinsurance after deductible	Inpatient mental health services require a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
If you are pregnant	Office visits	$0 copay/visit	20% coinsurance after deductible	Home or intentional out of hospital deliveries are not covered. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% coinsurance after deductible	20% coinsurance after deductible	
	Childbirth/delivery facility services	0% coinsurance after deductible	20% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	0% coinsurance after deductible	20% coinsurance after deductible	60 visits/contract period. Services for home health require a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Rehabilitation services	Rehabilitation Services: 0% coinsurance after deductible PT/OT/ST: $0 copay/therapy/day	20% coinsurance after deductible	Rehabilitation care - 90 days/contract period PT/OT/ST - 60 visits/contract period Services for custodial care are a policy exclusion. Services for rehabilitation care and PT/OT/ST require a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				occurrence.
	Habilitation services	$0 copay/therapy/day	20% coinsurance after deductible	Habilitative therapies - 60 visits/contract period. Services for custodial care are a policy exclusion. Habilitation services require written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Skilled nursing care	0% coinsurance after deductible	20% coinsurance after deductible	30 days/confinement. Services for skilled nursing require a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Durable medical equipment	20% coinsurance up to $2,000 limit	20% coinsurance after deductible	Durable medical equipment over $500 requires a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence. Durable medical equipment coinsurance is not subject to the contract period out of pocket maximum.
	Hospice services	0% coinsurance after deductible	20% coinsurance after deductible	Services for hospice require a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
If your child needs dental or eye care	Children's eye exam	$0 copay/visit	20% coinsurance after deductible	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic services including surgery
- Dental care (Adult)
- Glasses
- Long-term care
- Non-emergency care when travelling outside the U.S.
- Private-duty nursing
- Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric Surgery after written approval and completion of Weight Management program.
- Chiropractic care
- Hearing aids
- Infertility treatment
- Routine eye care
- Weight Loss Programs as part of our Comprehensive Weight Management Program

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Wisconsin Office of the Commissioner of Insurance at (800) 236-8517 or http://oci.wi.gov/ or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes.**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al: (800) 279-1301 or TTY 711.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa: (800) 279-1301 or TTY 711.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码: (800) 279-1301 or TTY 711.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne': (800) 279-1301 or TTY 711.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at https://www.deancare.com/health-insurance/group-plans-for-employers/sample-group-certificates/.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$20
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$80**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$420**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)s*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,900

In this example, Mia would pay:

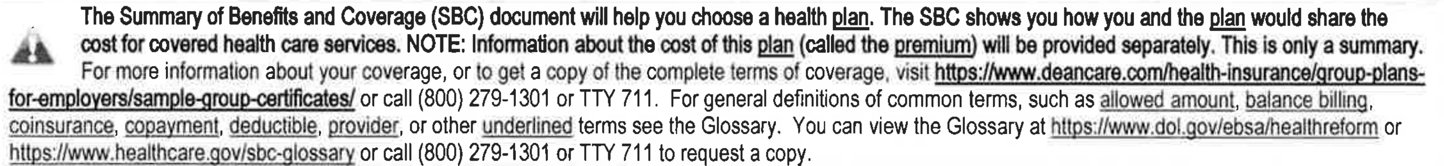
Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$0**

The plan would be responsible for the other costs of these EXAMPLE covered services.

PPO02959 / PHA01708

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2018 - 12/31/2018
Coverage for: Individual/Family | **Plan Type:** PPO



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Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0/individual network $0/family network $250/individual out-of-network $500/family out-of-network	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $6600 individual / $13200 family; for out-of-network providers $13200 individual / $26400 family. Included in the out-of-pocket limit for covered network services is a deductible and coinsurance limit, which for covered network services is $0 individual / $0 family. There is a deductible and coinsurance limit for covered out-of-network services, which is $750 individual / $1500 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balanced-billing charges, penalties for failure to obtain pre-authorization, and	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

	health care this plan doesn't cover.	
Will you pay less if you use a network provider?	Yes. See http://www.deancare.com/find-a-doc/ or call 1-800-279-1301 or TTY 711 for a list of network providers	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$0 copay/visit	20% coinsurance after deductible	No coverage for Chiropractic maintenance or long-term therapy.
	Specialist visit	$0 copay/visit	20% coinsurance after deductible	Infertility services are covered at 100% up to $2,000 policy life time maximum.
	Preventive care/screening/ immunization	$0 copay/visit	20% coinsurance after deductible	Services under the ACA guidelines will be covered as preventive. Services may have a limit on number of visits and/or specific age requirements. For additional information please see the Preventive Services section in your Member Certificate. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance after deductible	20% coinsurance after deductible	Certain covered diagnostic tests and/or imaging may require written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Imaging (CT/PET scans, MRIs)	$50 copay/visit	20% coinsurance after deductible	

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.deancare.com/pharmacy	Preferred generic drugs (Tier 1)	$5 copay / prescription (retail)	50% coinsurance / prescription (retail)	For mail order maintenance prescriptions, a 90-day supply (Tiers 1 & 2) for 2 copays; 90-day supply (Tier 3) for 3 copays.
	Non-preferred generic, Preferred brand drugs (Tier 2)	$15 copay / prescription (retail)	50% coinsurance / prescription (retail)	
	Non-preferred generic, Non-preferred brand drugs (Tier 3)	$35 copay / prescription (retail)	Not covered (retail and mail order)	
	Specialty drugs	50% coinsurance after deductible for infertility drugs/prescription (retail)	Not covered (retail and mail order)	Tobacco cessation products will be covered with a $0 copay if member enrolls in the Quit for Life program. Failure to enroll in Quit for Life will result in not covered Tobacco cessation products.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance after deductible	20% coinsurance after deductible	Outpatient hospital services require a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Physician/surgeon fees	0% coinsurance after deductible	20% coinsurance after deductible	
If you need immediate medical attention	Emergency room care	$60 copay/visit	$60 copay/visit	Copay is waived if admitted for observation or inpatient.
	Emergency medical transportation	0% coinsurance after deductible	0% coinsurance after in-network deductible	None
	Urgent care	$0 copay/visit	$0 copay/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance after deductible	20% coinsurance after deductible	Inpatient hospital services require a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Physician/surgeon fees	0% coinsurance after deductible	20% coinsurance after deductible	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$0 copay/outpatient visit 0% coinsurance after deductible for day treatment services	20% coinsurance after deductible	Outpatient mental health services require a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Inpatient services	0% coinsurance after deductible	20% coinsurance after deductible	Inpatient mental health services require a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
If you are pregnant	Office visits	$0 copay/visit	20% coinsurance after deductible	Home or intentional out of hospital deliveries are not covered. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% coinsurance after deductible	20% coinsurance after deductible	
	Childbirth/delivery facility services	0% coinsurance after deductible	20% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	0% coinsurance after deductible	20% coinsurance after deductible	60 visits/contract period. Services for home health require a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Rehabilitation services	Rehabilitation Services: 0% coinsurance after deductible PT/OT/ST: $0 copay/therapy/day	20% coinsurance after deductible	Rehabilitation care - 90 days/contract period PT/OT/ST - 60 visits/contract period Services for custodial care are a policy exclusion. Services for rehabilitation care and PT/OT/ST require a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
				occurrence.
	Habilitation services	$0 copay/therapy/day	20% coinsurance after deductible	Habilitative therapies - 60 visits/contract period. Services for custodial care are a policy exclusion. Habilitation services require written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Skilled nursing care	0% coinsurance after deductible	20% coinsurance after deductible	30 days/confinement. Services for skilled nursing require a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Durable medical equipment	20% coinsurance up to $2,000 limit	20% coinsurance after deductible	Durable medical equipment over $500 requires a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence. Durable medical equipment coinsurance is not subject to the contract period out of pocket maximum.
	Hospice services	0% coinsurance after deductible	20% coinsurance after deductible	Services for hospice require a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
If your child needs dental or eye care	Children's eye exam	$0 copay/visit	20% coinsurance after deductible	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

* For more information about limitations and exceptions, see the plan or policy document at https://www.deancare.com/health-insurance/group-plans-for-employers/sample-group-certificates/.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric Surgery
- Cosmetic services including surgery
- Dental care (Adult)
- Glasses
- Long-term care
- Non-emergency care when travelling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Chiropractic care
- Hearing aids
- Infertility treatment
- Routine eye care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Wisconsin Office of the Commissioner of Insurance at (800) 236-8517 or http://oci.wi.gov/ or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

* For more information about limitations and exceptions, see the plan or policy document at https://www.deancare.com/health-insurance/group-plans-for-employers/sample-group-certificates/.

Spanish (Español): Para obtener asistencia en Español, llame al: (800) 279-1301 or TTY 711.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa: (800) 279-1301 or TTY 711.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码: (800) 279-1301 or TTY 711.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne': (800) 279-1301 or TTY 711.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$0**
Specialist copayment	**$0**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$20
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$80**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$0**
Specialist copayment	**$0**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$420**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$0**
Specialist copayment	**$0**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)s*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$0**

The plan would be responsible for the other costs of these EXAMPLE covered services.