Dean Health Plan

SUN PRAIRIE AREA SCHOOLS

Effective Date: 01/01/2019

Product Type: HMO

Plan Code: 47413/

Plan Overview	Plan Providers - You Pay	Non-Plan Providers - You Pay
Deductible	$100 single / $200 family	N/A
Coinsurance	0% coinsurance after deductible	N/A
Office Visit Charge (Primary/Specialist)	$20 copay / $20 copay	Not Covered / Not Covered
Office Visit and Related Services	0% coinsurance after deductible	Not Covered
Preventive Services	$0 copay	Not Covered
Deductible and Coinsurance Limit	$100 single / $200 family	N/A
Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted)	$7150 single / $14300 family	N/A
Prescription Drugs, Insulin & Disposable Diabetic Supplies	Unless otherwise indicated, generic or brand name drugs can be found in any formulary tier)	
Tier 1	$5 copay	Not Covered
Tier 2	$20 copay	Not Covered
Tier 3	$40 copay	Not Covered
Diagnostic Services		
Diagnostic Services	0% coinsurance after deductible	Not Covered
CAT Scans/MRI/MRA	0% coinsurance after deductible	Not Covered
Hospital & Surgical Center		
Inpatient Hospital	0% coinsurance after deductible	Not Covered
Outpatient Hospital	0% coinsurance after deductible	Not Covered
Emergency Services		
Urgent Care	$20 copay and/or 0% coinsurance after deductible	$20 copay and/or 0% coinsurance after deductible
Emergency Room Services (Copay is waived if admitted)	$100 copay and/or 0% coinsurance after deductible	$100 copay and/or 0% coinsurance after deductible
Ambulance	$0 copay	$0 copay
Other Services		
Mental Health Inpatient	$0 copay per admission	Not Covered
Mental Health Day Treatment Programs	$0 copay	Not Covered
Mental Health Outpatient	$20 copay	Not Covered
Durable Medical Equipment	0% coinsurance after deductible	Not Covered
Physical, Speech & Occupational Therapy	$20 copay per therapy type per day	Not Covered
Plan Special Features		

Unless otherwise noted, all benefits are based on a Contract Year
This benefit summary is a highlight of your benefits and should not be relied upon to fully disclose your coverage. Please review your Member Certificate of Coverage for an exact description of the services and supplies that are covered, excluded, or limited and other terms and conditions of coverage. Your Member Certificate is available at www.deancare.com.

Date Prepared: 04/13/18

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.prevea360.com/Quote-Buy-Insurance/Employer-Group-Plans/Sample-group-certificates/ or call (877) 230-7555 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 (877) 230-7555 or TTY 711 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$3000/individual $6000/family	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?	$4000 individual / $8000 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, 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.prevea360.com/About-Prevea360-Health-Plan/Find-a-Prevea360-Provider-Doctor.aspx or call 1-877-230-7555 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% coinsurance after deductible	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	$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)	20% coinsurance after deductible	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	Not covered	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.prevea360.com/pharmacy	Preferred generic drugs (Tier 1)	20% coinsurance after deductible / prescription (retail)	Not covered (retail and mail order)	For mail order maintenance prescriptions, a 90-day supply (Tiers 1 - 3) policy coinsurance after deductible; Tier 4 not covered.
	Non-preferred generic, Preferred brand drugs (Tier 2)	20% coinsurance after deductible / prescription (retail)	Not covered (retail and mail order)	
	Non-preferred generic, Non-preferred brand drugs (Tier 3)	20% coinsurance after deductible / prescription (retail)	Not covered (retail and mail order)	
	Specialty drugs (Tier 4)	20% coinsurance after deductible / 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. Infertility drugs not covered (retail and mail

* For more information about limitations and exceptions, see the plan or policy document at https://www.prevea360.com/Quote-Buy-Insurance/Employer-Group-Plans/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)	
				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	
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. Copay is waived if admitted for observation or inpatient.
	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	20% coinsurance after deductible	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	20% 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 exclusion.
	Habilitation services	20% coinsurance after	Not covered	Habilitative therapies - 60 visits/contract

* For more information about limitations and exceptions, see the plan or policy document at https://www.prevea360.com/Quote-Buy-Insurance/Employer-Group-Plans/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)	
		deductible		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	20% coinsurance after deductible	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.)

- Acupuncture
- Cosmetic services including surgery
- Dental care (Adult)
- Glasses
- Infertility Treatment
- 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.)

- Bariatric Surgery after written approval and completion of Weight Management program.
- Chiropractic care
- Hearing aids
- Routine eye care
- 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.prevea360.com/Quote-Buy-Insurance/Employer-Group-Plans/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.prevea360.com/Quote-Buy-Insurance/Employer-Group-Plans/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	$3,000
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)*

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,060**

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

The plan's overall deductible	$3,000
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)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$800
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,820**

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

The plan's overall deductible	$3,000
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-ray)s*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Language Assistance – General Tagline

Dean Health Plan / Prevea360 Health Plan is required by federal law to provide the following information.

English - If you, or someone you're helping, have questions about Dean Health Plan / Prevea360 Health Plan, you have the right to get help and information in your preferred language at no cost. To talk with an interpreter, call Customer Care at 877-317-2410 (TTY: 711).

Spanish - Si usted, o alguien a quien usted está ayudando, tiene preguntas sobre Dean Health Plan / Prevea360 Health Plan, tiene derecho a obtener ayuda e información en su idioma preferido sin ningún costo. Para hablar con un intérprete, llame al Customer Care al 877-317-2410 (TTY: 711).

Hmong - Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Dean Health Plan / Prevea360 Health Plan, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau Customer Care rau ntawm tus xov tooj. 877-317-2410 (TTY: 711).

Chinese - 如果您，或是您正在協助的對象，有關於 Dean Health Plan / Prevea360 Health Plan方面的問題，您有權利免費以您偏好的語言得到幫助和訊息。洽詢口譯人員，請致電客戶照護專線 [在此插入數字 Customer Care. 877-317-2410 (TTY: 711)

German - Falls Sie oder jemand, dem Sie helfen, Fragen zum Dean Health / Prevea360 Health Plan haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 877-317-2410 (TTY: 711) an.

Arabic -

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Dean Health Plan / Prevea360 Health Planفلديك الحق في الحصول على المساعدة والمعلومات بلغتك المفضلة بدون اية تكلفة. للتحدث مع مترجم فوري اتصل بقسم خدمة العملاء على الرقم 877-317-2410 (TTY: 711)

Russian - Если у вас или лица, которому вы помогаете, есть вопросы по поводу Dean Health Plan / Prevea360 Health Plan, то вы можете получить ответы и бесплатную помощь на вашем языке. Чтобы поговорить с помощью переводчика позвоните по телефону Customer Care. 877-317-2410 (TTY: 711).

Korean - 만약 귀하 또는 귀하가 돕고 있는 어떤 사람에게 Dean Health Plan / Prevea360 Health Plan 에 관한 질문 사항이 있을 경우 귀하는 귀하의 사용 언어로 그러한 도움과 정보를 무료로 제공받을 수 있는 권리가 있습니다. 통역사와 이야기하시려면 고객 관리부Customer Care에877-317-2410 (TTY: 711) 번으로 전화하십시오.

Vietnamese - Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Dean Health Plan / Prevea360 Health Plan, quý vị có quyền được trợ giúp và nhận thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi Customer Care theo số 877-317-2410 (TTY: 711).

Pennsylvanian Dutch - Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Dean Health Plan / Prevea360 Health Plan, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 877-317-2410 (TTY: 711) uffrufe.

Laotian - ຖ້າທ່ານ, ຫຼືຄົນທີ່ທ່ານກໍາລັງຊ່ວຍເຫຼືອ, ມີຄໍາຖາມກ່ຽວກັບ Dean Health Plan / Prevea360 Health Plan, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ການໂອ້ລົມກັບນາຍພາສາ, ໃຫ້ໂທຫາ Customer Care. 877-317-2410 (TTY: 711).

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French - Si vous, ou quelqu'un que vous aidez, avez des questions à propos de Dean Health Plan / Prevea360 Health Plan, vous avez le droit d'obtenir de l'aide et des informations dans votre langue, et ce gratuitement. Pour parler via un interprète, appelez Customer Care au 877-317-2410 (TTY: 711).

Polish - Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie Dean Health Plan / Prevea360 Health Plan, macie prawo do uzyskania bezpłatnej pomocy i informacji we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer Customer Care. 877-317-2410 (TTY: 711)

Hindi - यदि आपके ,या आप द्वारा सहायता किए जा रहे किसी व्यक्ति के Dean Health Plan / Prevea360 Health Plan के बारे में प्रश्न हैं तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। किसी दुभाषिए से बात करने के लिए, 877-317-2410 (TTY: 711) पर कॉल करें।

Albanian - Nëse ju, ose dikush që po ndihmoni, keni pyetje për "Dean Health Plan / Prevea360 Health Plan", keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj të preferuar. Për të folur me një përkthyes, telefononi kujdesin ndaj klientit në numrin Customer Care. 877-317-2410 (TTY: 711).

Tagalog - Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Dean Health Plan / Prevea360 Health Plan, may karapatan ka na makakuha ng tulong at impormasyon sa gusto mong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa Customer Care sa 877-317-2410 (TTY: 711).

Non-Discrimination Statement: 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 or sex. Dean Health Plan / Prevea360 Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. 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). Dean Health / Prevea360 Health Plan 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 Dean Health Plan / Prevea360 Health Plan Customer Care Center at 877-317-2410 (TTY: 711). 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, or sex, you can file a grievance. 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 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
1-800-368-1019, 800-537-7697 (TDD)