




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://sbc.deancare.com/individual> 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 <a href="#">deductible</a> ?	\$5,000/Individual \$10,000/Family	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> ?	\$8,550 individual / \$17,100 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, 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="http://www.deancare.com/find-a-doc/">http://www.deancare.com/find-a-doc/</a> or call 1-800-279-1301 or 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	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	No coverage for Chiropractic maintenance or long-term therapy.
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	No coverage for infertility services. No coverage for acupuncture.
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not Covered	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 <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)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.deancare.com/pharmacy">www.deancare.com/pharmacy</a>	Preferred generic drugs (Tier 1)	\$15 <a href="#">copay</a> / prescription; <a href="#">deductible</a> does not apply (retail) Mail order maintenance prescriptions, a 90-day supply for 2 <a href="#">copays</a> .	Not Covered (retail and mail order)	None
	Non-preferred generic, Preferred brand drugs (Tier 2)	\$50 <a href="#">copay</a> / prescription; <a href="#">deductible</a> does not apply (retail) Mail order maintenance prescriptions, a 90-day supply for 3 <a href="#">copays</a> .	Not Covered (retail and mail order)	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://sbc.deancare.com/individual>.

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)	
	Non-preferred generic, Non-preferred brand drugs (Tier 3)	50% <a href="#">coinsurance</a> / prescription; <a href="#">deductible</a> does not apply (retail) Mail order maintenance prescriptions, a 90-day supply at <a href="#">coinsurance</a> listed above.	Not Covered (retail and mail order)	Infertility drugs not covered (retail and mail order)
	<a href="#">Specialty drugs</a> (Tier 4)	50% <a href="#">coinsurance</a> / prescription; <a href="#">deductible</a> does not apply (retail) Mail order maintenance prescriptions not covered.	Not Covered (retail and mail order)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	None
	Physician/surgeon fees	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$325 <a href="#">copay</a> /visit and/or 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	\$325 <a href="#">copay</a> /visit and/or 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Initial emergency services are covered with <a href="#">out-of-network providers</a> . <a href="#">Copay</a> is waived if admitted for observation or inpatient.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Initial urgent care services are covered with <a href="#">out-of-network providers</a> . You may incur a lower <a href="#">copay</a> at an SSM <a href="#">urgent care</a> clinic versus a hospital based facility.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	None
	Physician/surgeon fees	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	None
	Inpatient services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	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)	
If you are pregnant	Office visits	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	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	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	60 visits/contract period.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	Inpatient Rehabilitation care - 90 days/contract period. Physical, Occupational and Speech Therapy - 20 visits per therapy type/ contract period. Services for custodial care are a policy exclusion.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	Habilitative therapies - 20 visits per therapy type/contract period. Services for custodial care are a policy exclusion.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	30 days/confinement.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	None
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	None
If your child needs dental or eye care	Children's eye exam	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	Exams performed by an ophthalmologist will incur the specialty office visit cost share.
	Children's glasses	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	One pair per contract year.
	Children's dental check-up	Not Covered	Not Covered	This policy does not include pediatric dental services as required under the federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, agent, or the

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://sbc.deancare.com/individual>.

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)	
				Federally Facilitated Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

**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>Abortion (except in cases of rape, incest, or when the life of the mother is endangered)</li> <li>Acupuncture</li> <li>Bariatric Surgery</li> <li>Cosmetic services including surgery</li> </ul>	<ul style="list-style-type: none"> <li>Dental care (adult)</li> <li>Infertility treatment</li> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>Pediatric Dental Care</li> <li>Private-duty nursing</li> <li>Routine eye care (Adult)</li> <li>Routine foot care</li> <li>Weight Loss programs</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>Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids (Limited to one aid per ear every 36 months)</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/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>; Wisconsin Office of the Commissioner of Insurance at (800) 236-8517 or <http://oci.wi.gov/consinfo.htm>; Office of Personnel Management Multi State Plan Program at <https://www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review/>; or Healthcare.gov at [www.Healthcare.gov](http://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](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: 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](#).

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://sbc.deancare.com/individual>.

### Does this plan meet the Minimum Value Standards? Not applicable

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 (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](#) \$5,000
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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>	\$5,000
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$1,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$6,570</b>

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

- The [plan's](#) overall [deductible](#) \$5,000
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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>	\$1,700
<a href="#">Copayments</a>	\$800
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,520</b>

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

- The [plan's](#) overall [deductible](#) \$5,000
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:  
[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-rays*)  
[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>	\$2,400
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,700</b>

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

## 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 1-877-317-2410 (رقم هاتف الصم والبكم: 711).

**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)۔



## 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: [civilrightscordinator@deancare.com](mailto:civilrightscordinator@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 Health Plan; Prevea360 Health Plan; WellFirst Health