DeanHealthPlan by Medica

# COUNTY OF DANE

Benefit Summary

Effective: 01/01/2025

**Plan Code:** POS04239 / PHA03727 **Plan Type**: Copay **Network:** POS **Contract:** Contract Year **Plan 3-0**

| **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; Waived for dependents through age 18 | $10 copay; Waived for dependents through age 18 |
| Specialist Office Visit Charge | $5 copay; Waived for dependents through age 18 | $10 copay; Waived for dependents through age 18 |
| Preventive Services | $0 copay | $10 copay |
| Deductible & Coinsurance Limit | $100 single / $200 family | $200 single / $400 family |
| 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; 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* | $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 |

** copay is waived if admitted*

## Additional Plan Design Attributes

In and Out of Network benefits cross accumulate.