DeanHealthPlan by Medica

COUNTY OF DANE

Benefit Summary

Effective: 01/01/2027

Plan Code: 12709015 **Plan Type**: Copay **Network:** POS **Contract:** Contract Year **Plan 5-1**

Plan Overview	***Plan Providers - You Pay***	***Non-Plan Providers - You Pay***
Embedded Deductible*	$100 single / $200 family	$200 single / $400 family
Coinsurance	0% coinsurance after deductible	0% coinsurance after deductible
Primary Office Visit Charge	$5 copay	$10 copay
Specialist Office Visit Charge	$5 copay	$10 copay
Preventive Services	$0 copay	$10 copay
Deductible & Coinsurance Limit	Not Applicable	Not Applicable
Maximum Out-of-Pocket**	$250 single / $500 family	$500 single / $1,000 family

**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		$0 single / $0 family	
Rx Maximum Out-of-Pocket	$500 single / $1,500 family		$500 single / $1,500 family	
Mail Order	90-day supply (Tiers 1 & 2) for 2 copays; 90-day supply (Tier 3) for 3 copays; Tier 4 Not Covered			
	Tier 1	**Tier 2**	**Tier 3**	**Tier 4**
In-Network	$10 copay	$20 copay	$40 copay	30% coinsurance
Out-of-Network	50% coinsurance	50% coinsurance	Not Covered	50% coinsurance

**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	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 and/or 0% coinsurance after deductible	$5 copay and/or 0% coinsurance after in-network deductible
Emergency Room Services*	$100 copay and/or 0% coinsurance after deductible	$100 copay and/or 0% coinsurance after in-network deductible
Ambulance	$100 copay	$100 copay

** copay is waived if admitted*

Additional Plan Design Attributes

In and Out of Network benefits cross accumulate.

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