This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.deancare.com or by calling (800) 279-1301 or TTY (877) 733-6456.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$100** /per person network per contract period **$200** /per family network per contract period **$100** /per person non-network per contract period **$200** /per family non-network per contract period Copays do not apply toward the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$100** /person network Yes. **$200** /family network Yes. **$600** /person non-network Yes. **$1200** /family non-network	The **out-of-pocket** limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Copayments, premium, balance-billed charges, penalties for failure to obtain prior 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.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes, this plan uses **network providers**. You may use non-network providers, but you may pay more. For a list of **network**	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use

	providers, see www.deancare.com or call **(800) 279-1301 or TTY (877) 733-6456**.	the terms in-network, **preferred**, or participating for providers in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
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	---none---
	Specialist visit	0% coinsurance after deductible	20% coinsurance after deductible	Coverage for the diagnosis and nonsurgical treatment of TMD is limited to a $1,250 annual max. Infertility services are covered at 50% up to $4,000 life time maximum. Infertility services are not subject to yearly out-of-pocket maximum.
	Other practitioner office visit	0% coinsurance after deductible for chiropractor	20% coinsurance after deductible for chiropractor	No coverage for Chiropractic maintenance or long-term therapy. No coverage for acupuncture.
	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.
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

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	0% coinsurance after deductible	20% coinsurance after deductible	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 you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.deancare.com/pharmacy	Generic drugs	$5 copay/prescription (retail)	50% coinsurance /prescription (retail)	For mail order maintenance prescriptions, a 90 day supply of Generic and Brand prescriptions is available for two copays.
	Brand drugs	$10 copay/prescription (retail)	50% coinsurance /prescription (retail)	
	TIER 3 drugs	$25 copay/prescription (retail)	Not covered (retail and mail order)	For mail order maintenance prescriptions, a 90 day supply of Tier 3 prescriptions is available for three copays.
	Specialty drugs	Tobacco cessation $5 copay/prescription (retail) 50% coinsurance; not subject to out-of-pocket maximum for infertility drugs/prescription (retail)	Not covered (retail and mail order)	Tobacco cessation products will be covered with a 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 services	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 fee	0% coinsurance after deductible	20% coinsurance after deductible	
If you have mental	Mental/Behavioral	$0 copay/visit	$0 copay/visit	Outpatient mental health services require a written

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
health, behavioral health, or substance abuse needs	health outpatient services			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.
	Mental/Behavioral health inpatient services	$0 copay/admission	$0 copay/admission	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 $500 maximum per occurrence.
	Substance use disorder outpatient services	$0 copay/visit	$0 copay/visit	Services with outpatient Alcohol and other Drug Abuse (AODA) providers 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.
	Substance use disorder inpatient services	$0 copay/admission	$0 copay/admission	Services with inpatient Alcohol and other Drug Abuse (AODA) providers 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 you are pregnant	Prenatal and postnatal care	0% coinsurance after deductible	20% coinsurance after deductible	Home or intentional out of hospital deliveries are not covered.
	Delivery and all inpatient services	0% coinsurance after deductible	20% coinsurance after deductible	
If you need help recovering or have other special health	Home health care	0% coinsurance after deductible	20% coinsurance after deductible	Services for home health are limited to 40 visits per 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	Services for rehabilitation care are limited to 90 days per contract period. Services for rehabilitation care require a written prior authorization from our

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
needs				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 copay/therapy/day and/or 0% coinsurance after deductible	20% coinsurance after deductible	Services for PT/OT/ST are limited to 50 visits per contract year. Services for PT/OT/ST 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. Services for custodial care are a policy exclusion.
	Skilled nursing care	0% coinsurance after deductible	20% coinsurance after deductible	Services for skilled nursing are limited to 120 days per contract period. Services for skilled nursing 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.
	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 service	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	Eye exam	0% coinsurance after deductible	20% coinsurance after deductible	---none---
	Glasses	Not covered	Not covered	---none---
	Dental check-up	Not covered	Not covered	---none---

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Cosmetic services including surgery
- Dental care
- Glasses
- Long-term care
- Massage therapy
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Services and supplies not medically necessary
- Weight Management

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Chiropractic care
- Hearing aids
- Infertility treatment
- Routine eye care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at (800) 279-1301 or TTY (877) 733-6456. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at (877) 267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the insurer at: (800) 279-1301 or TTY (877) 733-6456. You may also contact your state insurance department at (800) 236-8517 or http://oci.wi.gov/. For plans subject to ERISA you may also contact the Department of Labor's Employee Benefit Security Administration at (866) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al: (800) 279-1301 or TTY (877) 733-6456.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa: (800) 279-1301 or TTY (877) 733-6456.
CHINESE (中文): 如果需要中文的帮助，**请拨打这个号码**: (800) 279-1301 or TTY (877) 733-6456.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne': (800) 279-1301 or TTY (877) 733-6456.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7290
- **Patient pays** $250

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$100
Copays	$0
Coinsurance	$0
Limits or exclusions	$150
Total	**$250**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $5220
- **Patient pays** $180

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$100
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$180**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.