DeanHealthPlan
A member of SSM Health

Plan 5 - 0

COUNTY OF DANE - WITHOUT Medicare **Network Type: POS**

Effective Date: 01/01/2023 **Plan Code: POS04239/PHA03727**

Plan Overview	*Plan Providers - You Pay*	*Non-Plan Providers - You Pay*
Deductible	$100 single / $200 family	$200 single / $400 family
Coinsurance	0% coinsurance after deductible	0% coinsurance after deductible
Office Visit Charge (Primary/Specialist)	$5 copay; Waived for dependents through age 18	$10 copay; Waived for dependents through age 18
Office Visit and Related Services	0% coinsurance after deductible	0% coinsurance after deductible
Preventive Services	$0 copay	$10 copay and/or 0% coinsurance after deductible
Deductible and Coinsurance Limit	$100 single / $200 family	$200 single / $400 family
Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted)	$250 single / $500 family	$500 single / $1,000 family
Prescription Drugs, Insulin & Disposable Diabetic Supplies	**Unless otherwise indicated, generic or brand name drugs can be found in any formulary tier)**	
Tier 1	$10 copay	50% coinsurance
Tier 2	$20 copay	50% coinsurance
Tier 3	$40 copay	Not Covered
Tier 4	30% coinsurance	50% coinsurance
Deductibles and/or Out of Pocket Maximums for Prescription Drugs	Rx Deductible: $0 single / $0 familyRx Max OOP: $500 single / $1,500 family	Rx Deductible: $0 single / $0 family; Rx Max OOP: $500 single / $1,500 family
Diagnostic Services		
Diagnostic Services (Xrays/Labs)	0% coinsurance after deductible	0% coinsurance after deductible
CAT Scans/MRI/MRA	0% coinsurance after deductible	0% coinsurance after deductible
Hospital & Surgical Center		
Inpatient Hospital	0% coinsurance after deductible	0% coinsurance after deductible
Outpatient Hospital	0% coinsurance after deductible	0% coinsurance after deductible
Emergency Services		
Urgent Care	$5 copay; Waived for dependents through age 18 and/or 0% coinsurance after deductible	$5 copay; Waived for dependents through age 18 and/or 0% coinsurance after in-network deductible
Emergency Room Services (Copay is waived if admitted)	$50 copay and/or 0%coinsurance after deductible	$50 copay and/or 0%coinsurance after in-network deductible
Ambulance	0% coinsurance after deductible	0% coinsurance after in-network deductible
Other Services		
Mental Health Inpatient	0% coinsurance after deductible	0% coinsurance after deductible
Mental Health Day Treatment Programs	0% coinsurance after deductible	0% coinsurance after deductible
Mental Health Outpatient	$5 copay; Waived for dependents through age 18	$10 copay
Durable Medical Equipment	0% coinsurance after deductible	0% coinsurance after deductible
Physical, Speech & Occupational Therapy	$5 copay per therapy type per day; Waived for dependents through age 18	$10 copay per therapy type per day; Waived for dependents through age 18
Plan Design Attributes	In and Out-of-Network deductibles and coinsurance combined.	

This renewal plan includes prescription drug coverage that is creditable
Unless otherwise noted, all benefits are based on a Contract Year
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 www.deancare.com.

Date Prepared: 08/25/22