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?	$2,000 Member / $4,000 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?	Yes. In-network preventive care services, emergency room visits, and pharmacy services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet 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?	In-Network Medical: $4,850 Member / $9,700 Family. Pharmacy: $1,500 Member / $3,000 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 after deductible	Not Covered	None
	Specialist visit	No charge after deductible	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 after deductible	Not Covered	Genetic testing requires Prior Authorization
	Imaging (CT/PET scans, MRIs)	No charge after deductible	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)	$10 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)	$20 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)	$30 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)	$20 copay/ prescription; deductible does not apply	Not Covered	May require prior authorization and filling within the Specialty Pharmacy Network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	Not Covered	Coverage is limited to medically necessary services.
	Physician/surgeon fees	No charge after deductible	Not Covered	Coverage is limited to medically necessary services.

* 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 you need immediate medical attention	Emergency room care	$100 copay; deductible does not apply	$100 copay; deductible does not apply	Coverage is limited to emergency care. Copayment waived if admitted as a hospital inpatient.
	Emergency medical transportation	No charge after in-network deductible	No charge after in-network deductible	Coverage is limited to emergency care.
	Urgent care	No charge after deductible	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 after deductible	Not covered	Prior authorization required.
	Physician/surgeon fees	No charge after deductible	Not covered	Prior authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge after deductible	Not covered	For provider and benefit information, call (608) 417-4709.
	Inpatient services	No charge after deductible	Not covered	Prior authorization required.
If you are pregnant	Office visits	No charge after deductible	Not covered	None
	Childbirth/delivery professional services	No charge after deductible	Not covered	Prior authorization required.
	Childbirth/delivery facility services	No charge after deductible	Not covered	Prior authorization required.
If you need help recovering or have other special health needs	Home health care	No charge after deductible	Not covered	Coverage is limited to 60 combined visits annually. Prior authorization required.
	Rehabilitation services	No charge after deductible	Not covered	Policy pays up to 50 combined habilitation and rehabilitation therapy visits annually. Prior authorization required for home therapy visits.
	Habilitation services	No charge after deductible	Not covered	
	Skilled nursing care	No charge after deductible	Not covered	Coverage is limited to 30 days annually. Prior authorization required.
	Durable medical equipment	No charge after deductible	Not covered	Prior authorization required for items over $750.

* 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)	
	Hospice services	No charge after deductible	Not covered	Prior authorization required.
If your child needs dental or eye care	Children's eye exam	No charge after deductible	Not covered	Limited to one routine exam annually. Other exams covered as medically necessary.
	Children's glasses	Basic model: No Charge (up to age 18)	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.)

- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Dental Care (Child)
- Glasses, Lenses and Frames - Adult
- 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.)

- Acupuncture (Limited)
- Chiropractic Care
- Hearing Aids (Limited)
- Infertility (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.

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	$2,000
■ Specialist copay	$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	$2,000
Copayments	$80
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,140**

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

■ The plan's overall deductible	$2,000
■ Specialist copay	$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	$2,000
Copayments	$380
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,440**

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

■ The plan's overall deductible	$2,000
■ Specialist copay	$0
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

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	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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

Physicians Plus

SUMMARY OF BENEFITS

Plan Name: 2017 HMO **Medical Plan:** HHPYNTHDAC
Certificate: 2017 Group HMO ACA **Pharmacy Plan:** PC74HBDF2CASB

Important: All Items with an asterisk (*) require prior authorization from Physicians Plus for coverage.
Questions? Call Member Services at (608) 282-8900 or (800) 545-5015

Benefit Overview	In-Network Providers, You Pay		Notes
	Per Member	**Per Family**	
Medical Deductible	$2,000	$4,000	
Medical Coinsurance	0%	0%	Benefits with different coinsurance noted below
Medical Maximum Out-of-Pocket	$4,850	$9,700	Includes Medical Deductible, Medical Copays and Medical Coinsurance
Pharmacy Maximum Out-of-Pocket	$1,500	$3,000	Includes Pharmacy Copays and Pharmacy Coinsurance
Overall Maximum Out-of-Pocket (MOOP)	$6,350	$12,700	Includes Medical and Pharmacy Deductible, Copays and Coinsurance
Office Visits	**In-Network Providers, You Pay**		**Notes**
Preventive	$0		Only for preventive services defined by Health Care Reform
Office Visit, Primary Care	Deductible		Includes PCP, Chiropractic and OB/GYN visits
Office Visit, Specialty Care	Deductible		
Immediate/Urgent Care	Deductible		
Behavioral Health/Alcohol and Other Drug Abuse (BH/AODA)	Deductible		For provider and benefit information, call Behavioral Health Management at (608) 417-4709
Hearing/Vision Exam, Primary Care	Deductible		Examples: PCP hearing exam/Optometry
Hearing/Vision Exam, Specialty Care	Deductible		Examples: Audiology, ENT/Ophthalmology
*Acupuncture	Deductible (Not covered for children)		Coverage is limited to 12 visits per policy year
Other Medical Services	**In-Network Providers, You Pay**		**Notes**
Office Surgery	Deductible		
Diagnostic Testing, Labs and X-rays	Deductible		*Genetic Testing requires prior authorization
Allergy Testing and Injections	Deductible		
High-Tech Radiology	Deductible		Includes MRI, MRA, CT/CAT, PET scans and nuclear medicine scans
Sleep Study Home	Deductible		
Sleep Study Facility	Deductible		
*Durable Medical Equipment (DME) and Supplies	Deductible		Items over $750 require prior authorization
Hearing Aids	Deductible		One basic aid per ear every 36 months
Oral Surgery	Deductible		*Orthognathic Surgery requires prior authorization
Therapies	Deductible		Coverage is 50 combined visits per policy year for physical, occupational, speech, habilitative, rehabilitative and home therapy
*Home Health Therapies	See Therapies above		
*Home Health Services	Deductible		Coverage is limited to 60 visits per policy year
Home Hospice	Deductible		
Cardiac Rehabilitation	Deductible		Coverage is limited to 36 visits per cardiac event
Radiation Therapy	Deductible		
Infusion/Injection Therapy	Deductible		*Certain infusions/injections require prior authorization
Infertility	Deductible		Coverage is limited to $2,000 per lifetime

This is a summary of the benefit plan and is not representative of all details of the plan. Please consult the Medical Certificate of Coverage for complete descriptions of the services, supplies, limits, exclusions and other terms and requirements of coverage. The Medical Certificate of Coverage and directory of network providers is available at www.pplusic.com.

Physicians Plus

SUMMARY OF BENEFITS

Plan Name: 2017 HMO **Medical Plan:** HHPYNTHDAC
Certificate: 2017 Group HMO ACA **Pharmacy Plan:** PC74HBDF2CASB

Important: All Items with an asterisk (*) require prior authorization from Physicians Plus for coverage.
Questions? Call Member Services at (608) 282-8900 or (800) 545-5015

Emergency Services	In-Network Providers, You Pay	Notes
Emergency Room (ER)	$100 Copay	Coverage is limited to emergency care
Ambulance, Ground	Deductible	Coverage is limited to emergency care
Ambulance, Air	Deductible	Coverage is limited to emergency care
Inpatient Services	**In-Network Providers, You Pay**	**Notes**
*Surgeries/Hospital Stays/Hospice/ Other Inpatient Services	Deductible	
*Behavioral Health/Alcohol and Other Drug Abuse (BH/AODA)	Deductible	
Labor and Delivery	Deductible	Please notify us within 48 hours
*Skilled Nursing Facility	Deductible	Coverage is limited to 30 days per policy year
*Transplant Services	Cost Depends on Type of Service	
Outpatient & Surgery Center	**In-Network Providers, You Pay**	**Notes**
Surgeries/Procedures/Ancillary/ Facility	Deductible	*Certain surgeries require prior authorization; see Medical Certificate for details
Colonoscopy	Deductible	
Pharmacy Benefits Overview		
Formulary Name	Three Tier Legacy	
Pharmacy Network	Standard Retail with Mail Order and Specialty	
Pharmacy Limits	Prior authorization, quantity limits, step therapy, age restrictions and other limits may apply	

Prescription Drugs, Insulin & Disposable Diabetic Supplies	You pay, for a 30-day supply	You pay, for a 90-day supply	Mail Order Benefit: You pay, for a 90-day supply
ACA Required Preventive Medications	$0	$0	$0
Tier 1: $	$10 Copay	$30 Copay	$25 Copay
Tier 2: $$	$20 Copay	$60 Copay	$50 Copay
Tier 3: $$$	$30 Copay	$90 Copay	$90 Copay
Tier 4: $$$$	$20 Copay	Not Covered	Not Covered
Formulary Insulin, Preferred	$10 Copay	$30 Copay	$25 Copay
Formulary Insulin, Non-Preferred	50% Coinsurance	50% Coinsurance	50% Coinsurance
Formulary Disposable Diabetic Supplies, Preferred	20% Coinsurance	20% Coinsurance	20% Coinsurance

Preferred and Non-Preferred Specialty medications limited to a one-month supply. May require filling within the Physicians Plus Specialty Pharmacy Network. Refer to your Formulary documents for more information.

Select medications, insulin and supplies may require prior authorization (PA) through the PA exception process for coverage and application to the Deductible and MOOP. If a PA is denied or not obtained, the member will be responsible for the full cost of the drug.

For a list of formulary drugs, tier ($) placement, prior authorization requirements and other limitations that may apply, please refer to your formulary at www.pplusic.com. Please contact Pharmacy Services at (608) 260-7803 or (800) 545-5015 with questions or comments.

This is a summary of the benefit plan and is not representative of all details of the plan. Please consult the Medical Certificate of Coverage for complete descriptions of the services, supplies, limits, exclusions and other terms and requirements of coverage. The Medical Certificate of Coverage and directory of network providers is available at www.pplusic.com.

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: $2,000 Member / $4,000 Family. Out-of-Network: $4,000 Member / $8,000 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?	Yes. In-network preventive care services, emergency room visits, and pharmacy services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet 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?	In-Network Medical: $4,850 Member / $5,000 Family. Pharmacy: $1,500 Member / $3,000 Family. Out-of-Network: $8,000 Member / $16,000 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, penalties, 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 after deductible	20% coinsurance	None
	Specialist visit	No charge after deductible	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 after deductible	20% coinsurance	Genetic testing requires Prior Authorization
	Imaging (CT/PET scans, MRIs)	No charge after deductible	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)	$10 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)	$20 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)	$30 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)	$20 copay/ prescription; deductible does not apply	Not Covered	May require prior authorization and filling within the Specialty Pharmacy Network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	20% coinsurance	Coverage is limited to medically necessary services.
	Physician/surgeon fees	No charge after deductible	20% coinsurance	Coverage is limited to medically necessary services.
If you need immediate medical attention	Emergency room care	$100 copay; deductible does not apply	$100 copay; 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 after in-network deductible	No charge after in-network deductible	Coverage is limited to emergency care.
	Urgent care	No charge after deductible	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 after deductible	20% coinsurance	Prior authorization required.
	Physician/surgeon fees	No charge after deductible	20% coinsurance	Prior authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge after deductible	20% coinsurance	For provider and benefit information, call (608) 417-4709.
	Inpatient services	No charge after deductible	20% coinsurance	Prior authorization required.
If you are pregnant	Office visits	No charge after deductible	20% coinsurance	None
	Childbirth/delivery professional services	No charge after deductible	20% coinsurance	Prior authorization required. Home or intentional out of hospital delivers are not covered.
	Childbirth/delivery facility services	No charge after deductible	20% coinsurance	Prior authorization required.
If you need help recovering or have other special health needs	Home health care	No charge after deductible	20% coinsurance	Coverage is limited to 60 combined visits annually. Prior authorization required.
	Rehabilitation services	No charge after deductible	20% coinsurance	Policy pays up to 50 combined habilitation and rehabilitation therapy visits annually. Prior authorization required for home therapy visits.
	Habilitation services	No charge after deductible	20% coinsurance	
	Skilled nursing care	No charge after deductible	20% coinsurance	Coverage is limited to 30 days annually. Prior authorization required.
	Durable medical equipment	No charge after deductible	20% coinsurance	Prior authorization required for items over $750.
	Hospice services	No charge after deductible	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 after deductible	20% coinsurance	Limited to one routine exam annually. Other exams covered as medically necessary.
	Children's glasses	Basic model: No Charge (up to age 18)	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.)

- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Dental Care (Child)
- Glasses, Lenses and Frames - Adult
- Long Term Care
- Non-Emergency care when traveling outside the United States
- 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
- Chiropractic Care
- Hearing Aids (Limited)
- Infertility (Limited)
- Routine Eye care
- Weight Loss Programs

* 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.

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	$2,000
■ Specialist copay	$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	$2,000
Copayments	$80
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,140**

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

■ The plan's overall deductible	$2,000
■ Specialist copay	$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	$2,000
Copayments	$380
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,440**

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

■ The plan's overall deductible	$2,000
■ Specialist copay	$0
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

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	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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

Physicians Plus

SUMMARY OF BENEFITS

Plan Name: 2017 POS **Medical Plan:** HPPYNTHDAC
Certificate: 2017 Group POS ACA **Pharmacy Plan:** PC74HBDF2CASB

Important: All Items with an asterisk (*) require prior authorization from Physicians Plus for coverage.
Questions? Call Member Services at (608) 282-8900 or (800) 545-5015

Benefit Overview	In-Network	Out-of-Network	Notes
	Member/Family	Member/Family	
Medical Deductible (Ded)	$2,000/$4,000	$4,000/$8,000	
Coinsurance (Coins)	0%	20%	Benefits with different coinsurance noted below
Medical Maximum Out-of-Pocket	$4,850/$9,700	$8,000/$16,000	Includes Medical Deductible, Medical Copays and Medical Coinsurance
Pharmacy Maximum Out-of-Pocket	$1,500/$3,000	N/A	Includes Pharmacy Copays and Pharmacy Coinsurance
Overall Maximum Out-of-Pocket (MOOP)	$6,350/$12,700	N/A	Includes Medical and Pharmacy Deductible, Copays and Coinsurance
Office Visits	**In-Network**	**Out-of-Network**	**Notes**
Preventive	$0	Ded then 20% Coins	Only for preventive services defined by Health Care Reform
Office Visit, Primary Care	Deductible	Ded then 20% Coins	Includes PCP, Chiropractic and OB/GYN visits
Office Visit, Specialty Care	Deductible	Ded then 20% Coins	
Immediate/Urgent Care	Deductible	Ded then 20% Coins	Urgent Care services received outside of the Physicians Plus service area covered per In-Network benefits
Behavioral Health/Alcohol and Other Drug Abuse (BH/AODA)	Deductible	Ded then 20% Coins	For provider and benefit information, call Behavioral Health Management at (608) 417-4709
Hearing/Vision Exam, Primary Care	Deductible	Ded then 20% Coins	Examples: PCP hearing exam/Optometry
Hearing/Vision Exam, Specialty Care	Deductible	Ded then 20% Coins	Examples: Audiology, ENT/Ophthalmology
*Acupuncture	Deductible (Not covered for children)	Not Covered	Coverage is limited to 12 visits per policy year
Other Medical Services	**In-Network**	**Out-of-Network**	**Notes**
Office Surgery	Deductible	Ded then 20% Coins	
Diagnostic Testing, Labs and X-rays	Deductible	Ded then 20% Coins	*Genetic Testing requires prior authorization
Allergy Testing and Injections	Deductible	Ded then 20% Coins	
High-Tech Radiology	Deductible	Ded then 20% Coins	Includes MRI, MRA, CT/CAT, PET scans and nuclear medicine scans
Sleep Study Home	Deductible	Ded then 20% Coins	
Sleep Study Facility	Deductible	Ded then 20% Coins	
*Durable Medical Equipment (DME) and Supplies	Deductible	Ded then 20% Coins	Items over $750 require prior authorization
Hearing Aids	Deductible	Ded then 20% Coins	One basic aid per ear every 36 months
Oral Surgery	Deductible	Ded then 20% Coins	*Orthognathic Surgery requires prior authorization
Therapies	Deductible	Ded then 20% Coins	Coverage is 50 combined visits per policy year for physical, occupational, speech, habilitative, rehabilitative and home therapy
*Home Health Therapies	See Therapies above	See Therapies above	
*Home Health Services	Deductible	Ded then 20% Coins	Coverage is limited to 60 visits per policy year
Home Hospice	Deductible	Ded then 20% Coins	
Cardiac Rehabilitation	Deductible	Ded then 20% Coins	Coverage is limited to 36 visits per cardiac event
Radiation Therapy	Deductible	Ded then 20% Coins	
Infusion/Injection Therapy	Deductible	Ded then 20% Coins	*Certain infusions/injections require prior authorization
Infertility	Deductible	Ded then 20% Coins	Coverage is limited to $2,000 per lifetime

This is a summary of the benefit plan and is not representative of all details of the plan. Please consult the Medical Certificate of Coverage for complete descriptions of the services, supplies, limits, exclusions and other terms and requirements of coverage. The Medical Certificate of Coverage and directory of network providers is available at www.pplusic.com.

Physicians Plus

SUMMARY OF BENEFITS

Plan Name: 2017 POS **Medical Plan:** HPPYNTHDAC
Certificate: 2017 Group POS ACA **Pharmacy Plan:** PC74HBDF2CASB

Important: All Items with an asterisk (*) require prior authorization from Physicians Plus for coverage.
Questions? Call Member Services at (608) 282-8900 or (800) 545-5015

Emergency Services	In-Network	Out-of-Network	Notes
Emergency Room (ER)	$100 Copay	Covered at In-Network level	Coverage is limited to emergency care
Ambulance, Ground	Deductible	Covered at In-Network level	Coverage is limited to emergency care
Ambulance, Air	Deductible	Covered at In-Network level	Coverage is limited to emergency care
Inpatient Services	**In-Network**	**Out-of-Network**	**Notes**
*Surgeries/Hospital Stays/Hospice/ Other Inpatient Services	Deductible	Ded then 20% Coins	
*Behavioral Health/Alcohol and Other Drug Abuse (BH/AODA)	Deductible	Ded then 20% Coins	
Labor and Delivery	Deductible	Ded then 20% Coins	Please notify us within 48 hours
*Skilled Nursing Facility	Deductible	Ded then 20% Coins	Coverage is limited to 30 days per policy year
*Transplant Services	Cost Depends on Type of Service	In-Network Benefit Only	
Outpatient & Surgery Center	**In-Network**	**Out-of-Network**	**Notes**
Surgeries/Procedures/Ancillary/ Facility	Deductible	Ded then 20% Coins	*Certain surgeries require prior authorization; see Medical Certificate for details
Colonoscopy	Deductible	Ded then 20% Coins	
Pharmacy Benefits Overview			
Formulary Name	Three Tier Legacy		
Pharmacy Network	Standard Retail with Mail Order and Specialty		
Pharmacy Limits	Prior authorization, quantity limits, step therapy, age restrictions and other limits may apply		

Prescription Drugs, Insulin & Disposable Diabetic Supplies	You pay, for a 30-day supply	You pay, for a 90-day supply	Mail Order Benefit: You pay, for a 90-day supply
ACA Required Preventive Medications	$0	$0	$0
Tier 1: $	$10 Copay	$30 Copay	$25 Copay
Tier 2: $$	$20 Copay	$60 Copay	$50 Copay
Tier 3: $$$	$30 Copay	$90 Copay	$90 Copay
Tier 4: $$$$	$20 Copay	Not Covered	Not Covered
Formulary Insulin, Preferred	$10 Copay	$30 Copay	$25 Copay
Formulary Insulin, Non-Preferred	50% Coinsurance	50% Coinsurance	50% Coinsurance
Formulary Disposable Diabetic Supplies, Preferred	20% Coinsurance	20% Coinsurance	20% Coinsurance

Preferred and Non-Preferred Specialty medications limited to a one-month supply. May require filling within the Physicians Plus Specialty Pharmacy Network. Refer to your Formulary documents for more information.

Select medications, insulin and supplies may require prior authorization (PA) through the PA exception process for coverage and application to the Deductible and MOOP. If a PA is denied or not obtained, the member will be responsible for the full cost of the drug.

For a list of formulary drugs, tier ($) placement, prior authorization requirements and other limitations that may apply, please refer to your formulary at www.pplusic.com. Please contact Pharmacy Services at (608) 260-7803 or (800) 545-5015 with questions or comments.

This is a summary of the benefit plan and is not representative of all details of the plan. Please consult the Medical Certificate of Coverage for complete descriptions of the services, supplies, limits, exclusions and other terms and requirements of coverage. The Medical Certificate of Coverage and directory of network providers is available at www.pplusic.com.