



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/](https://www.healthcare.gov/sbc-glossary) 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 ?	\$500 / individual \$1,000 / family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	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 ?	\$1,750 individual / \$3,500 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
		Preferred Provider (You will pay the least)	Network Provider (You will pay more)	Out of Network Provider (You will pay the most)	
<p>If you visit a health care provider's office or clinic</p>	Primary care visit to treat an injury or illness	\$0 copay/visit and/or 0% coinsurance after deductible	\$20 copay/visit and/or 0% coinsurance after deductible	Not Covered	No coverage for Chiropractic maintenance or long-term therapy. Visit deancare.com/valuechoice plan for a list of Tier 1 network providers .
	Specialist visit	\$0 copay/visit and/or 0% coinsurance after deductible	\$40 copay/visit and/or 0% coinsurance after deductible	Not Covered	No coverage for infertility services. Visit deancare.com/valuechoice plan for a list of Tier 1 network providers .
	Preventive care/screening/immunization	No charge	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

Common Medical Event	Services You May Need	What You Will Pay			Out of Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Network Provider (You will pay more)			
If you have a test	Diagnostic test (x-ray, blood work) Imaging (CT/PET scans, MRIs)	0% coinsurance after deductible	0% coinsurance after deductible	Not Covered	None	
		\$10 copay /prescription (retail); Mail order maintenance prescriptions, a 90-day supply for 2 copays .	0% coinsurance after deductible	Not Covered		
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at deancare.com/members/p/harmacy-benefits/member-drug-formulary	Generic (Tier 1)	\$10 copay /prescription (retail); Mail order maintenance prescriptions, a 90-day supply for 2 copays .	\$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)	\$25 copay /prescription (retail); Mail order maintenance prescriptions, a 90-day supply for 2 copays .	\$25 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)	\$50 copay /prescription (retail); Mail order maintenance prescriptions, a 90-day supply for 3 copays .	\$50 copay /prescription (retail); Mail order maintenance prescriptions, a 90-day supply for 3 copays .	Not Covered (retail and mail order)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance /prescription (retail); Mail order maintenance prescriptions not covered.	30% coinsurance /prescription (retail); Mail order maintenance prescriptions not covered.	Not Covered (retail and mail order)	None	
		50% coinsurance for infertility drugs/prescription (retail)	50% coinsurance for infertility drugs/prescription (retail)	Not Covered (retail and mail order)		
		0% coinsurance after deductible	0% coinsurance after deductible	Not Covered	None	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Network Provider (You will pay more)	Out of Network Provider (You will pay the most)	
If you need immediate medical attention	Physician/surgeon fees	0% coinsurance after deductible	0% coinsurance after deductible	Not Covered	
	Emergency room care	\$200 copay /visit and/or 0% coinsurance after deductible	\$200 copay /visit and/or 0% coinsurance after deductible	\$200 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	0% coinsurance after deductible	0% coinsurance after deductible	0% coinsurance after deductible	None
If you have a hospital stay	Urgent care	\$50 copay /visit and/or 0% coinsurance after deductible	\$50 copay /visit and/or 0% coinsurance after deductible	\$100 copay /visit and/or 0% coinsurance after deductible	Initial urgent care services are covered with out-of-network providers . Visit deancare.com/valuechoice plan for a list of Tier 1 network providers .
	Facility fee (e.g., hospital room)	0% coinsurance after deductible	0% coinsurance after deductible	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Physician/surgeon fees	0% coinsurance after deductible	0% coinsurance after deductible	Not Covered	
	Outpatient services	\$0 copay /office visit 0% coinsurance after deductible for other outpatient services	\$0 copay /outpatient office visit 0% coinsurance after deductible for other outpatient services	Not Covered	None
	Inpatient services	0% coinsurance after deductible	0% coinsurance after deductible	Not Covered	None
If you are pregnant	Office visits	0% coinsurance after deductible	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.
	Childbirth/delivery professional services	0% coinsurance after deductible	0% coinsurance after deductible	Not Covered	
	Childbirth/delivery facility services	0% coinsurance after deductible	0% coinsurance after deductible	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Network Provider (You will pay more)	Out of Network Provider (You will pay the most)	
If you need help recovering or have other special health needs					Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Visit deancare.com/valuechoice plan for a list of Tier 1 network providers .
	Home health care	0% coinsurance after deductible	0% coinsurance after deductible	Not Covered	60 visits/contract period.
	Rehabilitation services	Inpatient Rehabilitation services : 0% coinsurance after deductible; Physical, Occupational and Speech Therapy: \$0 copay /therapy/day	Inpatient Rehabilitation services : 0% coinsurance after deductible; Physical, Occupational and Speech Therapy: \$40 copay /therapy/day	Not Covered	Inpatient Rehabilitation Care - 90 days/contract period. Physical, Occupational and Speech Therapy - 60 visits/contract period. Services for custodial care are a policy exclusion. Visit deancare.com/valuechoice plan for a list of Tier 1 network providers .
	Habilitation services	\$0 copay /therapy/day	\$40 copay /therapy/day	Not Covered	Habilitative therapies - 60 visits/contract period. Services for custodial care are a policy exclusion. Visit deancare.com/valuechoice plan for a list of Tier 1 network providers .
	Skilled nursing care	0% coinsurance after deductible	0% coinsurance after deductible	Not Covered	30 days/confinement.
	Durable medical equipment	0% coinsurance after deductible	0% coinsurance after deductible	Not Covered	None
	Hospice services	0% coinsurance after deductible	0% coinsurance after deductible	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Network Provider (You will pay more)	Out of Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	\$0 copay/visit and/or 0% coinsurance after deductible	\$20 copay/visit and/or 0% coinsurance after deductible	Not Covered	Visit deancare.com/valuechoice plan for a list of Tier 1 network providers .
	Children's glasses	Not Covered	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	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)
- Hearing aids (Limited to one aid per ear every 36 months)
- Routine eye care (Adult)
- Weight Loss Programs as part of our Comprehensive Weight Management Program.
- Bariatric Surgery after written approval and completion of Weight Management program.
- Infertility Treatment
- Chiropractic care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 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): Dineke'ngo shika at'ohwol ninisingo, kwijigo 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](#) \$500
- [Specialist copayment](#) \$0
- [Hospital \(facility\) coinsurance](#) 0%
- [Other coinsurance](#) 0%

This EXAMPLE event includes services like:

- [Specialist](#) office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- [Diagnostic tests](#) (*ultrasounds and blood work*)
- [Specialist](#) visit (*anesthesia*)

Total Example Cost \$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$10
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$570

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's overall deductible](#) \$500
- [Specialist copayment](#) \$0
- [Hospital \(facility\) coinsurance](#) 0%
- [Other coinsurance](#) 0%

This EXAMPLE event includes services like:

- [Primary care physician](#) office visits (*including disease education*)
- [Diagnostic tests](#) (*blood work*)
- [Prescription drugs](#)
- [Durable medical equipment](#) (*glucose meter*)

Total Example Cost \$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,020

Mia's Simple Fracture

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

- The [plan's overall deductible](#) \$500
- [Specialist copayment](#) \$0
- [Hospital \(facility\) coinsurance](#) 0%
- [Other coinsurance](#) 0%

This EXAMPLE event includes services like:

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

Total Example Cost \$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$700

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.