



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, sbc.deancare.com/individual or call 877-394-9080 (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 877-394-9080 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$950 / individual \$1,900 / 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 ?	\$3,150 individual / \$6,300 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 877-394-9080 (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; deductible does not apply	Not Covered	No coverage for chiropractic maintenance or long-term therapy.
	Specialist visit	20% coinsurance after deductible	Not Covered	No coverage for infertility services. No coverage for acupuncture.
	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.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	Not Covered	None
	Imaging (CT/PET scans, MRIs)	20% 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	Preferred generic drugs (Tier 1)	\$5 copay / prescription; deductible does not apply (retail) Mail order maintenance prescriptions, a 90-day supply for 2 copays .	Not Covered (retail and mail order)	None
	Non-Preferred generic, Preferred brand drugs (Tier 2)	20% coinsurance after deductible / prescription (retail); Mail order maintenance prescriptions, a 90-day supply at coinsurance listed above.	Not Covered (retail and mail order)	
	Non-preferred generic, Non-preferred brand drugs (Tier 3)	20% coinsurance after deductible / prescription (retail); Mail order maintenance prescriptions, a 90-day supply at coinsurance listed above.	Not Covered (retail and mail order)	
	Specialty drugs (Tier 4)	20% coinsurance after deductible / prescription (retail); Mail order maintenance prescriptions not covered.	Not Covered (retail and mail order)	Infertility drugs not covered (retail and mail order).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	Not Covered	None
	Physician/surgeon fees	20% 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 immediate medical attention	Emergency room care	20% coinsurance after deductible	20% coinsurance after deductible	Initial emergency services are covered with out-of-network providers
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	None
	Urgent care	20% coinsurance after deductible	20% 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)	20% coinsurance after deductible	Not Covered	None
	Physician/surgeon fees	20% coinsurance after deductible	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$5 copay /outpatient visit; deductible does not apply	Not Covered	None
	Inpatient services	20% coinsurance after deductible	Not Covered	None
If you are pregnant	Office visits	20% 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	20% coinsurance after deductible	Not Covered	
	Childbirth/delivery facility services	20% coinsurance after deductible	Not Covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	Not Covered	60 visits/contract period.
	Rehabilitation services	Inpatient Rehabilitation services : 20% coinsurance after deductible ; Physical, Occupational and Speech Therapy: \$5	Not Covered	Inpatient Rehabilitation Care - 60 days/contract period. Physical, Occupational and Speech Therapy - 20 visits per therapy type/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)	
		copay /therapy/day; deductible does not apply		
	Habilitation services	\$5 copay /therapy/day; deductible does not apply	Not Covered	Habilitative therapies - 20 visits per therapy type/contract period. Services for custodial care are a policy exclusion.
	Skilled nursing care	20% coinsurance after deductible	Not Covered	30 days/confinement.
	Durable medical equipment	20% coinsurance after deductible	Not Covered	None
	Hospice services	20% coinsurance after deductible	Not Covered	None
If your child needs dental or eye care	Children's eye exam	\$5 copay /visit; deductible does not apply	Not Covered	Exams performed by an ophthalmologist will incur the specialty office visit cost share.
	Children's glasses	20% coinsurance after deductible	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 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 [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

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|--------------------------------------------------------------------------------------------|-------------------------------------------------------|----------------------------|
| ● Abortion (except in cases of rape, incest, or when the life of the mother is endangered) | ● Dental care (Adult) | ● Private-duty nursing |
| ● Acupuncture | ● Infertility Treatment | ● Routine eye care (Adult) |
| ● Bariatric Surgery | ● Long-term care | ● Routine foot care |
| ● Cosmetic services including surgery | ● Non-emergency care when travelling outside the U.S. | ● Weight Loss Programs |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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|---------------------|-------------------------------------------------------------|
| ● Chiropractic care | ● Hearing aids (Limited to one aid per ear every 36 months) |
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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: Dean Health Plan at 877-394-9080 (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: 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? 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 877-394-9080 (TTY: 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 877-394-9080 (TTY: 711).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 877-394-9080 (TTY: 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 877-394-9080 (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	\$950
■ 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*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$950
Copayments	\$0
Coinsurance	\$2,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,210

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$950
■ 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*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$950
Copayments	\$100
Coinsurance	\$700
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,770

Mia's Simple Fracture

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

■ The plan's overall deductible	\$950
■ 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-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$950
Copayments	\$20
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,270

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

Discrimination is Against the Law

The Health Plan complies with applicable Federal civil rights laws and will not discriminate against any person based on his or her race, color, creed, religion, national origin, sex, gender, gender identity, health status including mental and physical medical conditions, marital status, familial status, status with regard to public assistance, disability, sexual orientation, age, political beliefs, membership or activity in a local commission, or any other classification protected by law. The Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: TTY communication and written information in other formats such as large print, audio, and braille.
- 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 number on the back of your identification card. If you believe that we have failed to provide these services or discriminated in another way on the basis of your race, color, creed, religion, national origin, sex, gender, gender identity, health status including mental and physical medical conditions, marital status, familial status, status with regard to public assistance, disability, sexual orientation, age, political beliefs, membership or activity in a local commission, or any other classification protected by law, you can file a grievance with: Civil Rights Coordinator, Mail Route CP250, PO Box 9310, Minneapolis, MN 55443-9310, 952-992-3422, TTY: 711, civilrightscoordinator@medica.com.

You can file a grievance in person or by mail, fax, or email. You may also contact the Civil Rights Coordinator if you need assistance with filing a complaint. 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> or 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 800-368-1019, TTY: 800-537-7697. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

If you want free help translating this document, call 1-877-317-2410 (TTY: 711).

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Yog koj xav tau kev pab dawb txhais daim ntauv no, hu rau 1-877-317-2410.

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Nếu quý vị muốn giúp dịch tài liệu này miễn phí, gọi 1-877-317-2410.

Sanadnikun kaffaltimaleeakkaisiniifhiikamuyoobarbaadd-an 1-877-317-2410 tiinbilbilaa.

إذا كنت ترغب في مساعدة مجانية لترجمة هذا المستند، فاتصل على الرقم 1-877-317-2410.

Если вы хотите получить бесплатную помощь в переводе этого документа, позвоните по телефону 1-877-317-2410.

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Wenn Sie kostenlose Hilfe zur Übersetzung dieses Dokuments wünschen, rufen Sie 1-877-317-2410 an.

“यदि आप इस दस्तावेज़ का अनुवाद करने में मुफ्त सहायता चाहते हैं, तो 1-877-317-2410 पर कॉल करें।”

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