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, call 1-800-345-9474. 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 www.hshs.org/myhr or by calling **1-800-345-9474** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$3,300** Individual/**$6,600** Family	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. ***Out-of-network services*** *– must receive referral from Dean Health Plan, unless a true emergency*
Are there services covered before you meet your deductible?	Yes	Wellness and preventive care is covered at 100%, not subject to the deductible.
Are there other deductibles for specific services?	No, the prescription drug deductible is combined with medical deductible	You must pay all of the costs for these services up to the **deductible** amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$4,000** Individual **/$8,000** Family Limit The out-of-pocket limit includes the deductible and amounts cross-apply	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. ***Out-of-network services*** *– must receive referral from Dean Health Plan, unless a true emergency*
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for service, and health care this plan does not 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	You must obtain a referral from Dean Health Plan for out-of-network providers
Do you need a referral to see a specialist?	No	You can see the network **specialist** you choose without permission from this plan.

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	Your Costs if You Use a		Limitations & Exceptions
		HSHS/Prevea	Other Prevea360	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% Coinsurance	10% Coinsurance	---none---
	Specialist visit	0% Coinsurance	10% Coinsurance	
	Preventive care/screening/ immunization	No charge; deductible waived	No charge; deductible waived	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	0% Coinsurance	10% Coinsurance	Precertification may be required.
	Imaging (CT/PET scans, MRIs)	10% Coinsurance	10% Coinsurance	Precertification may be required.

* For more information about limitations and exceptions, see the plan or policy document at www.hshs.org/myhr
.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Pharmacy	Your Cost If You Use a Non-Network Pharmacy	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	Generic drugs	HSHS 10% coinsurance All Others 20% coinsurance	Not covered	Deductible and out-of-pocket limit applies. Retail – 30 day supply Mail – 90 day supply If you choose to receive a brand name medication when a direct generic equivalent is available, you must pay the difference in price between the brand drug and its generic equivalent in addition to the applicable copay and generic coinsurance. Maintenance medications at HSHS, mail order or Walgreens required for coverage after the second fill at a retail pharmacy. After the initial fill, specialty medications must be filled through OptumRx or HSHS to be covered. Prior authorization may be required.
	Preferred brand drugs	HSHS 20% coinsurance All Others 30% coinsurance	Not covered	
	Non-preferred brand drugs	HSHS 20% coinsurance after $15 copay All Others 30% coinsurance after $15 copay HSHS Mail Order $45 copay then 2% coinsurance Mail Order $45 copay then 30% coinsurance	Not covered	
	Specialty drugs	HSHS 20% coinsurance All Others 30% coinsurance	Not covered	

Common Medical Event	Services You May Need	Your Costs if You Use a		Limitations & Exceptions
		HSHS/Prevea	Other Prevea360	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance	10% Coinsurance	Precertification may be required. Must receive referral from Dean Health Plan for out-of-network providers
	Physician/ surgeon fees	10% Coinsurance	10% Coinsurance	
If you need immediate medical attention	Emergency room care	10% Coinsurance	10% Coinsurance	
	Emergency medical transportation	10% coinsurance	10% coinsurance	Precertification may be required for non-emergent air ambulance.
	Urgent care	10% Coinsurance	10% Coinsurance	

Common Medical Event	Services You May Need	Your Costs if You Use a		Limitations & Exceptions
		HSHS/Prevea	Other Prevea360	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance	10% Coinsurance	Precertification is required. Must receive referral from Dean Health Plan for out-of-network providers
	Physician/ surgeon fees	10% Coinsurance	10% Coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% Coinsurance office visits: 10% Coinsurance other outpatient services	10% Coinsurance	
	Inpatient services	10% Coinsurance	10% Coinsurance	Precertification required.
If you are pregnant	Office visits	10% Coinsurance	10% Coinsurance	
	Childbirth/delivery professional services	10% Coinsurance	10% Coinsurance	
	Childbirth/delivery facility services	10% Coinsurance	10% Coinsurance	Notification is required.

Common Medical Event	Services You May Need	Your Costs if You Use a HSHS/Prevea	Your Costs if You Use a Other Prevea360	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	10% Coinsurance	10% Coinsurance	120 visits per benefit period. Precertification required.
	Rehabilitation services	10% Coinsurance	10% Coinsurance	Precertification may be required.
	Habilitation services	10% Coinsurance	10% Coinsurance	Precertification may be required.
	Skilled nursing care	10% Coinsurance	10% Coinsurance	90 days per admission, renewable after 180 days between discharge and re-admission. Precertification required.
	Durable medical equipment	10% Coinsurance	10% Coinsurance	Precertification may be required.
	Hospice services	10% Coinsurance	10% Coinsurance	Precertification required.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	---none---
	Children's glasses	Not Covered	Not Covered	---none---
	Children's dental check-up	Not Covered	Not Covered	---none---

* For more information about limitations and exceptions, see the plan or policy document at www.hshs.org/myhr
.

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 Surgery
- Dental Care (routine adult)
- Glasses (Adult & Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss program – except for required preventive services

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

- Acupuncture
- Bariatric surgery (HSHS Facility only)
- Spinal manipulations
- Hearing aids – Up to $2,500 per hearing aid every 3 years
- Infertility testing – Coverage is limited to the diagnosis and treatment of underlying medical condition
- Private-duty nursing

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: 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.
Minimum Essential Coverage generally includes plan, 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 1-800-327-8497.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-327-8497.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-327-8497.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-327-8497.

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	$3,300
Specialist coinsurance	10%
Hospital Facility coinsurance	10%
Other coinsurance	10%

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	$3,300
Copayments	$0
Coinsurance	$900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,260**

Example assumes all care is received from Network Facilities and Network Specialists.

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

The plan's overall deductible	$3,300
Specialist coinsurance	10%
Hospital Facility coinsurance	10%
Other coinsurance	10%

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	$3,300
Copayments	$0
Coinsurance	$400
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,720**

Example assumes all care is received from Network Facilities and Network Specialists.

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

The plan's overall deductible	$3,300
Specialist coinsurance	10%
Hospital Facility coinsurance	10%
Other coinsurance	10%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

Example assumes all care is received from Network Facilities and Network Specialists.

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