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?	$2000/individual $4000/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 policy, the overall family deductible must be met before the plan begins to pay.
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?	$2000 individual / $4000 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, the overall family out-of-pocket limit must be 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	0% coinsurance after deductible	Not covered	No coverage for Chiropractic maintenance or long-term therapy.
	Specialist visit	0% coinsurance after deductible	Not covered	Infertility services are covered up to $2,000 policy lifetime benefit 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)	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 www.deancare.com/pharmacy	Preferred generic drugs (Tier 1)	0% 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.
	Non-preferred generic, Preferred brand drugs (Tier 2)	0% coinsurance after deductible / prescription (retail)	Not covered (retail and mail order)	
	Non-preferred generic, Non-preferred brand drugs (Tier 3)	0% coinsurance after deductible / prescription (retail)	Not covered (retail and mail order)	
	Specialty drugs	50% coinsurance after deductible 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 cessation products.
If you have outpatient	Facility fee (e.g., ambulatory	0% coinsurance after	Not covered	None

* 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)	
surgery	surgery center)	deductible		
	Physician/surgeon fees	0% coinsurance after deductible	Not covered	
If you need immediate medical attention	Emergency room care	0% coinsurance after deductible	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	None
	Urgent care	0% coinsurance after deductible	0% 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)	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	0% coinsurance after deductible	Not covered	None
	Inpatient services	0% coinsurance after deductible	Not covered	None
If you are pregnant	Office visits	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. 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	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 exclusion.
	Habilitation services	0% coinsurance after deductible	Not covered	Habilitative therapies - 60 visits/contract period. Services for custodial care are a policy exclusion.

* 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)	
	Skilled nursing care	0% coinsurance after deductible	Not covered	30 days/confinement.
	Durable medical equipment	0% coinsurance after deductible	Not covered	None
	Hospice services	0% coinsurance after deductible	Not covered	None
If your child needs dental or eye care	Children's eye exam	0% 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.)

- 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
- Weight Loss Programs as part of our Comprehensive Weight Management Program

* 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/.

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?	$2000/individual network $4000/family network $4000/individual out-of-network $8000/family out-of-network	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 policy, the overall family deductible must be met before the plan begins to pay.
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?	For network providers $2000 individual / $4000 family; for out-of-network providers. $8000 individual / $16000 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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balanced-billing charges, penalties for failure to obtain pre-authorization, 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	0% coinsurance after deductible	20% coinsurance after deductible	No coverage for Chiropractic maintenance or long-term therapy.
	Specialist visit	0% coinsurance after deductible	20% coinsurance after deductible	Infertility services are covered up to $2,000 policy lifetime benefit maximum.
	Preventive care/screening/ immunization	$0 copay/visit	20% coinsurance after deductible	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	20% coinsurance after deductible	Certain covered diagnostic tests and/or imaging may require written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Imaging (CT/PET scans, MRIs)	0% coinsurance after deductible	20% coinsurance after deductible	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.deancare.com/pharmacy	Preferred generic drugs (Tier 1)	0% coinsurance after deductible / prescription (retail)	20% coinsurance after deductible / prescription (retail)	For mail order maintenance prescriptions, a 90-day supply (Tiers 1 - 3) policy coinsurance after deductible.
	Non-preferred generic, Preferred brand drugs (Tier 2)	0% coinsurance after deductible / prescription (retail)	20% coinsurance after deductible / prescription (retail)	
	Non-preferred generic, Non-preferred brand drugs (Tier 3)	0% coinsurance after deductible / prescription (retail)	Not covered (retail and mail order)	

* 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)	
	Specialty drugs	50% coinsurance after deductible 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 cessation products.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance after deductible	20% coinsurance after deductible	Outpatient hospital services require a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Physician/surgeon fees	0% coinsurance after deductible	20% coinsurance after deductible	
If you need immediate medical attention	Emergency room care	0% coinsurance after deductible	0% coinsurance after in-network deductible	Copay is waived if admitted for observation or inpatient.
	Emergency medical transportation	0% coinsurance after deductible	0% coinsurance after in-network deductible	None
	Urgent care	0% coinsurance after deductible	0% coinsurance after in-network deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance after deductible	20% coinsurance after deductible	Inpatient hospital services require a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Physician/surgeon fees	0% coinsurance after deductible	20% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance after deductible	20% coinsurance after deductible	Outpatient mental health services require a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Inpatient services	0% coinsurance after deductible	20% coinsurance after deductible	Inpatient mental health services require a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a

* 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)	
				$500 maximum per occurrence.
If you are pregnant	Office visits	0% coinsurance after deductible	20% coinsurance after deductible	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	20% coinsurance after deductible	
	Childbirth/delivery facility services	0% coinsurance after deductible	20% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	0% coinsurance after deductible	20% coinsurance after deductible	60 visits/contract period. Services for home health require a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Rehabilitation services	0% coinsurance after deductible	20% coinsurance after deductible	Rehabilitation care - 90 days/contract period PT/OT/ST - 60 visits/contract period Services for custodial care are a policy exclusion. Services for rehabilitation care and PT/OT/ST require a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Habilitation services	0% coinsurance after deductible	20% coinsurance after deductible	Habilitative therapies - 60 visits/contract period. Services for custodial care are a policy exclusion. Habilitation services require written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Skilled nursing care	0% coinsurance after deductible	20% coinsurance after deductible	30 days/confinement. Services for skilled nursing require a written prior authorization from our Medical Affairs Division. Failure to

* 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)	
				obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Durable medical equipment	0% coinsurance after deductible	20% coinsurance after deductible	Durable medical equipment over $500 requires a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Hospice services	0% coinsurance after deductible	20% coinsurance after deductible	Services for hospice require a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
If your child needs dental or eye care	Children's eye exam	0% coinsurance after deductible	20% coinsurance after deductible	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

* 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/.

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 • 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 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.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al: (800) 279-1301 or TTY 711.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa: (800) 279-1301 or TTY 711.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码: (800) 279-1301 or TTY 711.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne': (800) 279-1301 or TTY 711.

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/.

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Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2000/individual network $4000/family network $4000/individual out-of-network $8000/family out-of-network	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 policy, the overall family deductible must be met before the plan begins to pay.
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?	For network providers $2000 individual / $4000 family; for out-of-network providers. $8000 individual / $16000 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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balanced-billing charges, penalties for failure to obtain pre-authorization, 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	0% coinsurance after deductible	20% coinsurance after deductible	No coverage for Chiropractic maintenance or long-term therapy.
	Specialist visit	0% coinsurance after deductible	20% coinsurance after deductible	Infertility services are covered up to $2,000 policy lifetime benefit maximum.
	Preventive care/screening/ immunization	$0 copay/visit	20% coinsurance after deductible	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	20% coinsurance after deductible	Certain covered diagnostic tests and/or imaging may require written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Imaging (CT/PET scans, MRIs)	0% coinsurance after deductible	20% coinsurance after deductible	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.deancare.com/pharmacy	Preferred generic drugs (Tier 1)	0% coinsurance after deductible / prescription (retail)	20% coinsurance after deductible / prescription (retail)	For mail order maintenance prescriptions, a 90-day supply (Tiers 1 - 3) policy coinsurance after deductible.
	Non-preferred generic, Preferred brand drugs (Tier 2)	0% coinsurance after deductible / prescription (retail)	20% coinsurance after deductible / prescription (retail)	
	Non-preferred generic, Non-preferred brand drugs (Tier 3)	0% coinsurance after deductible / prescription (retail)	Not covered (retail and mail order)	

* 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)	
	Specialty drugs	50% coinsurance after deductible 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 cessation products.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance after deductible	20% coinsurance after deductible	Outpatient hospital services require a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Physician/surgeon fees	0% coinsurance after deductible	20% coinsurance after deductible	
If you need immediate medical attention	Emergency room care	0% coinsurance after deductible	0% coinsurance after in-network deductible	Copay is waived if admitted for observation or inpatient.
	Emergency medical transportation	0% coinsurance after deductible	0% coinsurance after in-network deductible	None
	Urgent care	0% coinsurance after deductible	0% coinsurance after in-network deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance after deductible	20% coinsurance after deductible	Inpatient hospital services require a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Physician/surgeon fees	0% coinsurance after deductible	20% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance after deductible	20% coinsurance after deductible	Outpatient mental health services require a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Inpatient services	0% coinsurance after deductible	20% coinsurance after deductible	Inpatient mental health services require a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a

* 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)	
				$500 maximum per occurrence.
If you are pregnant	Office visits	0% coinsurance after deductible	20% coinsurance after deductible	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	20% coinsurance after deductible	
	Childbirth/delivery facility services	0% coinsurance after deductible	20% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	0% coinsurance after deductible	20% coinsurance after deductible	60 visits/contract period. Services for home health require a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Rehabilitation services	0% coinsurance after deductible	20% coinsurance after deductible	Rehabilitation care - 90 days/contract period PT/OT/ST - 60 visits/contract period Services for custodial care are a policy exclusion. Services for rehabilitation care and PT/OT/ST require a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Habilitation services	0% coinsurance after deductible	20% coinsurance after deductible	Habilitative therapies - 60 visits/contract period. Services for custodial care are a policy exclusion. Habilitation services require written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Skilled nursing care	0% coinsurance after deductible	20% coinsurance after deductible	30 days/confinement. Services for skilled nursing require a written prior authorization from our Medical Affairs Division. Failure to

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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)	
				obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Durable medical equipment	0% coinsurance after deductible	20% coinsurance after deductible	Durable medical equipment over $500 requires a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Hospice services	0% coinsurance after deductible	20% coinsurance after deductible	Services for hospice require a written prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
If your child needs dental or eye care	Children's eye exam	0% coinsurance after deductible	20% coinsurance after deductible	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.)

- Bariatric Surgery
- 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
- Weight Loss Programs

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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Chiropractic care	• Hearing aids • Infertility treatment	• Routine eye 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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/ebsa/healthreform. 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 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.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al: (800) 279-1301 or TTY 711.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa: (800) 279-1301 or TTY 711.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码: (800) 279-1301 or TTY 711.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne': (800) 279-1301 or TTY 711.

———— *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/.