DeanHealthPlan by Medica

DEANCARE.COM

Schedule of Benefits
HMO Group Plan

Medical Package ID: HMO06195
Certificate ID: HMO06195-PHA04526-0124

This Schedule of Benefits and the Member Certificate **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 are replaced on your group's renewal and supersede those which were previously issued. **Keep this Schedule of Benefits with your Member Certificate 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	Amount
Policy Deductible per Contract Period:	Single: $5100 Family: $10200
Policy Coinsurance after Deductible:	Paid by Plan: 70% Paid by You: 30%
Out-of-Pocket Expense Maximum per Contract Period:	Single: $8900 Family: $17800

- All references to "Deductible" are referring to your Deductible, as defined in your group Member Certificate.

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 Policy. Benefits on this Schedule are provided only when services are received according to the terms set forth in the Policy. You may view your Policy 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.

A. General Medical

Benefits	Amount You Pay
Office Visit (Primary Care Provider & Optometry)	$40 copay
Chiropractic Services	$40 copay
Specialty Office Visits	$80 copay
Diabetic Education	$0 copay
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: $40 copay Specialty Office Visits: $80 copay
Virtual Care/Virtual Visits • SSM Health Virtual Visits • Other Virtual Visit	 $0 copay 30% coinsurance after deductible
Preventive Services ***One annual wellness visit***	$0 copay

B. Medical Supplies/Durable Medical Equipment

Benefits	Amount You Pay
Medical Supplies and Durable Medical Equipment	30% coinsurance after deductible
Diabetic Supplies	30% coinsurance after deductible

C. Diagnostic Services

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

D. Hearing & Vision Services

Benefits	Amount You Pay
Hearing Services	30% coinsurance after deductible
Hearing Aids – Adults *Limited to one aid per ear every 36 months.*	30% coinsurance after deductible
Hearing Aids – Children through age 18 *Limited to one aid per ear every 36 months.*	30% coinsurance after deductible
Cochlear Implants	30% coinsurance after deductible
Routine Vision Exam – Children through age 18 Exams performed by an ophthalmologist will incur the specialty office visit copay	$40 copay per visit
Routine Vision Exam – Adult Exams performed by an ophthalmologist will incur the specialty office visit copay	$40 copay per visit
Non-Routine Vision Exam Exams performed by an ophthalmologist will incur the specialty office visit copay	$80 copay per visit
Vision Services	30% coinsurance after deductible
Eyeglasses – Children through age 18	30% coinsurance after deductible

E. Hospital & Surgical Services

Benefits	Amount You Pay
Inpatient Hospital	30% coinsurance after deductible
Inpatient Rehabilitative Confinement *Limited to 60 days per Member per Contract Period*	30% coinsurance after deductible
Outpatient Hospital	30% coinsurance after deductible
Ambulatory Surgical Center	30% coinsurance after deductible
Detoxification Services	30% coinsurance after deductible

F. Skilled Nursing Facility

Benefits	Amount You Pay
Licensed Skilled Nursing (Excludes Custodial Care and Other Non-Covered Expenses) *Limited to 30 days per Confinement*	30% coinsurance after deductible

G. Home Health Care

Benefits	Amount You Pay
Home Health Care *Limited to 60 visits per Contract Period*	30% coinsurance after deductible

H. Hospice Care

Benefits	Amount You Pay
Hospice Care	30% coinsurance after deductible

I. Palliative Care

Benefits	Amount You Pay
Palliative Care	$0 copay

J. Emergency & Urgent Care Services

Benefits	Amount You Pay
Ambulance Services	30% coinsurance after deductible
Emergency Room Services*	$500 copay and/or 30% coinsurance after deductible
Urgent Care Facility*	$40 copay and/or 30% coinsurance after 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. Cost-sharing requirements for items and services provided by Out-of-Network Providers at in-network facilities will be no greater than in-network requirements.	

K. Section Intentionally Omitted

L. Therapies, Rehabilitation & Habilitative Services

Benefits	Amount You Pay
Autism Spectrum Disorder – Intensive – Physician and Facility Charge *The Member is eligible for 4 cumulative years of intensive-level services*	$40 copay per therapy type per day
Autism Spectrum Disorder – Intensive – Related Services *The Member is eligible for 4 cumulative years of intensive-level services*	30% coinsurance after deductible
Autism Spectrum Disorder – Non-Intensive – Physician and Facility Charge	$40 copay per therapy type per day
Autism Spectrum Disorder – Non-Intensive – Related Services	30% coinsurance after deductible
Cognitive Rehabilitation Therapy *Limited to 20 visits per therapy type per Contract Period*	$40 copay per therapy type per day

L. Therapies, Rehabilitation & Habilitative Services (continued)

Benefits	Amount You Pay
Outpatient Physical, Speech and Occupational Therapy *Limited to 20 visits per therapy type per Contract Period*	$40 copay per therapy type per day
Habilitative Services *Limited to 20 visits per therapy type per Contract Period*	$40 copay per therapy type per day
Phase II Cardiac Rehabilitation	30% coinsurance after deductible
Post Cochlear Implants Aural Therapy *Limited to 30 visits per therapy type per Contract Period*	$40 copay per therapy type per day
Radiation Therapy	30% coinsurance after deductible

M. Dental Services

Benefits	Amount You Pay
Trauma/Accidental Injury to Teeth	30% coinsurance after deductible
Oral Surgery Consult	$80 copay per visit
Oral Surgical Services	30% coinsurance after deductible
Treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder	Covered at the corresponding benefit level, depending on type of services provided. For example, office visits are covered at the office visit benefit level and surgical services are covered at the surgical services benefit level.
TMJ DME	30% coinsurance after deductible

N. Behavioral Health & Addiction Services

Benefits	Amount You Pay
Inpatient/Residential Care – Behavioral Health & Addiction Services	30% coinsurance after deductible
Outpatient Behavioral Health & Addiction Services	$40 copay
Intensive Outpatient/Day Treatment/Partial Hospitalization	30% coinsurance after deductible

O. Transplants

Benefits	Amount You Pay
Transplant Services	30% coinsurance after deductible

P. Other Services

Benefits	Amount You Pay
Acupuncture *Limited to 10 visits per Contract Period*	$40 copay
Anesthesia Services	30% coinsurance after deductible
Allergy Injections	30% coinsurance after deductible
Genetic Counseling	Primary Care Provider: $40 copay Specialty Office Visits: $80 copay
Genetic Testing Services	30% coinsurance after deductible
Home Infusion Therapy	30% coinsurance after deductible
Infertility Services	Not Covered
Surgical Services	30% coinsurance after deductible
Travel Immunizations	30% coinsurance after deductible
Maternity Services	
Diagnostic Services	30% coinsurance after deductible
Physician and Hospital Services	30% coinsurance after deductible

Q. Outpatient Prescription Drugs – Tier Option

Benefits	Amount You Pay
TIER 1 Outpatient Prescription Drugs Preferred Generic *30-day supply*	$10 copay **
TIER 2 Outpatient Prescription Drugs Non-Preferred Generic, Preferred Brand*** *30-day supply*	$40 copay **
TIER 3 Outpatient Prescription Drugs Non-Preferred Generic, Non-Preferred Brand *30-day supply*	$75 copay **
TIER 4 Outpatient Specialty Prescription Drugs Specialty Drugs *30-day supply*	$150 copay **
Mail Order	90-day supply (Tier 1) for 2 copays; 90-day supply (Tiers 2 & 3) for 3 copays; Tier 4 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 covered preferred insulin prescriptions, you will not pay more than $35 for a 30 day supply.