# Dean Health Plan

SAUK PRAIRIE SCHOOL DISTRICT
Effective Date: 07/01/2018

Product Type: HMO
Plan Code: HMO03916/PHA01655

| Plan Overview | Plan Providers - You Pay | Non-Plan Providers - You Pay |
|---|---|---|
| Deductible | $0 single / $0 family | N/A |
| Coinsurance | 0% coinsurance after deductible | N/A |
| Office Visit Charge (Primary/Specialist) | $10 copay / $10 copay | Not Covered / Not Covered |
| Office Visit and Related Services | 0% coinsurance after deductible | Not Covered |
| Preventive Services | $0 copay | Not Covered |
| Deductible and Coinsurance Limit | $0 single / $0 family | N/A |
| Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted) | $7150 single / $14300 family | N/A |
| **Prescription Drugs, Insulin & Disposable Diabetic Supplies** | Unless otherwise indicated, generic or brand name drugs can be found in any formulary tier. | |
| Tier 1 | $2 copay | Not Covered |
| Tier 2 | $2 copay | Not Covered |
| Tier 3 | Not Covered | Not Covered |
| **Diagnostic Services** | | |
| Diagnostic Services | 0% coinsurance after deductible | Not Covered |
| CAT Scans/MRI/MRA | $0 copay | Not Covered |
| **Hospital & Surgical Center** | | |
| Inpatient Hospital | 0% coinsurance after deductible | Not Covered |
| Outpatient Hospital | 0% coinsurance after deductible | Not Covered |
| **Emergency Services** | | |
| Urgent Care | $10 copay and/or 0% coinsurance after deductible | $10 copay and/or 0% coinsurance after deductible |
| Emergency Room Services (Copay is waived if admitted) | $50 copay and/or 0% coinsurance after deductible | $50 copay and/or 0% coinsurance after deductible |
| Ambulance | $0 copay | $0 copay |
| **Other Services** | | |
| Mental Health Inpatient | $0 copay per admission | Not Covered |
| Mental Health Day Treatment Programs | $0 copay | Not Covered |
| Mental Health Outpatient | $10 copay | Not Covered |
| Durable Medical Equipment | $0 copay | Not Covered |
| Physical, Speech & Occupational Therapy | $10 copay per therapy type per day | Not Covered |
| Plan Special Features | 120 days per contract period (Skilled Nursing Facility) | |

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: 02/28/18

# Dean Health Plan

SAUK PRAIRIE SCHOOL DISTRICT
Effective Date: 07/01/2018

Product Type: POS
Plan Code: POS03272/PHA01677

| Plan Overview | Plan Providers - You Pay | Non-Plan Providers - You Pay |
|---|---|---|
| Deductible | $0 single / $0 family | $100 single / $200 family |
| Coinsurance | 0% coinsurance after deductible | 0% coinsurance after deductible |
| Office Visit Charge (Primary/Specialist) | $10 copay / $10 copay | 0% coinsurance after deductible / 0% coinsurance after deductible |
| Office Visit and Related Services | 0% coinsurance after deductible | 0% coinsurance after deductible |
| Preventive Services | $0 copay | 0% coinsurance after deductible |
| Deductible and Coinsurance Limit | $0 single / $0 family | $100 single / $200 family |
| Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted) | $7150 single / $14300 family | $14300 single / $28600 family |
| Prescription Drugs, Insulin & Disposable Diabetic Supplies | Unless otherwise indicated, generic or brand name drugs can be found in any formulary tier | |
| Tier 1 | $2 copay | 50% coinsurance |
| Tier 2 | $2 copay | 50% coinsurance |
| Tier 3 | Not Covered | Not Covered |
| Diagnostic Services | | |
| Diagnostic Services | 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 | $10 copay and/or 0% coinsurance after deductible | $10 copay and/or 0% coinsurance after in-network deductible |
| Emergency Room Services (Copay is waived if admitted) | $50 copay and/or 0% coinsurance after deductible | $50 copay and/or 0% coinsurance after in-network deductible |
| Ambulance | $0 copay | $0 copay |
| Other Services | | |
| Mental Health Inpatient | $0 copay per admission | $0 copay per admission |
| Mental Health Day Treatment Programs | $0 copay | $0 copay |
| Mental Health Outpatient | $10 copay | $10 copay |
| Durable Medical Equipment | 0% coinsurance after deductible | 50% coinsurance after deductible; not subject to out-of-pocket maximum |
| Physical, Speech & Occupational Therapy | $10 copay per therapy type per day | 0% coinsurance after deductible |
| **Plan Special Features** | 120 days per contract period (Skilled Nursing Facility) | |

This renewal plan includes prescription drug coverage that is creditable
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