DeanHealthPlan.
A member of SSM Health

BRODHEAD SCHOOL DISTRICT
Effective Date: 07/01/2022

Plan 2 - 1
Network Type: HMO HDHP
Plan Code: 2287482

Plan Overview	Plan Providers - You Pay	Non-Plan Providers - You Pay
Deductible	$3,000 single / $6,000 family	Not Covered
Coinsurance	0% coinsurance after deductible	Not Covered
Office Visit Charge (Primary/Specialist)	$50 copay	Not Covered
Office Visit and Related Services	0% coinsurance after deductible	Not Covered
Preventive Services	$0 copay	Not Covered
Deductible and Coinsurance Limit	$3,000 single / $6,000 family	Not Covered
Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted)	$6,000 single / $12,000 family	Not Covered
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	Not Covered
Tier 2	0% coinsurance after deductible	Not Covered
Tier 3	0% coinsurance after deductible	Not Covered
Tier 4	0% coinsurance after deductible	Not Covered
Diagnostic Services		
Diagnostic Services (Xrays/Labs)	0% coinsurance after deductible	Not Covered
CAT Scans/MRI/MRA	0% coinsurance after deductible	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	$70 copay and/or 0% coinsurance after deductible	$70 copay and/or 0% coinsurance after in-network deductible
Emergency Room Services (Copay is waived if admitted)	$250 copay and/or 0%coinsurance after deductible	$250 copay and/or 0%coinsurance after in-network deductible
Ambulance	0% coinsurance after deductible	0% coinsurance after deductible
Other Services		
Mental Health Inpatient	0% coinsurance after deductible	Not Covered
Mental Health Day Treatment Programs	0% coinsurance after deductible	Not Covered
Mental Health Outpatient	$50 copay	Not Covered
Durable Medical Equipment	0% coinsurance after deductible	Not Covered
Physical, Speech & Occupational Therapy	$50 copay per therapy type per day	Not Covered
Plan Design Attributes	Medical Copay Applies After Deductible. Aggregate Deductible Accumulation.	

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: 04/20/22

Brodhead School District
Insurance Plan Co-Pays 2022-23

Dean / MercyCare Health Insurance Plans

Single Plan Subscribers:	Dean Health Plan HMO	Dean Plan POS/PPO - Buy-up Option	MercyCare Plan HMO	MercyCare Plan PPO - Buy-up Option
Per Month:	**$613.71**	**$631.01**	**$565.40**	**$635.20**
Hours worked:	**Employee Copayment**	**Employee Copayment**	**Employee Copayment**	**Employee Copayment**
1700 + (10% co-pay)	$61.37	$78.67	$56.54	$126.34
1350 - 1699 (20% co-pay)	$122.74	$140.04	$113.08	$182.88
1215-1349 (25% co-pay)	$153.43	$170.73	$141.35	$211.15
900-1214 (35% co-pay)	$214.80	$232.10	$197.89	$267.69
Teachers & Administrators (12.6%)	$77.33	$94.63	$71.24	$141.04

Family Plan Subscribers:	Dean Health Plan HMO	Dean Plan POS/PPO - Buy-up Option	MercyCare Plan HMO	MercyCare Plan PPO - Buy-up Option
Per Month:	**$1,393.12**	**$1,432.39**	**$1,283.40**	**$1,442.00**
Hours worked:	**Employee Copayment**	**Employee Copayment**	**Employee Copayment**	**Employee Copayment**
1700 + (10% co-pay)	$139.31	$178.58	$128.34	$286.94
1350 - 1699 (20% co-pay)	$278.62	$317.89	$256.68	$415.28
1215-1349 (25% co-pay)	$348.28	$387.55	$320.85	$479.45
900-1214 (35% co-pay)	$487.59	$526.86	$449.19	$607.79
Teachers & Administrators (12.6%)	$175.53	$214.80	$161.71	$320.31

Delta Dental Insurance

Plan Subscribers:	Single	Family
Per Month:	**$57.98**	**$149.83**
Hours worked:	**Employee Copayment**	**Employee co-payment**
1700 + (10% co-pay)	$5.80	$14.98
1350 - 1699 (20% co-pay)	$11.60	$29.96
1215-1349 (25% co-pay)	$14.50	$37.46
900-1214 (35% co-pay)	$20.28	$52.44
Teachers & Administrators (12.6%)	$7.30	$18.88

Vision Insurance Rates (Delta Vision) - Optional

Single Plan: $8.94 p/month
Family Plan: $22.26 p/month