




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, [www.deancare.com/health-insurance/group-plans-for-employers/sample-group-certificates/](http://www.deancare.com/health-insurance/group-plans-for-employers/sample-group-certificates/) or call 800-279-1301 (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 [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 800-279-1301 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$100/Individual Network \$200/Family Network \$200/Individual Out-of-Network \$400/Family Out-of-Network	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care services</a> are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> \$250 individual / \$500 family. For <a href="#">out-of-network providers</a> \$500 individual / \$1,000 family  The total <a href="#">out-of-pocket limit</a> for covered pharmacy services is \$500 individual / \$1,500 family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance billing</a> charges, penalties for failure to obtain prior authorization, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="https://www.deancare.com/find-a-doc/">https://www.deancare.com/find-a-doc/</a> or call 800-279-1301 (TTY: 711) for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$5 <a href="#">copay</a> /visit and/or 0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	\$10 <a href="#">copay</a> /visit and/or 0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	No coverage for Chiropractic maintenance or long-term therapy.
	<a href="#">Specialist</a> visit	\$5 <a href="#">copay</a> /visit and/or 0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	\$10 <a href="#">copay</a> /visit and/or 0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Infertility services are covered at 100% up to \$2,000 policy lifetime maximum
	<a href="#">Preventive care/screening/immunization</a>	No charge	\$10 <a href="#">copay</a> /visit and/or 0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	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 <a href="#">preventive services</a> section in your Member Certificate. You may have to pay for services that are not preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Certain covered diagnostic tests and/or imaging may require written prior authorization from us. Failure to obtain prior authorization for services will result in a penalty of 50% of the <a href="#">allowed amount</a> , up to a \$500 maximum per occurrence
	Imaging (CT/PET scans, MRIs)	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.deancare.com/health-insurance/group-plans-for-employers/sample-group-certificates/](http://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)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="https://www.deancare.com/members/pharmacy-benefits">prescription drug coverage</a> is available at <a href="https://www.deancare.com/members/pharmacy-benefits">https://www.deancare.com/members/pharmacy-benefits</a>	Preferred generic drugs (Tier 1)	\$10 <a href="#">copay</a> /prescription (retail); Mail order maintenance prescriptions, a 90-day supply for 2 <a href="#">copays</a> .	50% <a href="#">coinsurance</a> /prescription (retail)	None
	Non-Preferred generic, Preferred brand drugs (Tier 2)	\$20 <a href="#">copay</a> /prescription (retail); Mail order maintenance prescriptions, a 90-day supply for 2 <a href="#">copays</a> .	50% <a href="#">coinsurance</a> /prescription (retail)	
	Non-preferred generic, Non-preferred brand drugs (Tier 3)	\$40 <a href="#">copay</a> /prescription (retail); Mail order maintenance prescriptions, a 90-day supply for 3 <a href="#">copays</a> .	Not Covered (retail and mail order)	
	<a href="#">Specialty drugs</a>	50% <a href="#">coinsurance</a> for infertility drugs / prescription (retail)	Not Covered (retail and mail order)	None
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Outpatient hospital services require a written prior authorization from us. Failure to obtain prior authorization for services will result in a penalty of 50% of the <a href="#">allowed amount</a> , up to a \$500 maximum per occurrence.
	Physician/surgeon fees	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$50 <a href="#">copay</a> /visit and/or 0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	\$50 <a href="#">copay</a> /visit and/or 0% <a href="#">coinsurance</a> after <a href="#">in-network deductible</a>	<a href="#">Copay</a> is waived if admitted for observation or inpatient
	<a href="#">Emergency medical transportation</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	0% <a href="#">coinsurance</a> after <a href="#">in-network deductible</a>	None
	<a href="#">Urgent care</a>	\$5 <a href="#">copay</a> /visit and/or 0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	\$5 <a href="#">copay</a> /visit and/or 0% <a href="#">coinsurance</a> after <a href="#">in-network deductible</a>	None

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.deancare.com/health-insurance/group-plans-for-employers/sample-group-certificates/](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 have a hospital stay	Facility fee (e.g., hospital room)	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Inpatient hospital services require a written prior authorization from us. Failure to obtain prior authorization for services will result in a penalty of 50% of the <a href="#">allowed amount</a> , up to a \$500 maximum per occurrence.
	Physician/surgeon fees	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$5 <a href="#">copay</a> /outpatient visit 0% <a href="#">coinsurance</a> after <a href="#">deductible</a> for day treatment services	\$10 <a href="#">copay</a> /outpatient visit 0% <a href="#">coinsurance</a> after <a href="#">deductible</a> for day treatment services	Outpatient mental health services require a written prior authorization from us. Failure to obtain prior authorization for services will result in a penalty of 50% of the <a href="#">allowed amount</a> , up to a \$500 maximum per occurrence.
	Inpatient services	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Inpatient mental health services require a written prior authorization from us. Failure to obtain prior authorization for services will result in a penalty of 50% of the <a href="#">allowed amount</a> , up to a \$500 maximum per occurrence.
If you are pregnant	Office visits	\$5 <a href="#">copay</a> /visit and/or 0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	\$10 <a href="#">copay</a> /visit and/or 0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Home or intentional out of hospital deliveries are not covered. <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
	Childbirth/delivery facility services	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Services for home health require a written prior authorization from us. Failure to obtain a prior authorization for services will result in a penalty of 50% of the <a href="#">allowed amount</a> , up to a \$500 maximum per occurrence.
	<a href="#">Rehabilitation services</a>	Inpatient <a href="#">Rehabilitation services</a> : 0% <a href="#">coinsurance</a> after <a href="#">deductible</a> ; Physical,	Inpatient <a href="#">Rehabilitation services</a> : 0% <a href="#">coinsurance</a> after <a href="#">deductible</a> ; Physical, Occupational and Speech	Inpatient Rehabilitation Care - 90 days/contract period. Physical, Occupational and Speech Therapy – 50 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 [www.deancare.com/health-insurance/group-plans-for-employers/sample-group-certificates/](http://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)	
		Occupational and Speech Therapy: \$5 <a href="#">copay</a> /therapy/day	Therapy: \$10 <a href="#">copay</a> /therapy/day	Services for rehabilitation care and Physical, Occupational and Speech Therapy require a written prior authorization from us. Failure to obtain prior authorization for services will result in a penalty of 50% of the <a href="#">allowed amount</a> , up to a \$500 maximum per occurrence.
	<a href="#">Habilitation services</a>	\$5 <a href="#">copay</a> /therapy/day and/or 0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	\$10 <a href="#">copay</a> /therapy/day and/or 0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Habilitative therapies - 50 visits/contract period. Services for custodial care are a policy exclusion. <a href="#">Habilitation services</a> require a written prior authorization from us. Failure to obtain prior authorization for services will result in a penalty of 50% of the <a href="#">allowed amount</a> , up to a \$500 maximum per occurrence.
	<a href="#">Skilled nursing care</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	120 days/confinement. Services for skilled nursing require a written prior authorization from us. Failure to obtain prior authorization for services will result in a penalty of 50% of the <a href="#">allowed amount</a> , up to a \$500 maximum per occurrence.
	<a href="#">Durable medical equipment</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Durable medical equipment</a> as stated in our medical policies require a written prior authorization from us. Failure to obtain prior authorization for services will result in a penalty of 50% of the <a href="#">allowed amount</a> , up to a \$500 maximum per occurrence.
	<a href="#">Hospice services</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Services for hospice require a written prior authorization from us. Failure to obtain prior authorization for services will result in a penalty of 50% of the <a href="#">allowed amount</a> , up to a \$500 maximum per occurrence.
<b>If your child needs dental or eye care</b>	Children's eye exam	\$5 <a href="#">copay</a> /visit and/or 0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	\$10 <a href="#">copay</a> /visit and/or 0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None

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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)	
	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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Cosmetic services including surgery</li> <li>• Dental care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when travelling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine foot care</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Acupuncture (Limited to 10 visits per Contract Period)</li> <li>• Bariatric Surgery after written approval and completion of Weight Management program.</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care</li> <li>• Hearing aids (Limited to one aid per ear every 36 months)</li> <li>• Infertility Treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (Adult)</li> <li>• Weight Loss Programs as part of our Comprehensive Weight Management Program.</li> </ul>

**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>; Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://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](http://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: Dean Health Plan at [www.deancare.com](http://www.deancare.com) or 800-279-1301 (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 P.O. Box 7873, Madison, WI 53707-7873, <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 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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### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 800-279-1301 (TTY: 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-279-1301 (TTY: 711).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码800-279-1301 (TTY: 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 800-279-1301 (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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$170</b>

**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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$420</b>

**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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$90
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$190</b>