DeanHealthPlan
A member of SSM Health

Plan 2 - 0

MONONA GROVE SCHOOL DISTRICT **Network Type: POS**

Effective Date: 01/01/2024 **Plan Code: POS04630/PHA04107**

Plan Overview	*Plan Providers - You Pay*	*Non-Plan Providers - You Pay*
Deductible	$200 single / $400 family	$500 single / $1,000 family
Coinsurance	0% coinsurance after deductible	20% coinsurance after deductible
Office Visit Charge (Primary/Specialist)	0% coinsurance after deductible	20% coinsurance after deductible
Office Visit and Related Services	0% coinsurance after deductible	20% coinsurance after deductible
Preventive Services	$0 copay	20% coinsurance after deductible
Deductible and Coinsurance Limit	$200 single / $400 family	$1,000 single / $2,000 family
Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted)	$6,600 single / $13,200 family	$13,200 single / $26,400 family
Prescription Drugs, Insulin & Disposable Diabetic Supplies	**Unless otherwise indicated, generic or brand name drugs can be found in any formulary tier)**	
Tier 1	$5 copay	50% coinsurance
Tier 2	$15 copay	50% coinsurance
Tier 3	$35 copay	Not Covered
Tier 4	Not Covered	Not Covered
Deductibles and/or Out of Pocket Maximums for Prescription Drugs	Rx Deductible: $0 single / $0 family	Rx Deductible: $0 single / $0 family
Diagnostic Services		
Diagnostic Services (Xrays/Labs)	0% coinsurance after deductible	20% coinsurance after deductible
CAT Scans/MRI/MRA	$150 copay	20% coinsurance after deductible
Hospital & Surgical Center		
Inpatient Hospital	0% coinsurance after deductible	20% coinsurance after deductible
Outpatient Hospital	0% coinsurance after deductible	20% coinsurance after deductible
Emergency Services		
Urgent Care	0% coinsurance after deductible	0% coinsurance after deductible and/or 0% coinsurance after in-network deductible
Emergency Room Services (Copay is waived if admitted)	$150 copay and/or 0%coinsurance after deductible	$150 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	20% coinsurance after deductible
Mental Health Day Treatment Programs	0% coinsurance after deductible	20% coinsurance after deductible
Mental Health Outpatient	0% coinsurance after deductible	20% coinsurance after deductible
Durable Medical Equipment	20% coinsurance up to $2,000 limit	20% coinsurance after deductible
Physical, Speech & Occupational Therapy	0% coinsurance after deductible	20% coinsurance after deductible
Plan Design Attributes		

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: 03/08/23