


Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Dean Health Care – Value Plan

Coverage Period: 1/1/2025 – 12/31/2025

Coverage for: Individual + Family | Plan Type: EPO

 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, call 1-800-345-9474. 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 [www.hshs.org/myhr](http://www.hshs.org/myhr) or by calling 1-800-345-9474 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$700 Individual/\$1,400 Family	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. <b>Out-of-network services</b> – <i>must receive referral from Dean Health Plan, unless a true emergency</i>
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes	Wellness and preventive care is covered at 100%, not subject to the deductible.
Are there other <a href="#">deductibles</a> for specific services?	No, the prescription drug deductible is combined with medical deductible	You must pay all of the costs for these services up to the <b>deductible</b> amount before this plan begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$3,800 Individual /\$7,600 Family Limit The out-of-pocket limit includes the deductible and amounts cross-apply	The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. <b>Out-of-network services</b> – <i>must receive referral from Dean Health Plan, unless a true emergency</i>
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for service, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes	You must obtain a referral from Dean Health Plan for out-of-network providers
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the network <a href="#">specialist</a> you choose without permission from this plan.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.hshs.org/myhr](http://www.hshs.org/myhr)

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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	Your Costs if You Use a		Limitations & Exceptions
		HSHS/Prevea	Other Prevea360	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	No charge; deductible waived	20% Coinsurance	---none---
	<a href="#">Specialist</a> visit	No charge; deductible waived	20% Coinsurance	
	<a href="#">Preventive care/screening/immunization</a>	No charge; deductible waived	No charge; deductible waived	Age and frequency schedules may apply.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge, Deductible Waived	20% Coinsurance	Precertification may be required.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	20% Coinsurance	Precertification may be required.

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Common Medical Event	Services You May Need	Your Cost If You Use a Network Pharmacy	Your Cost If You Use a Non-Network Pharmacy	Limitations & Exceptions
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <a href="http://www.optumrx.com">prescription drug coverage</a> is available at <a href="http://www.optumrx.com">www.optumrx.com</a></p>	Generic drugs	HSHS 10% coinsurance All Others 20% coinsurance	Not covered	Deductible and out-of-pocket limit applies. Retail – 30 day supply Mail – 90 day supply
	Preferred brand drugs	HSHS 20% coinsurance All Others 30% coinsurance	Not covered	If you choose to receive a brand name medication when a direct generic equivalent is available, you must pay the difference in price between the brand drug and its generic equivalent in addition to the applicable copay and generic coinsurance.
	Non-preferred brand drugs	HSHS 20% coinsurance after \$15 copay All Others 30% coinsurance after \$15 copay HSHS Mail Order \$45 copay then 20% coinsurance All Others Mail Order \$45 copay then 30% coinsurance	Not covered	Maintenance medications at HSHS, mail order or Walgreens required for coverage after the second fill at a retail pharmacy.
	<a href="#">Specialty drugs</a>	HSHS 20% coinsurance All Others 30% coinsurance	Not covered	After the initial fill, specialty medications must be filled through OptumRx or HSHS to be covered.  Prior authorization may be required.

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Common Medical Event	Services You May Need	Your Costs if You Use a		Limitations & Exceptions
		HSHS/Prevea	Other Prevea360	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	20% Coinsurance	Precertification may be required.
	Physician/ surgeon fees	20% Coinsurance	20% Coinsurance	Most receive referral from Dean Health Plan for out-of-network providers
If you need immediate medical attention	<a href="#">Emergency room care</a>	Facility - \$100 copay then 20% coinsurance, deductible waived Physician – 20% coinsurance	Facility - \$100 copay then 20% coinsurance, deductible waived Physician – 20% coinsurance	
	<a href="#">Emergency medical transportation</a>	20% coinsurance	20% coinsurance	Precertification may be required for non-emergent air ambulance.
	<a href="#">Urgent care</a>	20% coinsurance	20% coinsurance	

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Common Medical Event	Services You May Need	Your Costs if You Use a		Limitations & Exceptions
		HSHS/Prevea	Other Prevea360	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	Precertification is required. Must receive referral from Dean Health Plan for out-of-network providers
	Physician/ surgeon fees	20% coinsurance	20% coinsurance	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	No charge; Deductible Waived Office visits; 20% Coinsurance other outpatient services	No charge; Deductible Waived Office visits; 20% Coinsurance other outpatient services	
	Inpatient services	20% coinsurance	20% coinsurance	Precertification required.
<b>If you are pregnant</b>	Office visits	20% coinsurance	20% coinsurance	Deductible may apply for most non-office visit charges
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	---none---
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance	Notification is required.

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Common Medical Event	Services You May Need	Your Costs if You Use a		Limitations & Exceptions
		HSHS/Prevea	Other Prevea360	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% coinsurance	20% coinsurance	120 visits per benefit period. Precertification required.
	<a href="#">Rehabilitation services</a>	20% coinsurance, deductible waived	20% coinsurance	Precertification may be required.
	<a href="#">Habilitation services</a>	20% coinsurance, deductible waived	20% coinsurance	Precertification may be required.
	<a href="#">Skilled nursing care</a>	20% coinsurance	20% coinsurance	90 days per admission, renewable after 180 days between discharge and re-admission. Precertification required.
	<a href="#">Durable medical equipment</a>	20% coinsurance	20% coinsurance	Precertification may be required.
	<a href="#">Hospice services</a>	20% coinsurance	20% coinsurance	Precertification required.
<b>If your child needs dental or eye care</b>	Children’s eye exam	Not Covered	Not Covered	---none---
	Children’s glasses	Not Covered	Not Covered	---none---
	Children’s dental check-up	Not Covered	Not Covered	---none---

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### 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](#).)

- |  |   |  |
|--|---|--|
| <ul style="list-style-type: none"><li>• Cosmetic Surgery</li><li>• Dental Care (routine adult)</li><li>• Glasses (Adult &amp; Child)</li></ul> | <ul style="list-style-type: none"><li>• Long-term care</li><li>• Non-emergency care when traveling outside the U.S.</li></ul> | <ul style="list-style-type: none"><li>• Routine eye care (Adult &amp; Child)</li><li>• Routine foot care</li><li>• Weight loss program – except for required preventive services</li></ul> |
|--|---|--|

#### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [Plan](#) document.)

- |  |   |   |
|--|---|---|
| <ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric surgery (HSHS Facility only)</li></ul> | <ul style="list-style-type: none"><li>• Spinal manipulations</li><li>• Hearing aids – Up to \$2,500 per hearing aid every 3 years</li></ul> | <ul style="list-style-type: none"><li>• Infertility testing – Coverage is limited to the diagnosis and treatment of underlying medical condition</li><li>• Private-duty nursing</li></ul> |
|--|---|---|

**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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/ebsa/healthreform>. 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](http://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 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: 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 [plan](#), [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](#).

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**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-327-8497.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-327-8497.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-327-8497.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-327-8497.

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$700
■ <a href="#">Specialist</a> coinsurance	20%
■ Hospital Facility coinsurance	20%
■ Other coinsurance	20%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$700
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$2,400
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,160</b>

Example assumes all care is received from Network Facilities and Network Specialists.

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$700
■ <a href="#">Specialist</a> coinsurance	20%
■ Hospital Facility coinsurance	20%
■ Other coinsurance	20%

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$700
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$700
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,420</b>

Example assumes all care is received from Network Facilities and Network Specialists.

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$700
■ <a href="#">Specialist</a> coinsurance	20%
■ Hospital Facility coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic tests](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$700
<a href="#">Copayments</a>	\$100
<a href="#">Coinsurance</a>	\$300
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,100</b>

Example assumes all care is received from Network Facilities and Network Specialists.