




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 ?	\$100/individual network \$200/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 \$7150 individual / \$14300 family; for out-of-network providers \$14300 individual / \$28600 family. Included in the out-of-pocket limit for covered network services is a deductible and coinsurance limit, which for covered network services is \$100 individual / \$200 family. There is a deductible and coinsurance limit for covered out-of-network services, which is \$1250 individual / \$2500 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, 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	\$20 copay /visit and/or 0% coinsurance after deductible	20% coinsurance after deductible	No coverage for Chiropractic maintenance or long-term therapy.
	Specialist visit	\$20 copay /visit and/or 0% coinsurance after deductible	20% coinsurance after deductible	Infertility services are covered at 50% of \$4,000 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 us. 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)	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		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/phaarmacy	Generic drugs (Tier 1)	\$6 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 .
	Preferred brand drugs (Tier 2)	\$15 copay / prescription (retail)	50% coinsurance / prescription (retail)	
	Non-preferred brand drugs (Tier 3)	\$30 copay / 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.
	Specialty drugs	50% coinsurance for infertility drugs/prescription (retail)	Not covered (retail and mail order)	
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 us. 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	\$150 copay /visit	\$150 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	\$20 copay /visit	\$20 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 us. 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 mental health, behavioral health, or substance abuse services	Outpatient services	\$20 copay /outpatient visit 0% coinsurance after deductible for day treatment services	20% coinsurance after deductible	None
	Inpatient services	0% coinsurance after deductible	20% coinsurance after deductible	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 allowed amount , up to a \$500 maximum per

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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)	
				occurrence.
If you are pregnant	Office visits	\$20 copay /visit and/or 0% coinsurance after deductible	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 us. 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 us. 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.
	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 us. 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 us. 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.

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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)	
	Durable medical equipment	0% coinsurance after deductible	50% coinsurance after deductible ; not subject to out-of-pocket maximum	Durable medical equipment over \$500 requires a written prior authorization from us. 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.
	Hospice services	0% coinsurance after deductible	20% coinsurance after deductible	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 allowed amount , up to a \$500 maximum per occurrence.
If your child needs dental or eye care	Children's eye exam	\$20 copay /visit and/or 0% coinsurance after deductible	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](#).)

<ul style="list-style-type: none"> • Bariatric Surgery • Cosmetic services including surgery • Dental care (Adult) 	<ul style="list-style-type: none"> • Glasses • Long-term care • Non-emergency care when travelling outside the U.S. 	<ul style="list-style-type: none"> • Private-duty nursing • Routine foot care • Weight Loss Programs
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

<ul style="list-style-type: none"> • Acupuncture • Chiropractic care 	<ul style="list-style-type: none"> • Hearing aids • Infertility treatment 	<ul style="list-style-type: none"> • Routine eye care (Adult)
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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, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/ebsa/healthreform>. Other coverage

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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](#).

————— *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](#) \$100
- [Specialist copayment](#) \$20
- 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$20
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$180

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](#) \$20
- 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$620

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$100
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-rays*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$40
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$140

Language Assistance

English - ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-317-2410 (TTY: 711).

Hmong - LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-317-2410 (TTY: 711).

Tagalog - PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-317-2410 (TTY: 711).

Gujarati - સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-877-317-2410 (TTY: 711).

Hindi - ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-317-2410 (TTY: 711) पर कॉल करें।

Spanish - ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-317-2410 (TTY: 711).

Polish - UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-317-2410 (TTY: 711).

Korean - 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-317-2410 (TTY: 711)번으로 전화해 주십시오.

Russian - ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-317-2410 (телетайп: 711).

French - ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-317-2410 (ATS : 711).

Italian - ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-317-2410 (TTY: 711).

Chinese - 注意: 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-317-2410 (TTY: 711)。

Vietnamese - CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-317-2410 (TTY: 711).

Arabic - ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (رقم هاتف الصم والبكم: 711) 1-877-317-2410

German - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-317-2410 (TTY: 711).

Urdu - خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں 1-877-317-2410 (TTY: 711).

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Non-Discrimination Notice

The Health Plan*:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English such as: qualified interpreters and information written in other languages. If you need these services, contact the Customer Care Center at 1-877-317-2410 (TTY: 711).

The Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, or religion. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, or religion.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, or religion, you can file a grievance with the organization's Civil Rights Coordinator. If you need help filing a grievance, the Civil Rights Coordinator for the Health Plan is available to help you. You can file a grievance in person, by mail, or email at:

Civil Rights Coordinator
1277 Deming Way
Madison, Wisconsin 53717

Phone: 1-608-828-2216 (TTY: 711)
Email: civilrightscoordinator@deancare.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, by mail, or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Phone: 1-800-368-1019 or 1-800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

*Dean Administrative Services; Dean Health Plan; Prevea360 Health Plan; WellFirst Health