DeanHealthPlan by Medica.: HMO07184/PHA04931

**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, deancare.com/health-insurance/group-plans-for-employers/sample-group-certificates/ or call **(877)-379-7605** (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.healthcare.gov/sbc-glossary or call **(877)-379-7605** (TTY: **711**) to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $100 / individual<br>$200 / 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. Preventive care and preventive prescriptions from network providers 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?** | $250 individual / $500 family.<br>The total out-of-pocket for covered pharmacy services is $500 individual / $1,500 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 deancare.com/find-a-doc/ or call **(877)-379-7605** (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 **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 |
|---|---|---|---|---|
| | | 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 | $5 copay/visit and/or 0% coinsurance after deductible | Not Covered | No coverage for Chiropractic maintenance or long-term therapy. |
| | Specialist visit | $5 copay/visit and/or 0% coinsurance after deductible | Not Covered | 100% up to $2,000 policy lifetime maximum for covered infertility treatments. |
| | Preventive care/screening/ immunization | No charge | Not Covered | Services under the Affordable Care Act (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 are not preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Limited to one physical exam/year, unless additional visits are necessary. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 0% coinsurance after deductible | Not Covered | None |
| | Imaging (CT/PET scans, MRIs) | 0% coinsurance after deductible | Not Covered | |

| 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 deancare.com/members/pharmacy-benefits/member-drug-formulary | Generic (Tier 1) | $10 copay /prescription (retail); Mail order maintenance prescriptions, a 90-day supply for 2 copays. | Not Covered (retail and mail order) | None |
| | Preferred brand drugs (Tier 2) | $20 copay /prescription (retail); Mail order maintenance prescriptions, a 90-day supply for 2 copays. | Not Covered (retail and mail order) | |
| | Non-preferred brand drugs (Tier 3) | $40 copay /prescription (retail); Mail order maintenance prescriptions, a 90-day supply for 3 copays. | Not Covered (retail and mail order) | |
| | Specialty drugs | 30% coinsurance /prescription (retail); Mail order maintenance prescriptions not covered. 50% coinsurance for infertility drugs/prescription (retail) | Not Covered (retail and mail order) | None |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 0% coinsurance after deductible | Not Covered | None |
| | Physician/surgeon fees | 0% coinsurance after deductible | Not Covered | |
| **If you need immediate medical attention** | Emergency room care | $100 copay/visit and/or 0% coinsurance after deductible | $100 copay/visit and/or 0% coinsurance after deductible | Initial emergency services are covered with out-of-network providers. Copay is waived if admitted for observation or inpatient. |
| | Emergency medical transportation | $100 copay/visit | $100 copay | None |

| 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) | |
| | Urgent care | $5 copay/visit and/or 0% coinsurance after deductible | $5 copay/visit and/or 0% coinsurance after deductible | 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 | $5 copay/office visit 0% coinsurance after deductible for other outpatient services | Not Covered | None |
| | Inpatient services | 0% coinsurance after deductible | Not Covered | None |
| **If you are pregnant** | Office visits | 0% coinsurance after deductible | 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 | None |
| | Rehabilitation services | Inpatient Rehabilitation services: 0% coinsurance after deductible; Physical, Occupational and Speech Therapy: 0% coinsurance | Not Covered | Inpatient Rehabilitation Care - 90 days/contract period. Physical, Occupational and Speech Therapy - 50 visits/contract period. Services for custodial care are a policy exclusion. |
| | Habilitation services | 0% coinsurance | Not Covered | Habilitative therapies - 50 visits/contract period. Services for custodial care are a policy exclusion. |

| 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) | |
| | Skilled nursing care | 0% coinsurance after deductible | Not Covered | 120 days/confinement. |
| | Durable medical equipment | 0% coinsurance after deductible | Not Covered | None |
| | Hospice services | 0% coinsurance after deductible | Not Covered | None |
| **If your child needs dental or eye care** | Children's eye exam | $5 copay/visit and/or 0% coinsurance after deductible | 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)
- 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 (Limited to 10 visits per Contract Period)
- Bariatric Surgery after written approval and completion of Weight Management program.
- Chiropractic care
- Hearing aids (Limited to one aid per ear every 36 months)
- Infertility Treatment
- Routine eye care (Adult)
- 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: Dean Health Plan at **(877)-379-7605** (TTY: **711**) or deancare.com; U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa; Wisconsin Office of the Commissioner of Insurance at (800) 236-8517 or https://oci.wi.gov/consinfo.htm; or Healthcare.gov at www.Healthcare.gov or call 1-800-318-2596. 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 on how 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: Dean Health Plan at www.deancare.com or **(877)-379-7605** (TTY: **711**); U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/ebsa/healthreform or the Wisconsin Office of the Commissioner of Insurance at http://oci.wi.gov/ or call (800) 236-8517.

**Does this plan provide Minimum Essential Coverage?** **Yes**.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**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 **(877)-379-7605** (TTY: **711**).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **(877)-379-7605** (TTY: **711**).
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 **(877)-379-7605** (TTY: **711**).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **(877)-379-7605** (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** | **$100** |
| **Specialist copayment** | **$5** |
| **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** | **$12,700** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $100 |
| Copayments | $10 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$170** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$100** |
| **Specialist copayment** | **$5** |
| **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** | **$5,600** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $100 |
| Copayments | $300 |
| 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** | **$100** |
| **Specialist copayment** | **$5** |
| **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** | **$2,800** |

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $10 |
| Copayments | $300 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$310** |

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