DeanHealthPlan by Medica

DEANCARE.COM

Schedule of Benefits
POS Group Plan

Medical Package ID: POS04776
Certificate ID: POS04776-PHA04618-0124

This Schedule of Benefits and the Member Certificate and any riders **together with the employer Group Master Policy, applications, amendments and any other coverage documents** constitute the contract of insurance. These documents describe the essential features of your coverage and what rules you must follow to obtain covered services.

The employer Group Master Policy **may or may not include** expanded eligibility provisions, beyond those discussed in your Member Certificate. For example, the employer Group Master Policy indicates certain limits regarding dependent coverage. Please contact your employer's group administrator for details.

If necessary, the Schedule of Benefits and the Member Certificate and any riders are replaced on your group's renewal and supersede those which were previously issued. **Keep this Schedule of Benefits with your Member Certificate and any riders and refer to these documents when determining covered services.** Benefits will be administered in accordance with the coverage which was in effect at the time services were rendered. Services must always be Medically Necessary as determined by Us.

The benefits of the Member Certificate are subject to the following:

Cost Sharing Category	In-Network Amount	Out-of-Network Amount
Policy Deductible per Contract Period:	Single: $3200 Family: $6400	Single: $6000 Family: $12000
Policy Coinsurance after Deductible:	Paid by Plan: 90% Paid by You: 10%	Paid by Plan: 70% Paid by You: 30%
Out-of-Pocket Expense Maximum per Contract Period:	Single: $6350 Family: $12700	Single: $12700 Family: $25400

- **All references to "Deductible" are referring to your Deductible, as defined in your group Member Certificate.**
- **Copay amounts do apply to the maximum out-of-pocket expense.**

- If you selected family coverage, please read carefully:
  - Each Member on the family plan needs to meet the single Deductible amount before benefits are payable under this Policy for that Member's expenses. If all of the family's expenses added together meet the full family Deductible amount, before a Member meets the single Deductible amount, benefits will be payable under this Policy for all Members.

Policy Deductible and Out-of-Pocket Expense Maximum amounts are separate between Network and Out-of-Network Providers.

Qualified Dependent Children: Qualified Dependent Children who live outside the Service Area may see certain providers outside the Service Area and still have claims paid at an in-network rate. To locate these providers or for more details call Our Customer Care Center.

Please note: Some services/procedures require Prior Authorization; please see your Member Certificate for more details or call the Customer Care Center at 800-279-1301 (TTY: 711).

The Member is responsible for all costs that exceed the benefit maximum indicated for that service.

IMPORTANT: *This Schedule of Benefits is only a summary of your benefits. A complete description of the benefits and applicable exclusions and limitations are included in your Certificate. Benefits on this Schedule are provided only when services are received according to the terms set forth in the Certificate. You may view your Certificate any time at deancare.com.*

We cover services only when We find them to be Medically Necessary and consistent with the rules explained in your Policy documents. If a particular service, procedure or item is not specifically referenced in your Policy documents, coverage will be based on these rules. Generally, if not specifically referenced, the service, procedure or item will be subject to your Deductible and Policy Coinsurance amounts. Please contact the Customer Care Center if you have questions regarding whether and how a particular service, procedure or item is covered.

Your plan may have benefits in additional riders not described in the schedule of benefits, please see any attached benefit rider for more information about these benefits.

A. General Medical

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
Office Visit (Primary Care Provider & Optometry)	10% coinsurance after deductible	30% coinsurance after deductible
Chiropractic Services	10% coinsurance after deductible	30% coinsurance after deductible
Specialty Office Visits	10% coinsurance after deductible	30% coinsurance after deductible
Diabetic Education	10% coinsurance after deductible	30% coinsurance after deductible
Telehealth *Your cost sharing may be different for services delivered via telehealth as compared to virtual care provided by a designated virtual care provider. Member cost share is based on place and type of service as defined in this Policy.*	Primary Care Provider: 10% coinsurance after deductible Specialty Office Visits: 10% coinsurance after deductible	Primary Care Provider: 30% coinsurance after deductible Specialty Office Visits: 30% coinsurance after deductible
Virtual Care/Virtual Visits • SSM Health Virtual Visit • Other Virtual Visit	 10% coinsurance after deductible 10% coinsurance after deductible	 Not Covered
Preventive Services ***One annual wellness visit***	$0 copay	30% coinsurance after deductible

B. Medical Supplies/Durable Medical Equipment

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
Medical Supplies and Durable Medical Equipment	10% coinsurance after deductible	30% coinsurance after deductible
Diabetic Supplies	10% coinsurance after deductible	30% coinsurance after deductible

C. Diagnostic Services

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
X-Rays and Labs, including readings	10% coinsurance after deductible	30% coinsurance after deductible
Other Diagnostic Services	10% coinsurance after deductible	30% coinsurance after deductible
MRI/MRA	10% coinsurance after deductible	30% coinsurance after deductible
CAT Scans	10% coinsurance after deductible	30% coinsurance after deductible
PET Scans	10% coinsurance after deductible	30% coinsurance after deductible
Readings for: MRI/MRA, CAT Scans, and PET Scans	10% coinsurance after deductible	30% coinsurance after deductible

D. Hearing & Vision Services

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
Hearing Services	10% coinsurance after deductible	30% coinsurance after deductible
Hearing Aids – Adults ***Limited to one aid per ear every 36 months.***	10% coinsurance after deductible	Not Covered
Hearing Aids – Children through age 18 ***Limited to one aid per ear every 36 months.***	10% coinsurance after deductible	30% coinsurance after deductible
Cochlear Implants	10% coinsurance after deductible	30% coinsurance after deductible
Routine Vision Exam	10% coinsurance after deductible	30% coinsurance after deductible
Non-Routine Vision Exam	10% coinsurance after deductible	30% coinsurance after deductible
Vision Services	10% coinsurance after deductible	30% coinsurance after deductible
Eyeglasses – Children through age 18	Not Covered	Not Covered

E. Hospital & Surgical Services

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
Inpatient Hospital *Maximum IN copay expense per Contract Period is Unlimited single / Unlimited family*	10% coinsurance after deductible	30% coinsurance after deductible
Inpatient Rehabilitative Confinement *Maximum IN copay expense per Contract Period is Unlimited single / Unlimited family* *Combined benefit limited to 90 days per Member per Contract Period*	10% coinsurance after deductible	30% coinsurance after deductible
Detoxification Services *Maximum IN copay expense per Contract Period is Unlimited single / Unlimited family*	10% coinsurance after deductible	30% coinsurance after deductible
Outpatient Hospital *Maximum IN copay expense per Contract Period is Unlimited single / Unlimited family*	10% coinsurance after deductible	30% coinsurance after deductible
Ambulatory Surgical Center *Maximum IN copay expense per Contract Period is Unlimited single / Unlimited family*	10% coinsurance after deductible	30% coinsurance after deductible

F. Skilled Nursing Facility

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
Licensed Skilled Nursing (Excludes Custodial Care and Other Non-Covered Expenses) *Maximum IN copay expense per Contract Period is Unlimited single / Unlimited family* *Limited to 30 days per Confinement*	10% coinsurance after deductible	30% coinsurance after deductible

G. Home Health Care

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
Home Health Care *Limited to 60 visits per Contract Period*	10% coinsurance after deductible	30% coinsurance after deductible

H. Hospice Care

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
Hospice Care	10% coinsurance after deductible	30% coinsurance after deductible

I. Palliative Care

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
Palliative Care	10% coinsurance after deductible	30% coinsurance after deductible

J. Emergency & Urgent Care Services

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
Ambulance Services	10% coinsurance after deductible	10% coinsurance after in-network deductible
Emergency Room Services* *You may be responsible for other charges in addition to the facility Copay/Deductible/Coinsurance.**	10% coinsurance after deductible	10% coinsurance after in-network deductible
Urgent Care Facility* *You may be responsible for other charges in addition to the visit Copay/Deductible/Coinsurance.**	10% coinsurance after deductible	10% coinsurance after in-network deductible
* Other charges will result from services rendered by other providers who treated you during your urgent care or emergency room visit. These charges include, but are not limited to, physician visits, diagnostic services, procedures/treatments and various medical supplies. The amount charged for these services, excluding emergency services, received from an Out-of-Network Provider may exceed the Maximum Allowable Fee in which case you will be responsible for paying the difference between the amount charged and the Maximum Allowable Fee.		

K. Therapies, Rehabilitation & Habilitative Services

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
Autism Spectrum Disorder – Intensive – Physician and Facility Charge *The Member is eligible for 4 cumulative years of intensive-level services*	10% coinsurance after deductible	30% coinsurance after deductible
Autism Spectrum Disorder – Intensive – Related Services *The Member is eligible for 4 cumulative years of intensive-level services*	10% coinsurance after deductible	30% coinsurance after deductible
Autism Spectrum Disorder – Non-Intensive – Physician and Facility Charge	10% coinsurance after deductible	30% coinsurance after deductible
Autism Spectrum Disorder – Non-Intensive – Related Services	10% coinsurance after deductible	30% coinsurance after deductible
Outpatient Physical, Speech and Occupational Therapy *Limited to 60 visits per Contract Period (All therapies combined)*	10% coinsurance after deductible	30% coinsurance after deductible
Habilitative Services *Limited to 60 visits per Contract Period (All habilitative therapies combined)*	10% coinsurance after deductible	30% coinsurance after deductible
Phase II Cardiac Rehabilitation	10% coinsurance after deductible	30% coinsurance after deductible
Radiation Therapy	10% coinsurance after deductible	30% coinsurance after deductible

L. Dental Services

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
Trauma/Accidental Injury to Teeth	10% coinsurance after deductible	30% coinsurance after deductible
Oral Surgery Consult	10% coinsurance after deductible	30% coinsurance after deductible
Oral Surgical Services	10% coinsurance after deductible	30% coinsurance after deductible
Treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level.	Covered at the corresponding out-of-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit out-of-network benefit level and surgical services are covered at the surgical services out-of-network benefit level.
TMJ DME	10% coinsurance after deductible	30% coinsurance after deductible

M. Behavioral Health & Addiction Services

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
Inpatient/Residential Care – Behavioral Health & Addiction Services *Maximum IN copay expense per Contract Period is Unlimited single / Unlimited family*	10% coinsurance after deductible	30% coinsurance after deductible
Outpatient Behavioral Health & Addiction Services	10% coinsurance after deductible	30% coinsurance after deductible
Intensive Outpatient/Day Treatment/Partial Hospitalization	10% coinsurance after deductible	30% coinsurance after deductible

N. Transplants

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
Transplant Services *Maximum IN copay expense per Contract Period is Unlimited single / Unlimited family*	10% coinsurance after deductible	30% coinsurance after deductible

O. Other Services

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
Acupuncture *Combined benefit limited to 10 visits per Contract Period*	10% coinsurance after deductible	30% coinsurance after deductible
Anesthesia Services	10% coinsurance after deductible	30% coinsurance after deductible
Allergy Injections	10% coinsurance after deductible	30% coinsurance after deductible
Genetic Counseling	Primary Care Provider: 10% coinsurance after deductible Specialty Office Visits: 10% coinsurance after deductible	Primary Care Provider: 30% coinsurance after deductible Specialty Office Visits: 30% coinsurance after deductible
Genetic Testing Services	10% coinsurance after deductible	30% coinsurance after deductible
Infertility Services *$2,000 combined lifetime benefit maximum*	10% coinsurance after deductible	30% coinsurance after deductible
Maternity Services – Physician Services	10% coinsurance after deductible	30% coinsurance after deductible
Surgical Services	10% coinsurance after deductible	30% coinsurance after deductible
Travel Immunizations	10% coinsurance after deductible	Not Covered

HEALTH SAVINGS ACCOUNT QUALIFYING HIGH DEDUCTIBLE HEALTH PLANS:

- We intend for this Plan to be a "High Deductible Health Plan" ("HDHP") compatible with a "Health Savings Account" ("HSA"), as described in Section 223 of the Internal Revenue Code, as amended. Individuals must carefully review their own circumstances and consult with their own tax advisors/financial advisors to determine the extent to which they will be eligible for tax benefits under Internal Revenue Code Section 223. Among other things, individuals will often be unable to make tax-deferred contributions to an HSA if they have health coverage from any other source. We make no guarantee that any individual will be eligible for tax benefits associated with an HSA as a result of his or her coverage under this Policy.
- We bear no responsibility for the establishment or administration of any HSA.
- Each year, this Policy's Deductible and Out-of-Pocket Expense Maximum may be automatically adjusted based on federal guidelines.
- If you selected family coverage, please read carefully:
    - Each Member on the family plan needs to meet the single Deductible amount before benefits are payable under this Policy for that Member's expenses. If all of the family's expenses added together meet the full family Deductible amount, before a Member meets the single Deductible amount, benefits will be payable under this Policy for all Members.
    - Each Member on a family plan needs to meet the single Out-of-Pocket Expense Maximum amount before We will pay 100% of the allowed charges for that Member. If all of the family's expenses added together meet the full family Out-of-Pocket Expense Maximum amount, before a Member meets the single Out-of-Pocket Expense Maximum amount, We will pay 100% of the allowed charges under this Policy for all Members.

Rider – Prescription Drugs – Tier Option

Cost-sharing applicable after Policy Deductible is met

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
TIER 1 Outpatient Prescription Drugs*** Preferred Generic *30-day supply*	10% coinsurance after deductible	30% coinsurance after deductible
TIER 2 Outpatient Prescription Drugs *** Non-Preferred Generic, Preferred Brand *30-day supply*	10% coinsurance after deductible	30% coinsurance after deductible
TIER 3 Outpatient Prescription Drugs Non-Preferred Generic, Non-Preferred Brand *30-day supply*	10% coinsurance after deductible	Not Covered
TIER 4 Outpatient Prescription Drugs Specialty Drugs *30-day supply*	10% coinsurance after deductible	30% coinsurance after deductible
Mail Order	90-day supply (Tiers 1 - 3) policy coinsurance after deductible; Tier 4 Not Covered	Not Covered
Outpatient Prescription Drugs – Infertility	50% coinsurance after deductible	Not Covered

***For certain generic maintenance drugs, as defined by Us, a retail provider must dispense a 90-day supply. This requirement will apply after you have received three consecutive 30-day supplies. A Member may request an exception to this requirement by either: 1) asking the retail pharmacy provider to contact pharmacy benefit manager, or 2) contacting Our Customer Care Center.