

CITY OF WATERTOWN (#C01254)

Dean Health Plan

Rate Sheet

Rates Effective: January 1, 2027 - December 31, 2027

Alternates for HMO MultiTier Plan

Enrollment	Subscribers	Members	HMO-MultiTier		HMO		HMO HDHP		HMO		HMO HDHP	
			\$0 OV Copay	\$500 Ded	\$20 OV Copay	\$500 Ded	\$3,000 Ded	\$750 Ded	\$40 OV Copay	\$500 Ded	\$3,500 Ded	\$7,000 Limit
Subscriber Only	46	46	\$1,750/\$3,500 Limit	0% Coins	\$1,750/\$3,500 Limit	0% Coins	\$3,000/\$6,000 Limit	0% Coins	\$1,750/\$3,500 Limit	0% Coins	\$3,500/\$7,000 Limit	0% Coins
Subscriber + Family	113	386	\$10/\$35/\$60/30% Rx	0% Coins	\$10/\$35/\$60/30% Rx	0% Coins	0%/\$0/0%/\$0	0% Coins	\$10/\$35/\$60/30% Rx	0% Coins	0%/\$0/0%/\$0	0% Coins
Subtotal Active	159	432										
Medicare Eligible Enrollment												
Subscriber Only, Medicare	0	0	\$999.34		\$977.25		\$862.74		\$953.24		\$837.65	
Subscriber + One, 2 w/ Medicare	0	0	\$1,998.69		\$1,954.49		\$1,725.49		\$1,906.48		\$1,675.31	
Subscriber + One, 1 w/ Medicare	0	0	\$2,051.28		\$2,005.93		\$1,770.89		\$1,956.65		\$1,719.39	
Subscriber + Family, 1 w/ Medicare	0	0	\$2,735.04		\$2,674.57		\$2,361.19		\$2,608.87		\$2,292.52	
Subscriber + Family, 2 or more w/ Medicare	0	0	\$2,682.45		\$2,623.13		\$2,315.78		\$2,558.70		\$2,248.44	
Subtotal Medicare Eligible	0	0										
Total	159	432										
Monthly Premium			\$312,125.04		\$332,690.61		\$293,709.53		\$324,517.67		\$285,167.75	
Annual Premium			\$3,745,500		\$3,992,287		\$3,524,514		\$3,894,212		\$3,422,013	
Change from Current Rates												
RENEWAL ACCEPTANCE												
Please select one of the following:												
Renew with renewing plan indicated above	☐											
Renew with a plan change	☐											
Circle desired alternative above												
Plan changes made less than 45 days prior to the renewal will result in a second SBC mailing												
Title:												
Signature:												
Date:												

Sam's: 90.267

12757285

12778634

12850830

12850835

12850849

Please return this page to:

Chris Centi
Account Manager
Dean Health Plan
Direct: 608-220-2203
Fax: 608-252-0834
E-Mail: chris.centi@deancare.com

To ensure a correct January billing statement and correct SBC information is mailed to your insured employees, return this renewal acceptance no later than Friday, November 20, 2026

All plans noted as Focus include only Dean Clinic & SSM Affiliates locations in Dane, Rock & Sauk counties.

To view your SBC information please contact your Account Executive

If you cannot locate your SBC, please contact your Account Executive for assistance.

Plan Code: HMO07048 / PHA05657

Plan Type: Value Choice

Network: HMO-MultiTier

Contract: Contract Year

Plan 1-0

Plan Overview

Plan Providers - You Pay

Non-Plan Providers - You Pay

Embedded Deductible*	\$500 single / \$1,000 family	Not Applicable
Coinsurance	0% coinsurance after deductible	Not Applicable
Primary Office Visit Charge	Tier 1: \$0 copay / Tier 2: \$40 copay	Not Covered
Specialist Office Visit Charge	Tier 1: \$40 copay / Tier 2: \$80 copay	Not Covered
Preventive Services	\$0 copay	Not Covered
Deductible & Coinsurance Limit	Not Applicable	Not Applicable
Maximum Out-of-Pocket**	\$1,750 single / \$3,500 family	Not Applicable

*The plan begins making payments as soon as one family member has reached their individual deductible

**Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted

Prescription Drugs, Insulin & Disposable Diabetic Supplies*

4 Tier Select

Rx Deductible	\$0 single / \$0 family		Not Applicable
Rx Maximum Out-of-Pocket	No Separate Rx Out-of-Pocket Max		No Separate Rx Out-of-Pocket Max
Mail Order	90-day supply (Tiers 1 & 2) for 2 copays; 90-day supply (Tier 3) for 3 copays; Tier 4 Not Covered		
	<u>Tier 1</u>	<u>Tier 2</u>	<u>Tier 3</u>
In-Network	\$10 copay	\$35 copay	\$60 copay
Out-of-Network	Not Covered	Not Covered	Not Covered

*Unless otherwise indicated, generic or brand name drugs can be found in any formulary tier

*This new plan includes prescription drug coverage that is creditable

Diagnostic Services

Plan Providers - You Pay

Non-Plan Providers - You Pay

Diagnostic Services (Xrays/Labs)	0% coinsurance after deductible	Not Covered
CAT Scans/MRI/MRA	0% coinsurance after deductible	Not Covered

Hospital & Surgical Center

Inpatient Hospital	0% coinsurance after deductible	Not Covered
Outpatient Hospital	0% coinsurance after deductible	Not Covered

Emergency Services

Urgent Care	Tier 1: \$0 copay / Tier 2: \$40 copay (and/or 0% coinsurance after deductible)	\$40 copay and/or 0% coinsurance after deductible
Emergency Room Services*	Tier 1: \$125 copay / Tier 2: \$125 copay (and/or 0% coinsurance after deductible)	\$125 copay and/or 0% coinsurance after deductible
Ambulance	\$125 copay	\$125 copay

* copay is waived if admitted

Additional Plan Design Attributes

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This is a highlight of your benefits and should not be relied upon to fully disclose your coverage.

Please review your Member Certificate of Coverage for an exact description of the services and supplies that are covered, excluded, or limited and other terms and conditions of coverage. Your Member Certificate is available at <https://app.deancare.com/sites/sbc/employergroup>

Quote ID# 0558457-06

Date Prepared: 9/24/2026 8:23:28 AM

Plan Code: 12757285

Plan Type: Copay

Network: HMO

Contract: Contract Year **Plan 1-1**

Plan Overview

Plan Providers - You Pay

Non-Plan Providers - You Pay

Embedded Deductible*	\$500 single / \$1,000 family	Not Applicable
Coinsurance	0% coinsurance after deductible	Not Applicable
Primary Office Visit Charge	\$20 copay	Not Covered
Specialist Office Visit Charge	\$40 copay	Not Covered
Preventive Services	\$0 copay	Not Covered
Deductible & Coinsurance Limit	Not Applicable	Not Applicable
Maximum Out-of-Pocket**	\$1,750 single / \$3,500 family	Not Applicable

*The plan begins making payments as soon as one family member has reached their individual deductible

**Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted

Prescription Drugs, Insulin & Disposable Diabetic Supplies*

4 Tier Select

Rx Deductible	\$0 single / \$0 family		Not Applicable	
Rx Maximum Out-of-Pocket	No Separate Rx Out-of-Pocket Max		No Separate Rx Out-of-Pocket Max	
Mail Order	90-day supply (Tiers 1 & 2) for 2 copays; 90-day supply (Tier 3) for 3 copays; Tier 4 Not Covered			
	<u>Tier 1</u>	<u>Tier 2</u>	<u>Tier 3</u>	<u>Tier 4</u>
In-Network	\$10 copay	\$35 copay	\$60 copay	30% coinsurance
Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered

*Unless otherwise indicated, generic or brand name drugs can be found in any formulary tier

*This new plan includes prescription drug coverage that is creditable

Diagnostic Services

Plan Providers - You Pay

Non-Plan Providers - You Pay

Diagnostic Services (Xrays/Labs)	0% coinsurance after deductible	Not Covered
CAT Scans/MRI/MRA	0% coinsurance after deductible	Not Covered

Hospital & Surgical Center

Inpatient Hospital	0% coinsurance after deductible	Not Covered
Outpatient Hospital	0% coinsurance after deductible	Not Covered

Emergency Services

Urgent Care	\$20 copay and/or 0% coinsurance after deductible	\$20 copay and/or 0% coinsurance after deductible
Emergency Room Services*	\$125 copay and/or 0% coinsurance after deductible	\$125 copay and/or 0% coinsurance after deductible
Ambulance	\$125 copay	\$125 copay

* copay is waived if admitted

Additional Plan Design Attributes

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Plan Code: 12850830

Plan Type: Copay

Network: HMO

Contract: Contract Year

Plan 1-3

Plan Overview

Plan Providers - You Pay

Non-Plan Providers - You Pay

Embedded Deductible*	\$750 single / \$1,500 family	Not Applicable
Coinsurance	0% coinsurance after deductible	Not Applicable
Primary Office Visit Charge	\$20 copay	Not Covered
Specialist Office Visit Charge	\$40 copay	Not Covered
Preventive Services	\$0 copay	Not Covered
Deductible & Coinsurance Limit	Not Applicable	Not Applicable
Maximum Out-of-Pocket**	\$2,000 single / \$4,000 family	Not Applicable

*The plan begins making payments as soon as one family member has reached their individual deductible

**Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted

Prescription Drugs, Insulin & Disposable Diabetic Supplies*

4 Tier Select

Rx Deductible	\$0 single / \$0 family		Not Applicable
Rx Maximum Out-of-Pocket	No Separate Rx Out-of-Pocket Max		No Separate Rx Out-of-Pocket Max
Mail Order	90-day supply (Tiers 1 & 2) for 2 copays; 90-day supply (Tier 3) for 3 copays; Tier 4 Not Covered		
	<u>Tier 1</u>	<u>Tier 2</u>	<u>Tier 3</u>
In-Network	\$10 copay	\$35 copay	\$60 copay
Out-of-Network	Not Covered	Not Covered	Not Covered

*Unless otherwise indicated, generic or brand name drugs can be found in any formulary tier

*This new plan includes prescription drug coverage that is creditable

Diagnostic Services

Plan Providers - You Pay

Non-Plan Providers - You Pay

Diagnostic Services (Xrays/Labs)	0% coinsurance after deductible	Not Covered
CAT Scans/MRI/MRA	0% coinsurance after deductible	Not Covered

Hospital & Surgical Center

Inpatient Hospital	0% coinsurance after deductible	Not Covered
Outpatient Hospital	0% coinsurance after deductible	Not Covered

Emergency Services

Urgent Care	\$20 copay and/or 0% coinsurance after deductible	\$20 copay and/or 0% coinsurance after deductible
Emergency Room Services*	\$125 copay and/or 0% coinsurance after deductible	\$125 copay and/or 0% coinsurance after deductible
Ambulance	\$125 copay	\$125 copay

* copay is waived if admitted

Additional Plan Design Attributes

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Plan Code: 12850835

Plan Type: Copay

Network: HMO

Contract: Contract Year

Plan 1-4

Plan Overview

Plan Providers - You Pay

Non-Plan Providers - You Pay

Embedded Deductible*	\$500 single / \$1,000 family	Not Applicable
Coinsurance	0% coinsurance after deductible	Not Applicable
Primary Office Visit Charge	\$40 copay	Not Covered
Specialist Office Visit Charge	\$80 copay	Not Covered
Preventive Services	\$0 copay	Not Covered
Deductible & Coinsurance Limit	Not Applicable	Not Applicable
Maximum Out-of-Pocket**	\$1,750 single / \$3,500 family	Not Applicable

*The plan begins making payments as soon as one family member has reached their individual deductible

**Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted

Prescription Drugs, Insulin & Disposable Diabetic Supplies*

4 Tier Select

Rx Deductible	\$0 single / \$0 family		Not Applicable	
Rx Maximum Out-of-Pocket	No Separate Rx Out-of-Pocket Max		No Separate Rx Out-of-Pocket Max	
Mail Order	90-day supply (Tiers 1 & 2) for 2 copays; 90-day supply (Tier 3) for 3 copays; Tier 4 Not Covered			
	<u>Tier 1</u>	<u>Tier 2</u>	<u>Tier 3</u>	<u>Tier 4</u>
In-Network	\$10 copay	\$35 copay	\$60 copay	30% coinsurance
Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered

*Unless otherwise indicated, generic or brand name drugs can be found in any formulary tier

*This new plan includes prescription drug coverage that is creditable

Diagnostic Services

Plan Providers - You Pay

Non-Plan Providers - You Pay

Diagnostic Services (Xrays/Labs)	0% coinsurance after deductible	Not Covered
CAT Scans/MRI/MRA	0% coinsurance after deductible	Not Covered

Hospital & Surgical Center

Inpatient Hospital	0% coinsurance after deductible	Not Covered
Outpatient Hospital	0% coinsurance after deductible	Not Covered

Emergency Services

Urgent Care	\$40 copay and/or 0% coinsurance after deductible	\$40 copay and/or 0% coinsurance after deductible
Emergency Room Services*	\$125 copay and/or 0% coinsurance after deductible	\$125 copay and/or 0% coinsurance after deductible
Ambulance	\$125 copay	\$125 copay

* copay is waived if admitted

Additional Plan Design Attributes

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Quote ID# 0558457-06

Date Prepared: 9/24/2026 8:23:28 AM

CITY OF WATERTOWN (#C01254)

Dean Health Plan

Rate Sheet

Rates Effective: January 1, 2027 - December 31, 2027

Alternates for POS Plan

POS	POS HDHP	POS	POS HDHP	POS
\$20 OV Copay \$500 Ded 0% Coins	\$3,000 Ded 0% Coins	\$20 OV Copay \$750 Ded 0% Coins	\$3,500 Ded 0% Coins	\$40 OV Copay \$500 Ded 0% Coins
\$1,750/\$3,500 Limit \$10/\$35/\$60/30% Rx	\$3,000/\$6,000 Limit 0%/0%/0%/0% Rx	\$2,000/\$4,000 Limit \$10/\$35/\$60/30% Rx	\$3,500/\$7,000 Limit 0%/0%/0%/0% Rx	\$1,750/\$3,500 Limit \$10/\$35/\$60/30% Rx
Renewal Rates	Plan 2 - 1	Plan 2 - 2	Plan 2 - 3	Plan 2 - 4
Plan 2 - 0	Plan 2 - 1	Plan 2 - 2	Plan 2 - 3	Plan 2 - 4
\$1,155.64	\$996.63	\$1,128.32	\$966.12	\$1,130.64
\$2,837.10	\$2,446.73	\$2,770.03	\$2,371.82	\$2,775.72

Increase

Over Current

9.0%

9.0%

Subscribers	Members
1	1
2	6
3	7

Enrollment

Subscriber Only
Subscriber + Family
Subtotal Active

Medicare Eligible Enrollment

Subscriber Only, Medicare
Subscriber + One, 2 w/ Medicare
Subscriber + One, 1 w/ Medicare
Subscriber + Family, 1 w/ Medicare
Subscriber + Family, 2 or more w/ Medicare
Subtotal Medicare Eligible

Total

Monthly Premium
Annual Premium

Change from Current Rates

RENEWAL ACCEPTANCE

Please select one of the following:

Renew with renewing plan indicated above
Renew with a plan change

Circle desired alternative above

Plan changes made less than 45 days prior to the renewal will result in a second SBC mailing

Title:

Signature:

Date:

Medical code
Pharmacy code

POS05279
PHA05656

+ 6768
\$6,829.84
\$81,958

9.0%

-6.0%

6.4%

-8.9%

6.6%

12778643

12850853

12850861

Please return this page to:

Chris Centi
Account Manager
Dean Health Plan
Direct: 608-220-2203
Fax: 608-252-0834
E-Mail: chris.centi@deancare.com

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