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?	$0	See the Common Medical Events chart below for your costs for services this plan covers. 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?	$7150 individual / $14300 family. Included in the out-of-pocket limit is a deductible and coinsurance limit, which for covered services is $0 individual / $0 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, 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 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	Not covered	No coverage for Chiropractic maintenance or long-term therapy.
	Specialist visit	$20 copay/visit	Not covered	Infertility services are covered at 50% of $4,000 life time maximum.
	Preventive care/screening/ immunization	$0 copay/visit	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 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	Not covered	None
	Imaging (CT/PET scans, MRIs)	PET: 0% coinsurance after deductible CT/MRI: $0 copay/visit	Not covered	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.deancare.com/pharmacy	Generic drugs (Tier 1)	$6 copay / prescription (retail)	Not covered (retail and mail order)	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)	Not covered (retail and mail order)	
	Non-preferred brand drugs (Tier 3)	$30 copay / prescription (retail)	Not covered (retail and mail order)	
	Specialty drugs	50% coinsurance for infertility drugs/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

* 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)	
				cessation products.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance after deductible	Not covered	None
	Physician/surgeon fees	0% coinsurance after deductible	Not covered	
If you need immediate medical attention	Emergency room care	$150 copay/visit	$150 copay/visit	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	None
	Urgent care	$20 copay/visit	$20 copay/visit	Initial urgent care services are covered with out-of-network providers.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance after deductible	Not covered	None
	Physician/surgeon fees	0% coinsurance after deductible	Not covered	
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	Not covered	None
	Inpatient services	0% coinsurance after deductible	Not covered	None
If you are pregnant	Office visits	$20 copay/visit	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	0% coinsurance after deductible	Not covered	
	Childbirth/delivery facility services	0% coinsurance after deductible	Not covered	
If you need help recovering or have other special health needs	Home health care	0% coinsurance after deductible	Not covered	60 visits/contract period.
	Rehabilitation services	Rehabilitation Services: 0% coinsurance after deductible	Not covered	Rehabilitation care - 90 days/contract period PT/OT/ST - 60 visits/contract period Services for custodial care are a policy

* 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)	
		PT/OT/ST: $0 copay/therapy/day		exclusion.
	Habilitation services	$0 copay/therapy/day	Not covered	Habilitative therapies - 60 visits/contract period. Services for custodial care are a policy exclusion.
	Skilled nursing care	0% coinsurance after deductible	Not covered	30 days/confinement.
	Durable medical equipment	$0 copay	Not covered	None
	Hospice services	0% coinsurance after deductible	Not covered	None
If your child needs dental or eye care	Children's eye exam	$20 copay/visit	Not covered	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.)

- Cosmetic services including surgery
- Dental care (Adult)
- Glasses
- 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
- Bariatric Surgery after written approval and completion of Weight Management program.
- Chiropractic care
- Hearing aids
- Infertility treatment
- Routine eye care (Adult)
- Weight Loss Programs as part of our Comprehensive Weight Management Program

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

* 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/.

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	$0
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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$20
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$80**

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

The plan's overall deductible	$0
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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$520**

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

The plan's overall deductible	$0
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-ray)s*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$40
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$40**

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).

German - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 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).

Albanian - KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-877-317-2410 (TTY: 711).

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

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

Spanish - ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 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）。

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

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).

Pennsylvanian Dutch - Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-877-317-2410 (TTY: 711).

Laotian - ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-877-317-2410 (TTY: 711).

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

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Non-Discrimination Notice:

Dean Health Plan / Prevea360 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 877-317-2410 (TTY: 711)

Dean Health Plan / Prevea360 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. Dean Health Plan / Prevea360 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 Dean Health Plan / Prevea360 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, Civil Rights Coordinator for Dean Health Plan / Prevea360 Health Plan is available to help you. You can file a grievance in person, by mail or email:

Civil Rights Coordinator
1277 Deming Way
Madison, Wisconsin 53717

Phone: 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 hhs.gov/civil-rights/filing-a-complaint/index.html, 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 800-537-7697 (TDD)