

 **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.DeanCare.com/Shop-Plans/Individual-Family-Plans or call 1 (877) 394-9080 (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 (877) 394-9080 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$0 individual / \$0 family for network services. There is no coverage for non-network services.	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Preventive care and preventive prescriptions from network providers 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?	\$1,650 individual / \$3,300 family for network services. There is no coverage for non-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.DeanCare.com/SearchFocusNetwork-2026 or call 1 (877) 394-9080 (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)	Non-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: \$5 copay /visit. Deductible does not apply. Chiropractic care: \$5 copay /visit. Deductible does not apply.	Not covered	10% coinsurance for other outpatient services. Primary care visits provided at an outpatient facility may be subject to coinsurance and deductible .
	Specialist visit	\$45 copay /visit. Deductible does not apply.	Not covered	None
	Preventive care /screening/immunization	No charge. Deductible does not apply.	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Limited to one physical exam/year, unless additional visits are necessary.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not covered	*May require prior authorization.
	Preferred generic drugs	\$5 copay /prescription. Deductible does not apply.	Not covered	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.DeanCare.com/WIDrugList-2026	Preferred brand, Non-preferred generic drugs	\$125 copay /prescription. Deductible does not apply.	Not covered	*May require prior authorization. See Prescription Drugs section of plan or policy document for more details on prescription drug coverage information.
	Non-preferred brand, Non-preferred generic drugs	50% coinsurance	Not covered	
	Specialty drugs	60% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	*May require prior authorization.
	Physician/surgeon fees	10% coinsurance	Not covered	*May require 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)	Non-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	Network deductible applies.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Network deductible applies.
	Urgent care	10% coinsurance	10% coinsurance	Network deductible applies. If a non-network provider charges more than the allowed amount , you may have to pay the difference (balance billing).
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not covered	*May require prior authorization.
	Physician/surgeon fees	10% coinsurance	Not covered	*May require prior authorization.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$5 copay /office visit. Deductible does not apply. 10% coinsurance for other outpatient services	Not covered	Other outpatient services include intensive outpatient programs, diagnostic evaluations and psychological testing. *May require prior authorization.
	Inpatient services	10% coinsurance	Not covered	*May require prior authorization.
If you are pregnant	Office visits	10% coinsurance	Not covered	Cost sharing does not apply to network preventive services .
	Childbirth/delivery professional services	10% coinsurance	Not covered	Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery facility services	10% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not covered	Limited to 60 visits/year.
	Rehabilitation services	10% coinsurance	Not covered	Outpatient: Limited to 20 visits per therapy/year; Cardiac rehabilitation 36 visits/year. Visit limits do not apply to services for treatment of a mental health and/or substance use disorder condition.
	Habilitation services	10% coinsurance	Not covered	Outpatient: Limited to 20 visits per therapy/year; Cardiac rehabilitation 36 visits/year. Visit limits do not apply to services for treatment of a mental health and/or substance use disorder condition.
	Skilled nursing care	10% coinsurance	Not covered	Limited to 30 days per admission. Coverage is limited to 60 days/year for inpatient rehabilitation .
	Durable medical equipment	10% coinsurance	Not covered	Limited to one purchase per item every three years for most items.
	Hospice services	10% coinsurance	Not covered	None
If your child needs dental or eye care	Children's eye exam	\$5 copay /visit. Deductible does not apply.	Not covered	Limited to one routine vision exam/year to end of month member turns 19.
	Children's glasses	10% coinsurance	Not covered	Limited to one pair of glasses or contacts/year to end of month member turns 19.
	Children's dental check-up	Not covered	Not covered	Coverage is available through a stand-alone dental policy.

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 .)		
● Abortion, elective, induced, except as medically necessary to protect the life of the mother or in the case of rape or incest ● Acupuncture ● Bariatric surgery ● Cosmetic surgery ● Dental care (Adult)	● Dental care (Child) (coverage is available through a stand-alone dental policy) ● Dental check-up ● Infertility treatment ● Long-term care	● Non-emergency care when traveling outside the U.S. ● Private-duty nursing ● Routine eye care (Adult) ● 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.)		
● Chiropractic care ● Hearing aids limited to one per ear every 3 years		

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 (877) 394-9080** (TTY: **711**) or the Wisconsin Office of the Commissioner of Insurance at 800-236-8517 outside of Madison or 608-266-0103 in Madison. 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: Medica at **1 (877) 394-9080** (TTY: **711**) or the Wisconsin Office of the Commissioner of Insurance at 800-236-8517 outside of Madison or 608-266-0103 in Madison.

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 Minimum Value Standards? Not Applicable.
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 (877) 394-9080** (TTY: **711**).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1 (877) 394-9080** (TTY: **711**).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 **1 (877) 394-9080** (TTY: **711**).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' **1 (877) 394-9080** (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](#) \$0
- [Specialist copayment](#) \$45
- [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	\$0
Copayments	\$10
Coinsurance	\$1,100
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,170

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

- The [plan's overall deductible](#) \$0
- [Specialist copayment](#) \$45
- [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	\$0
Copayments	\$800
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$900

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

- The [plan's overall deductible](#) \$0
- [Specialist copayment](#) \$45
- [Hospital \(facility\) coinsurance](#) 10%
- [Other coinsurance](#) 10%

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	\$0
Copayments	\$100
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$400

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 ntawv 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 Sprachassistenzen 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: XIYYEEFANNOO: Ingiliffaa dubbattu taanaan, tajaajjili deggersa afaan bilisaa ni jira. Tajaajjili deggersa bu'ura dhiheessii odeeffannoo kaffattii tokko malee ni jira. Lakkoofsa bilbilaa 1-800-952-3455 (TTY: 711) Tajaajjila Fayyaaf, lakkoofsa Medica 1-877-317-2410 (TTY: 711), Dean Health Plan/Prevea360 Health Plan, ykn dhiheessaa keessan dubbisaa.

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

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 전화하십시오, 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: ຂໍຄວນເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາລາວ, ຈະມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ນອກຈາກນີ້ ຈະມີເຄື່ອງຊ່ວຍເຫຼືອ ແລະ ບໍລິການແບບທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້ໂດຍບໍ່ເສຍຄ່າ. ໂທຫາຕື້ 1-800-952-3455 (TTY: 711) ສໍາລັບ Medica, ໂທ 1-877-317-2410 (TTY: 711) ສໍາລັບ Dean Health Plan/Prevea360 Health Plan ຫຼື ວິມັກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

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 takođe 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 serbisyong 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/ထာနိုလီယဲအ်း ဟ်သုဉ်ဟ်သး- နမ့ၢ်ကတိၤကညီကိဉ်န့ၢ် တၢ်အိၣ်ဒီး ကျိတၢ်ဆိၣ်ထွဲမၤစၢၤ လၢတလၢ်ဘျုးလၢ်စ့ၤလၢနီၣ်လီၤ. တၢ်အိၣ်ဒီး ပုၤနီၣ်နီၣ်ကိၤတဆုၣ်တကျၢၤအဂီၢ် မီးလီၤဒီးတၢ်တိၤစၢၤမၤစၢၤလၢအကြးအဘျုးလၢကဟ့ၣ်တၢ်ဂ့ၢ်တၢ်ကျိၤ လၢတၢ်မၤနီၣ်အိၣ်သ့တဖၣ် လၢတလၢ်ဘျုးလၢ်စ့ၤ လၢနီၣ်လီၤ. 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, မ့တမ့ၢ် ကတိၤတၢ်ဒီး နပုၤလၢဟ့ၣ်နၤတၢ်ကွၢ်ထွဲတက့ၢ်.

Amharic/ አማርኛ:- ማሰባሰቢያ:- አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀጥልዎታል። መረጃን በተደራሽ ቅርጽ 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።