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. Please read the FEHB Plan brochure (RI 73-189) that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure**. Benefits may vary if you have other coverage, such as Medicare. 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 get the FEHB Plan brochure at https://www.deancare.com/members/federal-employee-members and view the Glossary at https://www.dol.gov/ebsa/healthreform or https://www.healthcare.gov/sbc-glossary/. You can call 1-800-279-1301 (TTY: 711) to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$ 500/Self Only $ 1,000/Self Plus One $ 1,000/Self and Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. Copayments and coinsurance amounts do not count toward your deductible, which generally starts over January 1. When a covered service/supply is subject to a deductible, only the Plan allowance for the service/supply counts toward the deductible. 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?	$5,000 individual / $10,000 family	The out-of-pocket limit, or catastrophic maximum, 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 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, plus you may be balance billed)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit and/or 10% coinsurance after deductible	Not covered	No coverage for Chiropractic maintenance or long-term therapy.
	Specialist visit	$40 copay/visit and/or 10% coinsurance after deductible	Not covered	None
	Preventive care/screening/ immunization	No charge	Not covered	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 aren't 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)	$0 copay/visit	Not covered	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	Not covered	None

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, plus you may be balance billed)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at deancare.com/members/pharmacy-benefits	Generic drugs	$10 copay / prescription (retail); Mail order maintenance prescriptions, a 90-day supply for 2 copays.	Not covered (retail and mail order)	None
	Preferred brand drugs	30% coinsurance max of $75 / prescription (retail); Mail order maintenance prescriptions, a 90-day supply at coinsurance listed above.	Not covered (retail and mail order)	None
	Non-preferred brand drugs	50% coinsurance, minimum of $50 / prescription max of $150/prescription (retail); Mail order maintenance prescriptions, a 90-day supply at coinsurance listed above.	Not covered (retail and mail order)	None
	Specialty drugs	$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)	10% coinsurance after deductible	Not covered	None

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, plus you may be balance billed)	
	Physician/surgeon fees	10% coinsurance after deductible	Not covered	None
If you need immediate medical attention	Emergency room care	10% coinsurance after deductible	10% coinsurance after deductible	Initial emergency services are covered with out-of-network providers. Copay is waived if admitted for observation or inpatient.
	Emergency medical transportation	10% coinsurance after deductible	10% coinsurance after deductible	None
	Urgent care	$20 copay/visit and/or 10% coinsurance after deductible	$20 copay/visit and/or 10% coinsurance after deductible	Initial urgent care services are covered with out-of-network providers.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible	Not covered	None
	Physician/surgeon fees	10% coinsurance after deductible	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit	Not covered	None
	Inpatient services	10% coinsurance after deductible	Not covered	None
If you are pregnant	Office visits	Primary Care Visit - $20 copay/visit and/or 10% coinsurance after deductible; Specialist Visit - $40 copay/visit and/or 10% coinsurance after deductible	Not covered	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	10% coinsurance after deductible	Not covered	
	Childbirth/delivery facility services	10% coinsurance after deductible	Not covered	
If you need help recovering or have	Home health care	10% coinsurance after deductible	Not covered	None

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, plus you may be balance billed)	
other special health needs	Rehabilitation services	Rehabilitation Services: 10% coinsurance after deductible PT/OT/ST: $40 copay/therapy/day	Not covered	Rehabilitation care - 90 days/contract period Services for custodial care are a policy exclusion.
	Habilitation services	$40 copay/therapy/day and/or 10% coinsurance after deductible	Not covered	Services for custodial care are a policy exclusion.
	Skilled nursing care	10% coinsurance after deductible	Not covered	120 days/confinement.
	Durable medical equipment	10% coinsurance after deductible	Not covered	None
	Hospice services	10% coinsurance after deductible	Not covered	None
If your child needs dental or eye care	Children's eye exam	$20 copay/visit	Not covered	Exams performed by an ophthalmologist will incur the specialty office visit cost share.
	Children's glasses	$0 copay	Not covered	One pair per contract year.
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your FEHB Plan brochure for more information and a list of any other excluded services.)

- Cosmetic services including surgery
- Dental care (Adult)
- Glasses (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care

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

- Acupuncture (Limited to 10 visits per contract period)
- Bariatric Surgery after written approval and completion of Weight Management program.
- Chiropractic care
- Hearing aids (Limited to one aid per ear every 36 months)
- Infertility treatment
- Routine eye care (Adult)
- Weight Loss Programs as part of our Comprehensive Weight Management Program

Your Rights to Continue Coverage: You can get help if you want to continue your coverage after it ends. See the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at 1-800-279-1301 (TTY: 711) or visit www.opm.gov.insure/health. Generally, if you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, a conversion policy (a non-FEHB individual policy), spouse equity coverage, or temporary continuation of coverage (TCC). 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: If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal. For information about your appeal rights please see Section 3, "How you get care," and Section 8 "The disputed claims process," in your FEHB Plan brochure. If you need assistance, you can contact: Dean Health Plan at deancare.com or 1-800-279-1301 (TTY: 711); Wisconsin Office of the Commissioner of Insurance at (800) 236-8517 or http://oci.wi.gov/ or 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 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 1-800-279-1301 (TTY: 711).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-279-1301 (TTY: 711).
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-800-279-1301 (TTY: 711).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-279-1301 (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** **$500**
- **Specialist copayment** **$40**
- **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	$500
Copayments	$10
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,670**

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

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$40**
- **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	$500
Copayments	$300
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,820**

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

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$40**
- **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	$500
Copayments	$400
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,000**

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