DeanHealthPlan
A member of SSM Health

Plan 2 - 0

MINERAL POINT SCHOOL DISTRICT **Network Type: POS**

Effective Date: 07/01/2022 **Plan Code: POS03720/PHA01678**

Plan Overview	*Plan Providers - You Pay*	*Non-Plan Providers - You Pay*
Deductible	$4,000 single / $8,000 family	$8,000 single / $16,000 family
Coinsurance	0% coinsurance after deductible	20% coinsurance after deductible
Office Visit Charge (Primary/Specialist)	$20 copay	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	$4,000 single / $8,000 family	Not Applicable
Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted)	$7,150 single / $14,300 family	$14,300 single / $28,600 family
Prescription Drugs, Insulin & Disposable Diabetic Supplies	**Unless otherwise indicated, generic or brand name drugs can be found in any formulary tier)**	
Tier 1	$0 copay	50% coinsurance
Tier 2	$5 copay	50% coinsurance
Tier 3	$20 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	0% coinsurance after deductible	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	$20 copay and/or 0% coinsurance after deductible	$20 copay and/or 0% coinsurance after in-network deductible
Emergency Room Services (Copay is waived if admitted)	$75 copay and/or 0%coinsurance after deductible	$75 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	$20 copay	20% coinsurance after deductible
Durable Medical Equipment	0% coinsurance after deductible	50% coinsurance after deductible; not subject to out-of-pocket maximum
Physical, Speech & Occupational Therapy	$20 copay per therapy type per day	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: 03/24/22