DeanHealthPlan
A member of SSM Health

COUNTY OF ROCK

Benefit Summary

Effective: 01/01/2024

Plan Code: POS04301 / PHA03893 **Plan Type**: Copay **Network:** POS **Contract:** Contract Year **Plan 1-0**

Plan Overview	***Plan Providers - You Pay***	***Non-Plan Providers - You Pay***
Embedded Deductible*	$500 single / $1,500 family	$750 single / $2,250 family
Coinsurance	10% coinsurance after deductible	35% coinsurance after deductible
Primary Office Visit Charge	$15 copay	35% coinsurance after deductible
Specialist Office Visit Charge	$15 copay	35% coinsurance after deductible
Preventive Services	$0 copay	35% coinsurance after deductible
Deductible & Coinsurance Limit	$1,500 single / $3,000 family	$2,250 single / $4,300 family
Maximum Out-of-Pocket**	$3,650 single / $7,300 family	$3,650 single / $7,300 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	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			
	Tier 1	**Tier 2**	**Tier 3**	**Tier 4**
In-Network	$10 copay	$25 copay	$50 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)	10% coinsurance after deductible	35% coinsurance after deductible
CAT Scans/MRI/MRA	10% coinsurance after deductible	35% coinsurance after deductible

Hospital & Surgical Center

Inpatient Hospital	10% coinsurance after deductible	35% coinsurance after deductible
Outpatient Hospital	10% coinsurance after deductible	35% coinsurance after deductible

Emergency Services

Urgent Care	$15 copay and/or 10% coinsurance after deductible	$15 copay and/or 10% coinsurance after in-network deductible
Emergency Room Services*	$300 copay and/or 10% coinsurance after deductible	$300 copay and/or 10% coinsurance after in-network deductible
Ambulance	10% coinsurance after deductible	10% coinsurance after in-network deductible

** copay is waived if admitted*

Additional Plan Design Attributes

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# 0487751-01 Date Prepared: