DeanHealthPlan
A member of SSM Health

COUNTY OF ROCK

Effective Date: 01/01/2022

Product Type: PPO

Plan Code: PPO03936/PHA02489

Plan Overview	Plan Providers - You Pay	Non-Plan Providers - You Pay
Deductible	$650 single / $1,950 family	$650 single / $1,950 family
Coinsurance	25% coinsurance after deductible	25% coinsurance after deductible
Office Visit Charge (Primary/Specialist)	$25 copay	$25 copay
Office Visit and Related Services	25% coinsurance after deductible	25% coinsurance after deductible
Preventive Services	$0 copay	$0 copay and/or 25% coinsurance after deductible
Deductible and Coinsurance Limit	$1,950 single / $4,000 family	$1,950 single / $4,000 family
Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted)	$5,600 single / $11,300 family	$5,600 single / $11,300 family
Prescription Drugs, Insulin & Disposable Diabetic Supplies	Unless otherwise indicated, generic or brand name drugs can be found in any formulary tier)	
Tier 1	$10 copay	50% coinsurance
Tier 2	$25 copay	50% coinsurance
Tier 3	$50 copay	Not Covered
Tier 4	$100 copay	Not Covered
Diagnostic Services		
Diagnostic Services (Xrays/Labs)	25% coinsurance after deductible / 25% coinsurance after deductible	25% coinsurance after deductible / 25% coinsurance after deductible
CAT Scans/MRI/MRA	25% coinsurance after deductible	25% coinsurance after deductible
Hospital & Surgical Center		
Inpatient Hospital	25% coinsurance after deductible	25% coinsurance after deductible
Outpatient Hospital	25% coinsurance after deductible	25% coinsurance after deductible
Emergency Services		
Urgent Care	25% coinsurance after deductible	25% coinsurance after in-network deductible
Emergency Room Services (Copay is waived if admitted)	$200 copay and/or 25% coinsurance after deductible	$200 copay and/or 25% coinsurance after in-network deductible
Ambulance	25% coinsurance after deductible	25% coinsurance after in-network deductible
Other Services		
Mental Health Inpatient	25% coinsurance after deductible	25% coinsurance after deductible
Mental Health Day Treatment Programs	25% coinsurance after deductible	25% coinsurance after deductible
Mental Health Outpatient	$25 copay	$25 copay
Durable Medical Equipment	25% coinsurance after deductible	25% coinsurance after deductible
Physical, Speech & Occupational Therapy	25% coinsurance after deductible	25% coinsurance after deductible
Plan Special Features	In and Out-of-Network deductibles and coinsurance combined.	

This renewal plan includes prescription drug coverage that is creditable
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
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: 10/07/21

DeanHealthPlan. A member of SSM Health : PPO03936/PHA02489

Coverage for: Individual/Family | Plan Type: PPO

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, deancare.com/health-insurance/group-plans-for-employers/sample-group-certificates/ or call (800) 279-1301 (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 www.healthcare.gov/sbc-glossary or call (800) 279-1301 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$650/Individual Network $1,950/Family Network $650/Individual Out-of-Network $1,950/Family Out-of-Network	Generally, you must pay all of 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 yet 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 $5,600 individual / $11,300 family. For out-of-network providers $5,600 individual / $11,300 family. Included in the out-of-pocket limit for covered services is a deductible and coinsurance limit, which for covered network services is $1,950 individual / $4,000 family. There is a deductible and coinsurance limit for covered out-of-network services, which is $1,950 individual / $4,000 family.	The out-of-pocket limit is the most you could pay in a year for covered services.The deductible and coinsurance limit does not include copayments. Once the deductible and coinsurance limit is met, the plan pays 100% of allowed amounts, not including copayments; the members pay copayments until they reach the total out-of-pocket limit. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

What is not included in the out-of-pocket limit?	Premiums, balance billing 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.
Will you pay less if you use a network provider?	Yes. See deancare.com/find-a-doc/ or call (800) 279-1301 (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 **copayment** and **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	$25 copay/visit and/or 25% coinsurance after deductible	$25 copay/visit and/or 25% coinsurance after deductible	No coverage for Chiropractic maintenance or long-term therapy.
	Specialist visit	$25 copay/visit and/or 25% coinsurance after deductible	$25 copay/visit and/or 25% coinsurance after deductible	Infertility services are covered at 100% up to $2,000 policy lifetime maximum.
	Preventive care/screening/ immunization	No charge	No charge	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 are not 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)	25% coinsurance after deductible	25% coinsurance after deductible	Certain covered diagnostic tests and/or imaging may require written prior authorization

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)	
	Imaging (CT/PET scans, MRIs)	25% coinsurance after deductible	25% coinsurance after deductible	from us. 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 deancare.com/members/pharmacy-benefits	Preferred generic drugs (Tier 1)	$10 copay /prescription (retail); Mail order maintenance prescriptions, a 90-day supply for 2 copays.	50% coinsurance /prescription (retail)	None
	Non-Preferred generic, Preferred brand drugs (Tier 2)	$25 copay /prescription (retail); Mail order maintenance prescriptions, a 90-day supply for 2 copays.	50% coinsurance /prescription (retail)	
	Non-preferred generic, Non-preferred brand drugs (Tier 3)	$50 copay /prescription (retail); Mail order maintenance prescriptions, a 90-day supply for 3 copays.	Not Covered (retail and mail order)	
	Specialty drugs (Tier 4)	$100 copay /prescription (retail); Mail order maintenance prescriptions not covered. 50% coinsurance for infertility drugs/prescription (retail)	Not Covered (retail and mail order)	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance after deductible	25% coinsurance after deductible	Outpatient hospital services require a written prior authorization from us. 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	25% coinsurance after deductible	copay/visit	

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 need immediate medical attention	Emergency room care	$200 copay/visit and/or 25% coinsurance after deductible	$200 copay/visit and/or 25% coinsurance after in-network deductible	Copay is waived if admitted for observation or inpatient.
	Emergency medical transportation	25% coinsurance after deductible	25% coinsurance after in-network deductible	None
	Urgent care	25% coinsurance after deductible	25% coinsurance after in-network deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance after deductible	25% coinsurance after deductible	Inpatient hospital services require a written prior authorization from us. 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	25% coinsurance after deductible	25% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/outpatient visit 25% coinsurance after deductible for day treatment services	$25 copay /visit and/or 25% coinsurance after deductible	None
	Inpatient services	25% coinsurance after deductible	25% coinsurance after deductible	Inpatient mental health services require a written prior authorization from us. 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	Office visits	$25 copay/visit and/or 25% coinsurance after deductible	$25 copay/visit and/or 25% 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	25% coinsurance after deductible	25% coinsurance after deductible	
	Childbirth/delivery facility services	25% coinsurance after deductible	25% coinsurance after deductible	
If you need help recovering or have other special health	Home health care	25% coinsurance after deductible	25% coinsurance after deductible	100 visits/contract period. Services for home health require a written prior authorization from us. Failure to obtain a prior authorization for

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)	
needs				services will result in a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence.
	Rehabilitation services	25% coinsurance after deductible	25% coinsurance after deductible	Inpatient Rehabilitation Care - 90 days/contract period. Services for custodial care are a policy exclusion. Services for rehabilitation care and Physical, Occupational and Speech Therapy require a written prior authorization from us. 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	25% coinsurance after deductible	25% coinsurance after deductible	Habilitative therapies - 60 visits/contract period. Services for custodial care are a policy exclusion. Habilitation services require written prior authorization from us. 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	25% coinsurance after deductible	25% coinsurance after deductible	120 days/confinement. Services for skilled nursing require a written prior authorization from us. 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	25% coinsurance after deductible	25% coinsurance after deductible	Durable medical equipment as stated in our medical policies requires prior authorization from us. 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	25% coinsurance after deductible	25% coinsurance after deductible	Services for hospice require a written prior authorization from us. Failure to obtain prior authorization for services will result in a

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)	
				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	$25 copay/visit and/or 25% coinsurance after deductible	25% 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)
- Long-term care
- Non-emergency care when travelling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (Limited to 10 visits per Contract Period)
- Chiropractic care
- Hearing aids (Limited to one aid per ear every 36 months)
- Infertility Treatment
- Routine eye care (Adult)

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; Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: Dean Health Plan at www.deancare.com or 800-279-1301 (TTY: 711); U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/ebsa/healthreform or the Wisconsin Office of the Commissioner of Insurance at P.O. Box 7873, Madison, WI 53707-7873, http://oci.wi.gov/ or call (800) 236-8517.

Does this plan provide Minimum Essential Coverage? **Yes**.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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 (TTY: 711).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 279-1301 (TTY: 711).
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码(800) 279-1301 (TTY: 711).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 279-1301 (TTY: 711).

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

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	$650
Specialist copayment	$25
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$650
Copayments	$10
Coinsurance	$2,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,620

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

The plan's overall deductible	$650
Specialist copayment	$25
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$650
Copayments	$600
Coinsurance	$60
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$1,330

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

The plan's overall deductible	$650
Specialist copayment	$25
Hospital (facility) coinsurance	25%
Other coinsurance	25%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$650
Copayments	$300
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,350

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