Dean Health Plan, Inc.
SCHEDULE OF BENEFITS
POS Group Plan

Medical Package ID: POS03294
Certificate ID: POS03294-PHA01690-0117-W

Please see your Health Insurance Benefit Summary (HIBS) document for your contract Effective Date.

This Schedule of Benefits and the Member Certificate and any riders **together with the employer Group Master Policy, applications, amendments and any other coverage documents** constitute the contract of insurance. These documents describe the essential features of your coverage and what rules you must follow to obtain covered services.

The employer Group Master Policy **may or may not include** expanded eligibility provisions, beyond those discussed in your Member Certificate. For example, the employer Group Master Policy indicates certain limits regarding dependent coverage. Please contact your employer's group administrator for details.

If necessary, the Schedule of Benefits and the Member Certificate and any riders are replaced on your group's renewal and supersede those which were previously issued. **Keep this Schedule of Benefits with your Member Certificate and any riders and refer to these documents when determining covered services.** Benefits will be administered in accordance with the coverage which was in effect at the time services were rendered. Services must always be Medically Necessary as determined by Us.

The benefits of the Member Certificate are subject to the following:

	In-Network	**Out-of-Network**
Policy Deductible per Contract Period:		
Single	**$2500**	**$5000**
Family	**$5000**	**$10000**
Policy Coinsurance after Deductible:		
Paid by Plan	**80%**	**60%**
Paid by You	**20%**	**40%**
Deductible and Coinsurance Limit per Contract Period:		
Single	**$5000**	**$10000**
Family	**$10000**	**$20000**
Out-of-Pocket Expense Maximum per Contract Period:		
Single	**$7150**	**$14300**
Family	**$14300**	**$28600**

- **All references to "Deductible" are referring to your Deductible, as defined in your group Member Certificate.**
- **Copay amounts do not apply to the Deductible and Coinsurance Limit.**
- **Copay amounts do apply to the maximum out-of-pocket expense.**

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POS Group Plan

Policy Deductible and Out-of-Pocket Expense Maximum amounts are separate between Network and Out-of-Network Providers.

Qualified Dependent Children: Qualified Dependent Children who live outside the Service Area may see certain providers outside the Service Area and still have claims paid at an in-network rate. To locate these providers or for more details call Our Customer Care Center.

Please note: Some services/procedures require Prior Authorization; please see your Member Certificate for more details or call the Customer Care Center at (800) 279-1301 or TTY 711.

The Member is responsible for all costs that exceed the benefit maximum indicated for that service.

IMPORTANT: *This Schedule of Benefits is only a summary of your benefits. A complete description of the benefits and applicable exclusions and limitations are included in your Certificate. Benefits on this Schedule are provided only when services are received according to the terms set forth in the Certificate. You may view your Certificate any time at deancare.com.*

We cover services only when We find them to be Medically Necessary and consistent with the rules explained in your Policy documents. If a particular service, procedure or item is not specifically referenced in your Policy documents, coverage will be based on these rules. Generally, if not specifically referenced, the service, procedure or item will be subject to your Deductible and Policy Coinsurance amounts. Please contact the Customer Care Center if you have questions regarding whether and how a particular service, procedure or item is covered.

Your plan may have benefits in additional riders not described in the schedule of benefits, please see any attached benefit rider for more information about these benefits.

Benefits	In-Network You Pay	Out-of-Network You Pay
A. General Medical		
Office Visit (Primary Care Provider & Optometry)	$20 copay	$20 copay
Chiropractic Services	$20 copay	$20 copay
Specialty Office Visits	$20 copay	$20 copay
Diabetic Education	$0 copay	40% coinsurance after deductible
Preventive Services ***1 exam per Contract Period***	$0 copay	40% coinsurance after deductible

Dean Health Plan, Inc.
SCHEDULE OF BENEFITS
POS Group Plan

Benefits	In-Network You Pay	Out-of-Network You Pay
B. Medical Supplies/Durable Medical Equipment		
Medical Supplies and Durable Medical Equipment	20% coinsurance after deductible	40% coinsurance after deductible
Diabetic Supplies	20% coinsurance after deductible	40% coinsurance after deductible

Benefits	In-Network You Pay	Out-of-Network You Pay
C. Diagnostic Services		
X-Rays and Labs, including readings	20% coinsurance after deductible	40% coinsurance after deductible
Other Diagnostic Services	20% coinsurance after deductible	40% coinsurance after deductible
MRI/MRA	$0 copay	40% coinsurance after deductible
CAT Scans	$0 copay	40% coinsurance after deductible
PET Scans	20% coinsurance after deductible	40% coinsurance after deductible
Readings for: MRI/MRA, CAT Scans, and PET Scans	20% coinsurance after deductible	40% coinsurance after deductible

Benefits	In-Network You Pay	Out-of-Network You Pay
D. Hearing & Vision Services		
Hearing Services	20% coinsurance after deductible	40% coinsurance after deductible
Diagnostic Hearing Services	20% coinsurance after deductible	40% coinsurance after deductible
Hearing Aids – Adults ***Limited to one aid per ear every 36 months.***	20% coinsurance after deductible	Not Covered
Hearing Aids – Children through age 18 ***Limited to one aid per ear every 36 months.***	20% coinsurance after deductible	40% coinsurance after deductible
Cochlear Implants	20% coinsurance after deductible	40% coinsurance after deductible
Routine Vision Exam	$20 copay per visit	$20 copay per visit
Non-Routine Vision Exam	$20 copay per visit	$20 copay per visit
Vision Services	20% coinsurance after deductible	40% coinsurance after deductible
Diagnostic Vision Services	20% coinsurance after deductible	40% coinsurance after deductible
Eyeglasses – Children through age 18	Not Covered	Not Covered

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POS Group Plan

Benefits	In-Network You Pay	Out-of-Network You Pay
E. Hospital & Surgical Services		
Inpatient Hospital ***Maximum IN copay expense per Contract Period is Unlimited single / Unlimited family***	20% coinsurance after deductible	40% coinsurance after deductible
Inpatient Rehabilitative Confinement ***Maximum IN copay expense per Contract Period is Unlimited single / Unlimited family*** ***Combined benefit limited to 90 days per Member per Contract Period***	20% coinsurance after deductible	40% coinsurance after deductible
Detoxification Services ***Maximum IN copay expense per Contract Period is Unlimited single / Unlimited family***	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient Hospital ***Maximum IN copay expense per Contract Period is Unlimited single / Unlimited family***	20% coinsurance after deductible	40% coinsurance after deductible
Ambulatory Surgical Center ***Maximum IN copay expense per Contract Period is Unlimited single / Unlimited family***	20% coinsurance after deductible	40% coinsurance after deductible

F. Skilled Nursing Care Services		
Licensed Skilled Nursing (Excludes Custodial Care and Other Non-Covered Expenses) ***Maximum IN copay expense per Contract Period is Unlimited single / Unlimited family*** ***Limited to 30 days per Confinement***	20% coinsurance after deductible	40% coinsurance after deductible
Home Health Care ***Limited to 60 visits per Contract Period***	20% coinsurance after deductible	40% coinsurance after deductible
Hospice Care	20% coinsurance after deductible	40% coinsurance after deductible

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SCHEDULE OF BENEFITS
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Benefits	In-Network You Pay	Out-of-Network You Pay
G. Emergency & Urgent Care Services		
Ambulance Services	20% coinsurance after deductible	20% coinsurance after in-network deductible
Emergency Room Services ***You may be responsible for other charges in addition to the facility Copay/Deductible/ Coinsurance**** ***Copay is waived if admitted for Observation or Inpatient.***	$75 copay and/or 20% coinsurance after deductible	$75 copay and/or 20% coinsurance after in-network deductible
Urgent Care Services ***You may be responsible for other charges in addition to the visit Copay/Deductible/ Coinsurance****	$20 copay and/or 20% coinsurance after deductible	$20 copay and/or 20% coinsurance after in-network deductible
* Other charges will result from services rendered by other providers who treated you during your urgent care or emergency room visit. These charges include, but are not limited to, physician visits, diagnostic services, procedures/treatments and various medical supplies. The amount charged for these services received from an Out-of-Network Provider may exceed the Maximum Allowable Fee in which case you will be responsible for paying the difference between the amount charged and the Maximum Allowable Fee.		

Benefits	In-Network You Pay	Out-of-Network You Pay
H. Therapies & Rehabilitation Services		
Autism – Intensive – Physician and Facility Charge ***The Member is eligible for 4 cumulative years of intensive-level services***	$20 copay per therapy type per day	$20 copay per therapy type per day
Autism – Intensive – Related Services ***The Member is eligible for 4 cumulative years of intensive-level services***	20% coinsurance after deductible	40% coinsurance after deductible
Autism – Non-Intensive – Physician and Facility Charge	$20 copay per therapy type per day	$20 copay per therapy type per day
Autism – Non-Intensive – Related Services	20% coinsurance after deductible	40% coinsurance after deductible

Benefits	In-Network You Pay	Out-of-Network You Pay
H. Therapies & Rehabilitation Services (continued)		
Outpatient Physical, Speech and Occupational Therapy ***Unlimited visits per Contract Period (All therapies combined)***	$20 copay per therapy type per day	$20 copay per therapy type per day
Habilitative Services ***Limited to 60 visits per Contract Period (All habilitative therapies combined)***	$20 copay per therapy type per day	$20 copay per therapy type per day
Phase II Cardiac Rehabilitation	20% coinsurance after deductible	40% coinsurance after deductible
Pulmonary Rehabilitation	20% coinsurance after deductible	40% coinsurance after deductible
Radiation Therapy	20% coinsurance after deductible	40% coinsurance after deductible

Benefits	In-Network You Pay	Out-of-Network You Pay
I. Dental Services		
Trauma/Accidental Injury to Teeth	20% coinsurance after deductible	40% coinsurance after deductible
Oral Surgery Consult	$20 copay per visit	$20 copay per visit
Oral Surgical Services	20% coinsurance after deductible	40% coinsurance after deductible
TMD Surgical Services	20% coinsurance after deductible	40% coinsurance after deductible
TMD Office Consult	$20 copay per visit	$20 copay per visit
TMD DME	20% coinsurance after deductible	40% coinsurance after deductible

Benefits	In-Network You Pay	Out-of-Network You Pay
J. Behavioral Health & Addiction Services		
Inpatient/Residential Care – Behavioral Health & Addiction Services ***Maximum IN/OON copay expense per Contract Period is $ 0 single / $ 0 family***	$0 copay per admission	$0 copay per admission
Outpatient Behavioral Health & Addiction Services	$20 copay	$20 copay
Intensive Outpatient/Day Treatment/Partial Hospitalization	$0 copay	$0 copay

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Benefits	In-Network You Pay	Out-of-Network You Pay
K. Transplants & Kidney Disease Services		
Transplant Services ***Maximum IN copay expense per Contract Period is Unlimited single / Unlimited family***	20% coinsurance after deductible	40% coinsurance after deductible
Kidney Disease Treatment	20% coinsurance after deductible	40% coinsurance after deductible

Benefits	In-Network You Pay	Out-of-Network You Pay
L. Other Services		
Acupuncture ***Combined benefit limited to 10 visits per Contract Period***	$20 copay	$20 copay
Anesthesia Services	20% coinsurance after deductible	40% coinsurance after deductible
Allergy Injections	20% coinsurance after deductible	40% coinsurance after deductible
Infertility Services ***$2,000 combined lifetime benefit maximum***	50% of $4,000	50% of $4,000
Maternity Services – Physician Services	20% coinsurance after deductible	40% coinsurance after deductible
Surgical Services	20% coinsurance after deductible	40% coinsurance after deductible

Dean Health Plan, Inc.
SCHEDULE OF BENEFITS
Prescription Drug Benefits

Pharmacy Package ID: PHA01690

Benefits	In-Network You Pay	Out-of-Network You Pay
Rider – Prescription Drugs	**Generic/Brand Option**	**Generic/Brand Option**
Generic Outpatient Prescription Drugs ***30-day supply***	$5 copay**	50% coinsurance
Brand Outpatient Prescription Drugs ***30-day supply***	$20 copay**	50% coinsurance
TIER 3 Outpatient Prescription Drugs Brand ***30-day supply***	$40 copay**	Not Covered
Mail Order	90-day supply (Generic and Brand) for 2 copays; 90-day supply (Tier 3) for 3 copays	Not Covered
Outpatient Prescription Drugs – Infertility	50% coinsurance	Not Covered

**Regardless of the tier your oral chemotherapy falls into you will never pay more than $100 for a 30 day supply, in compliance with the Wisconsin law governing coverage of oral chemotherapy drugs.