Dean Health Plan

BRODHEAD SCHOOL DISTRICT

Effective Date: 07/01/2018

Product Type: POS HDHP

Plan Code: POS03322/PHA01908

Plan Overview	Plan Providers - You Pay	Non-Plan Providers - You Pay
Deductible	$3000 single / $6000 family	$6000 single / $12000 family
Coinsurance	0% coinsurance after deductible	20% coinsurance after deductible
Office Visit Charge (Primary/Specialist)	0% coinsurance after deductible / 0% coinsurance after deductible	20% 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	$3000 single / $6000 family	$12000 single / $24000 family
Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted)	$3000 single / $6000 family	$12000 single / $24000 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% coinsurance after deductible	20% coinsurance after deductible
Tier 2	0% coinsurance after deductible	20% coinsurance after deductible
Tier 3	0% coinsurance after deductible	Not Covered
Tier 4	0% coinsurance after deductible	20% coinsurance afte
Diagnostic Services		
Diagnostic Services	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	0% coinsurance after deductible	0% coinsurance after in-network deductible
Emergency Room Services (Copay is waived if admitted)	0% coinsurance after deductible	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	0% coinsurance after deductible	20% coinsurance after deductible
Physical, Speech & Occupational Therapy	0% coinsurance after deductible	20% coinsurance after deductible
Plan Special Features	HSA Qualified High Deductible Health Plan with Aggregate Deductible. E-Visits	

This renewal plan includes prescription drug coverage that is creditable
Unless otherwise noted, all benefits are based on a Contract Year
This benefit summary 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: 02/21/18

FOCUS ON BENEFITS 2018

Brodhead School District

HEALTH PLAN SUMMARY

Effective July 1, 2018, we will continue to offer a health plan through MercyCare and Dean Health Plans for all benefit-eligible employees.

About the Health Plan: Preventive care is covered at 100% and no deductible applies. For other services, these plans require a deductible before eligible services are paid at 100%.

Mercy PPO	In Network	Out of Network
Deductible *per calendar year*	$3,000 /single $6,000/family	$6,000 /single $12,000/family
Out of Pocket Max *per calendar year*	$3,000 /single $6,000/family	$12,000 /single $24,000/family
Physician Services *Office visits, Urgent Care Clinic, Retail Health Clinics, Chiropractic Manipulation*	You pay 0% after deductible	You pay 20% after deductible
Preventive Services *Well child, Immunizations, Certain Prenatal Services, Screening*	You pay $0	You pay 20% after deductible
Mental/ Behavioral/ Substance Use *Outpatient*	You pay 0% after deductible	You pay 20% after deductible
Ambulance	You pay 0% after deductible	You pay 20% after deductible
Hospital	You pay 0% after deductible	You pay 20% after deductible
Prescription Drugs *Retail (31 day supply) GenRx* Generic Preferred Brand Non-Preferred Brand	You pay 0% after deductible	Not Covered
Specialty Drugs	You pay 0% after deductible	Not Covered
90 dayRx / Mail Order Generic Preferred Brand Non-Preferred Brand	You pay 0% after deductible	Not Covered

Brodhead School District will contribute $3,000 single / $6,000 family into a Health Savings Account on your behalf.

Please review your benefit plan summary document for more detailed coverage information.

MercyCare Health Plans

Our plan uses the **MercyCare** Network for participating providers.

BALANCE BILLING

The amount that the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. Always use an in- network provider for the highest coverage of services.

SUMMARY OF BENEFITS COVERAGE

Refer to your summary of benefit coverage (SBC) for a more detailed explanation about your health plan benefits, including mail order prescriptions and other health services.

QUESTIONS?

Call customer service at **800-895-2421** call the phone number on the back of your ID card or visit **www.mercyhealthplans.com**.

Brodhead School District
Insurance Plan Co-Pays 2018-19

Health Insurance Plans

Family Plan Subscribers:	**Dean Health Plan**	**MercyCare Plan**
Per Month:	**$1,288.72**	**$1,483.84**
Hours worked:	Employee co-payment	Employee co-payment
1700 + (10% co-pay)	$128.87	$148.38
1350 - 1699 (20% co-pay)	$257.74	$296.77
1215-1349 (25% co-pay)	$322.18	$370.96
900-1214 (35% co-pay)	$451.05	$519.34
Teachers & Administrators (12.6%)	$162.38	$186.96

Single Plan Subscribers:	**Dean Health Plan**	**MercyCare Plan**
Per Month:	**$567.72**	**$653.71**
Hours worked:	Employee co-payment	Employee co-payment
1700 + (10% co-pay)	$56.77	$65.37
1350 - 1699 (20% co-pay)	$113.54	$130.74
1215-1349 (25% co-pay)	$141.93	$163.43
900-1214 (35% co-pay)	$198.70	$228.80
Teachers & Administrators (12.6%)	$71.53	$82.37

Dental Insurance

	Delta - Single	**Delta - Family**
Per Month:	**$56.15**	**$145.11**
Hours worked:	Employee co-payment	Employee co-payment
1700 + (10% co-pay)	$5.62	$14.51
1350 - 1699 (20% co-pay)	$11.23	$29.02
1215-1349 (25% co-pay)	$14.04	$36.28
900-1214 (35% co-pay)	$19.65	$50.79
Teachers & Administrators (12.6%)	$7.07	$18.28

Vision Insurance Rates (Delta Vision) - Optional

Family Plan: $21.63 p/month
Single Plan: $8.69 p/month