



 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, go to www.Medica.com or call 1 (800) 952-3455 (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 www.healthcare.gov/sbc-glossary or call 1 (800) 952-3455 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$1,900 per person / \$3,800 per family in-network and \$2,850 per person / \$5,700 per family for out-of-network services.	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, prescription drugs and hospice from in-network providers.	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?	\$2,900 per person / \$5,800 per family in-network. \$4,350 per person / \$8,700 per family for out-of-network services.	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, 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, 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 www.Medica.com/FindCare or call 1 (800) 952-3455 (TTY: 711) for a list of Medica Choice with UnitedHealthcare 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 don't need a referral to see a specialist.	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
		In-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	Primary care: 0% coinsurance Chiropractic: 0% coinsurance Retail Health: 0% coinsurance Virtual: \$0 copay . Deductible does not apply.	Primary: 10% coinsurance Chiropractic: 10% coinsurance Retail Health: 10% coinsurance Virtual: 10% coinsurance	Limited to 15 visits per member, per year for out-of-network chiropractic care.
	Specialist visit	0% coinsurance	10% coinsurance	None
	Preventive care/screening/immunization	No charge. Deductible does not apply.	10% coinsurance	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. Routine physicals and eye exams are not covered out-of-network.
If you have a test	Diagnostic test (x-ray, blood work)	Lab: 0% coinsurance X-ray: 0% coinsurance	Lab: 10% coinsurance X-ray: 10% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	10% coinsurance	None



Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.Medica.com/DrugCost1	Generic drugs	Retail: \$10/prescription. Deductible does not apply. Mail order: \$20/prescription. Deductible does not apply.	10% coinsurance	Up to a 31-day supply/retail or 93-day supply/mail order prescription. Mail order drugs not covered out-of-network. Insulin: Your cost-share will not exceed per retail prescription unit. ACA preventive drugs covered at no charge. Deductible does not apply.
	Preferred brand drugs	Retail: \$45/prescription. Deductible does not apply. Mail order: \$90/prescription. Deductible does not apply.	10% coinsurance	
	Non-preferred brand drugs	Retail: \$90/prescription. Deductible does not apply. Mail order: \$180/prescription. Deductible does not apply.	10% coinsurance	
	Specialty drugs	Preferred: 20% coinsurance . No more than \$300 copay /prescription. Deductible does not apply. Non-Preferred: 40% coinsurance . Deductible does not apply.	Not covered	Up to a 31-day supply per prescription received from a designated specialty pharmacy. Amounts reimbursed or paid by a provider or manufacturer, on your behalf for a product or service, will not apply toward your cost share.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	10% coinsurance	None
	Physician/surgeon fees	0% coinsurance	10% coinsurance	None
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	In-network deductible and out-of-pocket applies.
	Emergency medical transportation	0% coinsurance	0% coinsurance	In-network deductible and out-of-pocket applies.
	Urgent care	0% coinsurance	0% coinsurance	In-network deductible and out-of-pocket applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	10% coinsurance	None
	Physician/surgeon fees	0% coinsurance	10% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$0 copay /office visit	10% coinsurance	None
	Inpatient services	0% coinsurance	10% coinsurance	Residential treatment is covered as part of inpatient services.



Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge. Deductible does not apply.	10% coinsurance	Cost sharing does not apply to in-network 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., certain ultrasounds.)
	Childbirth/delivery professional services	0% coinsurance	10% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	10% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	10% coinsurance	Limited to 40 visits per member per year in and out-of-network combined.
	Rehabilitation services	0% coinsurance	10% coinsurance	Physical and occupational therapy combined limited to 20 visits out-of-network per member per year. Out-of-network speech therapy is limited to 20 visits per member per year. Visit limits are not applicable to behavioral health conditions.
	Habilitation services	0% coinsurance	10% coinsurance	Physical and occupational therapy combined limited to 20 visits out-of-network per member per year. Out-of-network speech therapy is limited to 20 visits per member per year. Visit limits are not applicable to behavioral health conditions.
	Skilled nursing care	0% coinsurance	10% coinsurance	30 day limit combined in and out-of-network per member per year.
	Durable medical equipment	0% coinsurance	10% coinsurance	None
	Hospice services	No charge. Deductible does not apply.	10% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	Not covered	None
	Children's glasses	Not covered	Not covered	Glasses are not covered by the plan .
	Children's dental check-up	Not covered	Not covered	Dental check-ups are not covered by the plan .



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 other [excluded services](#).)

- Acupuncture exceeding 15 visits per member per year for in-network and out-of-network acupuncture services combined
- Bariatric surgery
- Chiropractic care exceeding 15 visits per member per year out-of-network
- Cosmetic surgery
- Dental check-up
- Glasses
- Hearing aids except for members 17 years of age and younger who are certified as deaf or hearing impaired if prescribed by a physician or licensed audiologist; coverage is limited to one hearing aid every three years
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care except for some conditions
- Weight loss programs

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

- Non-emergency care when traveling outside the U.S.
- 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: Medica at **1 (800) 952-3455** (TTY: **711**) or for group health coverage subject to ERISA, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; for all other group health coverage, 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 on how 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: for group health coverage subject to ERISA, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; for all other group health coverage you may also contact Medica at **1 (800) 952-3455** (TTY: **711**) or the Wisconsin Office of Commissioner of Insurance at (608) 266-3585 or 1-800-236-8517.

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 Standard? 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) 952-3455** (TTY: **711**).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1 (800) 952-3455** (TTY: **711**).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 **1 (800) 952-3455** (TTY: **711**).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' **1 (800) 952-3455** (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](#) \$1,900
- [Specialist coinsurance](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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

- The [plan's](#) overall [deductible](#) \$1,900
- [Specialist coinsurance](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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

- The [plan's](#) overall [deductible](#) \$1,900
- [Specialist coinsurance](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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*)

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*)

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	\$12,700
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Total Example Cost	\$5,600
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Total Example Cost	\$2,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,900
Copayments	\$10
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,970

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,900
Copayments	\$100
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$2,000

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,900
Copayments	\$10
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,910

Note: The amount the patient pays assumes the patient is not participating in a Flexible Spending Account (FSA), a Health Savings Account (HSA), or a Health Reimbursement Arrangement (HRA), including an HRA funded through a Voluntary Employee Beneficiary Association (VEBA-HRA). If you have a FSA, HSA, HRA, or VEBA-HRA, then you may have additional funds that could help cover certain out-of-pocket expenses such as [deductibles](#), [copayments](#), [coinsurance](#), and benefits otherwise not covered.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-952-3455 (TTY: 711) for Medica, call 1-877-317-2410 (TTY: 711) for Dean Health Plan/Prevea360 Health Plan, or speak to your provider.

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia de idiomas. También están disponibles de forma gratuita asistencia y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-952-3455 (TTY: 711) para Medica, llame al 1-877-317-2410 (TTY: 711) para Dean Health Plan/Prevea360 Health Plan o hable con su proveedor de atención médica.

Vietnamese/Việt: LƯU Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-952-3455 (TTY: 711) đối với Medica, gọi theo số 1-877-317-2410 (TTY: 711) đối với Dean Health Plan/Prevea360 Health Plan hoặc trao đổi với nhà cung cấp dịch vụ của quý vị.

Chinese Traditional: 注意：如果您說中文，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-952-3455 (TTY: 711) 聯絡 Medica，致電 1-877-317-2410 (TTY: 711) 聯絡 Dean Health Plan/Prevea360 Health Plan，或與您的提供者討論。

Hmong/Lus Hmoob: LUS CEEV: Yog hais tias koj hais Lus Hmoob ces muaj kev pab txhais lus pub dawb rau koj. Muaj khoom siv thiab muaj kev saib xyuas pab uas tsim nyog los npaj kom muaj cov ntaub ntauv uas siv tau dawb. Hu rau 1-800-952-3455 (TTY: 711) rau Medica, hu rau 1-877-317-2410 (TTY: 711) rau Dean Health Plan/Prevea360 Health Plan, los sis tham rau koj tus kws kuaj mob.

German/Deutsch: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-952-3455 (TTY: 711) für Medica bzw. 1-877-317-2410 (TTY: 711) für Dean Health Plan/Prevea360 Health Plan oder sprechen Sie mit Ihrem Gesundheitsdienstleister.

Cushitic-Oromo: XIYYEEFFANNOO: Ingiliffaa dubbattu taanaan, tajaajilli deggersa afaan bilisaa ni jira. Tajaajilli deggersa bu'ura dhiheessii odeeffannoo kaffaltii tokko malee ni jira. Lakkoofsa bilbilaa 1-800-952-3455 (TTY: 711) Tajaajila Fayyaaf, lakkoofsa Medica 1-877-317-2410 (TTY: 711), Dean Health Plan/Prevea360 Health Plan, ykn dhiheessaa keessan dubbisaa.

العربية/Arabic

كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. تنبيه: (الهاتف النصي: 711) للتواصل مع 1-800-952-3455 اتصل على الرقم المعلومات بتنسيقات يمكن الوصول إليها مجانًا. Dean Health Plan/Prevea360 Health Plan، اتصل على الرقم 1-877-317-2410 (الهاتف النصي: 711) بشأن خطة الرعاية الصحية Medica



Korean/한국어: 주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. Medica 의 경우 1-800-952-3455(TTY: 711)번으로, Dean Health Plan/Prevea360 Health Plan 의 경우 1-877-317-2410(TTY: 711)번으로 전화하시거나, 서비스 제공업체에 문의하십시오.

Russian/Русский: Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-952-3455 (TTY: 711) относительно Medica, позвоните по телефону 1-877-317-2410 (TTY: 711) относительно Dean Health Plan/Prevea360 Health Plan или обратитесь к своему поставщику услуг.

Laos/ ລາວ: ຂໍ້ຄວນເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ນອກຈາກນີ້ ຈະມີເຄື່ອງຊ່ວຍເສີມ ແລະ ບໍລິການແບບທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້ໂດຍບໍ່ເສຍຄ່າ. ໂທຫາຕີ 1-800-952-3455 (TTY: 711) ສຳລັບ Medica, ໂທ 1-877-317-2410 (TTY: 711) ສຳລັບ Dean Health Plan/Prevea360 Health Plan ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

French/ Français: ATTENTION : si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-952-3455 (TTY : 711) pour Medica, appelez le 1-877-317-2410 (TTY : 711) pour le régime de santé Dean Health Plan/Prevea360, ou parlez à votre prestataire de santé.

Serbo-Croatian: PAŽNJA: Ako govorite srpski, dostupne su vam besplatne usluge tumača. Odgovarajuća dodatna pomagala i usluge za pružanje informacija u pristupačnim formatima su također dostupne besplatno. Za Medica zdravstveno osiguranje pozovite 1-800-952-3455 (TTY: 711), za Dean/Prevea360 zdravstveno osiguranje pozovite 1-877-317-2410 (TTY: 711) ili razgovarajte sa svojim pružaocem usluga.

Tagalog: PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyonang tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-952-3455 (TTY: 711) para sa Medica, tumawag sa 1-877-317-2410 (TTY: 711) para sa Dean Health Plan/Prevea360 Health Plan, o makipag-usap sa iyong tagapagbigay ng serbisyo.

Karen/ ထာနုာ်လီၤဖဲအံၤ: ဟံသုာ်ဟံသး- နမ့ၢ်ကတိၤကညီၣ်န့ၢ် တၢ်အိၣ်ဒီး ကျိၣ်တၢ်ဆိၣ်ထွဲၣ်မၤစၢၤ လၢတလၢာ်ဘျုးလၢာ်စ့ၤလၢနဂီၢ်လီၤ. တၢ်အိၣ်ဒီး ပုၤနီၣ်ခိၣ်ကိၢ်တဆူၣ်တကျၢၤအဂီၢ် ပီးလီၤဒီးတၢ်တိၤမၤစၢၤလၢအကြးအဘျုး လၢကဟ့ၣ်တၢ်ဂ့ၢ်တၢ်ကျိၣ်ၤ လၢတၢ်မၤန့ၢ်အိၣ်သ့တဖၣ် လၢတလၢာ်ဘျုးလၢာ်စ့ၤ လၢနဂီၢ်လီၤ. ကိး 1-800-952-3455 (TTY: 711) လၢ Medica အဂီၢ်, ကိး 1-877-317-2410 (TTY: 711) လၢ Dean Health Plan/Prevea360 Health Plan အဂီၢ်, မ့တမ့ၢ်ကတိၤတၢ်ဒီး နပုၤလၢဟ့ၣ်နၢတၢ်ကွၢ်ထွဲၣ်တက့ၢ်.

Amharic/ አማርኛ:- ማሰሰቢያ:- አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። ማረጃን በተደራሰብ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። ለMedica በ1-800-952-3455 (TTY: 711) ይደውሉ፣ ለDean የጤና እቅድ/Prevea360 የጤና እቅድ በ1-877-317-2410 (TTY: 711) ይደውሉ ወይም ለእርስዎን አቅራቢ የሆነውን ያነጋግሩ።