DeanHealthPlan by Medica

DEANCARE.COM

Schedule of Benefits
PPO Group Plan

Medical Package ID: PPO04424
Certificate ID: PPO04424-PHA03713-0124

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: $2500 Family: $5000	Single: $5000 Family: $10000
Policy Coinsurance after Deductible:	Paid by Plan: 100% Paid by You: 0%	Paid by Plan: 80% Paid by You: 20%
Deductible and Coinsurance Limit per Contract Period:	Single: $2500 Family: $5000	Single: $14300 Family: $28600
Out-of-Pocket Expense Maximum per Contract Period:	Single: $7150 Family: $14300	Single: $14300 Family: $28600

- **All references to "Deductible" are referring to your Deductible, as defined in your group Member Certificate.**
- **Copay amounts do not apply to the Deductible and Coinsurance Limit.**
- **Copay amounts do apply to the maximum out-of-pocket expense.**

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

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)	$30 copay	20% coinsurance after deductible
Chiropractic Services	$30 copay	20% coinsurance after deductible
Specialty Office Visits	$30 copay	20% coinsurance after deductible
Diabetic Education	$0 copay	20% 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: $30 copay Specialty Office Visits: $30 copay	Primary Care Provider: 20% coinsurance after deductible Specialty Office Visits: 20% coinsurance after deductible
Virtual Care/Virtual Visits • SSM Health Virtual Visit • Other Virtual Visit	 $0 copay 0% coinsurance after deductible	 Not Covered
Preventive Services ***One annual wellness visit***	$0 copay	20% 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	0% coinsurance after deductible	20% coinsurance after deductible
Diabetic Supplies	0% coinsurance after deductible	20% coinsurance after deductible

C. Diagnostic Services

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
X-Rays and Labs, including readings	0% coinsurance after deductible	20% coinsurance after deductible
Other Diagnostic Services	0% coinsurance after deductible	20% coinsurance after deductible
MRI/MRA	0% coinsurance after deductible	20% coinsurance after deductible
CAT Scans	0% coinsurance after deductible	20% coinsurance after deductible
PET Scans	0% coinsurance after deductible	20% coinsurance after deductible
Readings for: MRI/MRA, CAT Scans, and PET Scans	0% coinsurance after deductible	20% coinsurance after deductible

D. Hearing & Vision Services

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
Hearing Services	0% coinsurance after deductible	20% coinsurance after deductible
Hearing Aids – Adults *Limited to one aid per ear every 36 months.*	0% coinsurance after deductible	Not Covered
Hearing Aids – Children through age 18 *Limited to one aid per ear every 36 months.*	0% coinsurance after deductible	20% coinsurance after deductible
Cochlear Implants	0% coinsurance after deductible	20% coinsurance after deductible
Routine Vision Exam	$30 copay per visit	20% coinsurance after deductible
Non-Routine Vision Exam	$30 copay per visit	20% coinsurance after deductible
Vision Services	0% coinsurance after deductible	20% 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*	0% coinsurance after deductible	20% 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*	0% coinsurance after deductible	20% coinsurance after deductible
Detoxification Services *Maximum IN copay expense per Contract Period is Unlimited single / Unlimited family*	0% coinsurance after deductible	20% coinsurance after deductible
Outpatient Hospital *Maximum IN copay expense per Contract Period is Unlimited single / Unlimited family*	0% coinsurance after deductible	20% coinsurance after deductible
Ambulatory Surgical Center *Maximum IN copay expense per Contract Period is Unlimited single / Unlimited family*	0% coinsurance after deductible	20% 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*	0% coinsurance after deductible	20% 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*	0% coinsurance after deductible	20% coinsurance after deductible

H. Hospice Care

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
Hospice Care	0% coinsurance after deductible	20% coinsurance after deductible

I. Palliative Care

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
Palliative Care	$0 copay	20% coinsurance after deductible

J. Emergency & Urgent Care Services

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
Ambulance Services	0% coinsurance after deductible	0% coinsurance after in-network deductible
Emergency Room Services* *You may be responsible for other charges in addition to the facility Copay/Deductible/Coinsurance.* Copay is waived if admitted for Observation or Inpatient.*	$125 copay and/or 0% coinsurance after deductible	$125 copay and/or 0% coinsurance after in-network deductible
Urgent Care Facility* *You may be responsible for other charges in addition to the visit Copay/Deductible/Coinsurance.**	$30 copay and/or 0% coinsurance after deductible	$30 copay and/or 0% 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*	$30 copay per therapy type per day	20% coinsurance after deductible
Autism Spectrum Disorder – Intensive – Related Services *The Member is eligible for 4 cumulative years of intensive-level services*	0% coinsurance after deductible	20% coinsurance after deductible
Autism Spectrum Disorder – Non-Intensive – Physician and Facility Charge	$30 copay per therapy type per day	20% coinsurance after deductible
Autism Spectrum Disorder – Non-Intensive – Related Services	0% coinsurance after deductible	20% coinsurance after deductible
Outpatient Physical, Speech and Occupational Therapy *Limited to 60 visits per Contract Period (All therapies combined)*	$30 copay per therapy type per day	20% coinsurance after deductible
Habilitative Services *Limited to 60 visits per Contract Period (All habilitative therapies combined)*	$30 copay per therapy type per day	20% coinsurance after deductible
Phase II Cardiac Rehabilitation	0% coinsurance after deductible	20% coinsurance after deductible
Radiation Therapy	0% coinsurance after deductible	20% coinsurance after deductible

L. Dental Services

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
Trauma/Accidental Injury to Teeth	0% coinsurance after deductible	20% coinsurance after deductible
Oral Surgery Consult	$30 copay per visit	20% coinsurance after deductible
Oral Surgical Services	0% coinsurance after deductible	20% 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	0% coinsurance after deductible	20% 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***	0% coinsurance after deductible	20% coinsurance after deductible
Outpatient Behavioral Health & Addiction Services	$30 copay	20% coinsurance after deductible
Intensive Outpatient/Day Treatment/Partial Hospitalization	0% coinsurance after deductible	20% 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***	0% coinsurance after deductible	20% 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***	$30 copay	20% coinsurance after deductible
Anesthesia Services	0% coinsurance after deductible	20% coinsurance after deductible
Allergy Injections	0% coinsurance after deductible	20% coinsurance after deductible
Genetic Counseling	Primary Care Provider: $30 copay Specialty Office Visits: $30 copay	Primary Care Provider: 20% coinsurance after deductible Specialty Office Visits: 20% coinsurance after deductible
Genetic Testing Services	0% coinsurance after deductible	20% coinsurance after deductible
Infertility Services ***$2,000 combined lifetime benefit maximum***	100% after $2,000	100% after $2,000
Maternity Services – Physician Services	0% coinsurance after deductible	20% coinsurance after deductible
Surgical Services	0% coinsurance after deductible	20% coinsurance after deductible
Travel Immunizations	0% coinsurance after deductible	Not Covered

Rider – Prescription Drugs – Tier Option

Cost-sharing applicable after Rx Deductible of $250 single/$500 family per Contract Period

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
TIER 1 Outpatient Prescription Drugs*** Brand and Generic *30-day supply*	$10 copay after deductible **	50% coinsurance after deductible
TIER 2 Outpatient Prescription Drugs *** Brand and Generic *30-day supply*	$25 copay after deductible **	50% coinsurance after deductible
TIER 3 Outpatient Prescription Drugs Brand and Generic *30-day supply*	$50 copay after deductible **	Not Covered
TIER 4 Outpatient Prescription Drugs Brand and Generic *30-day supply*	30% coinsurance **	50% coinsurance after deductible
Mail Order	90-day supply (Tiers 1 & 2) for 2 copays; 90-day supply (Tier 3) for 3 copays; Tier 4 Not Covered	Not Covered
Outpatient Prescription Drugs – Infertility	50% coinsurance	Not Covered

**Regardless of the tier your oral chemotherapy falls into you will never pay more than $100 for a 30 day supply, in compliance with the Wisconsin law governing coverage of oral chemotherapy drugs.

***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.