

Plan Code: POS04240 / PHA03727

Plan Type: Copay

Network: POS

Contract: Contract Year Plan 4-0

Plan Overview

Plan Providers - You Pay

Non-Plan Providers - You Pay

Embedded Deductible*	\$100 single / \$200 family	\$400 single / \$800 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	Not Applicable
Maximum Out-of-Pocket**	\$250 single / \$500 family	\$400 single / \$800 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			
	<u>Tier 1</u>	<u>Tier 2</u>	<u>Tier 3</u>	<u>Tier 4</u>
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.

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>