Dean Health Plan

SCHOOL DISTRICT OF BRODHEAD

Effective Date: 07/01/2017

Product Type: POS HDHP

Plan Code: POS03322/PHA01465

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
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
Diagnostic Services	0% coinsurance after deductible	20% coinsurance after deductible
CAT Scans/MRI/MRA	0% coinsurance after deductible	20% coinsurance after deductible
Inpatient Hospital	0% coinsurance after deductible	20% coinsurance after deductible
Outpatient Hospital	0% coinsurance after deductible	20% coinsurance after deductible
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
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 plan is NOT auto-linked to an HRA administrator

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: 05/11/17

MercyCare Health Plans™

BRODHEAD SCHOOL DISTRICT2017-2018
PLAN: PPO CO-100/80 (HSA)
$3000S/$6000F DED.
RX: DEDUCTIBLE THEN 100% COVERAGE
NON-EMBEDDED DED.

	Network Providers You Pay	Non-Network Providers You Pay
Deductible	$3000 Single, $6000 Family	$6000 Single, $12000 Family
Coinsurance	0 % coinsurance after deductible	20 % coinsurance after deductible
Office visit charge	0 % coinsurance after deductible	20 % coinsurance after deductible
Maximum Out of Pocket (Medical & Rx)	$3000 Single, $6000 Family	$12000 Single, $24000 Family
Preventive Services	$0	20 % coinsurance after deductible
Diagnostic Services (lab and x-ray)	0 % coinsurance after deductible	20 % coinsurance after deductible
Hospital inpatient services*	0 % coinsurance after deductible	20 % coinsurance after deductible
Hospital outpatient services*	0 % coinsurance after deductible	20 % coinsurance after deductible
Emergency room charge (waived upon admission)	0 % coinsurance after deductible	20 % coinsurance after deductible
Ambulance	0 % coinsurance after deductible	20 % coinsurance after deductible
Urgent care charge	0 % coinsurance after deductible	20 % coinsurance after deductible
Mental Health inpatient*	0 % coinsurance after deductible	20 % coinsurance after deductible
Mental Health day treatment*	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 and Occupational therapy	0 % coinsurance after deductible	20 % coinsurance after deductible
* Prior authorization required for these services		
Prescription drug coverage		
Tier 1	0 % coinsurance after deductible	N/A
Tier 2	0 % coinsurance after deductible	N/A
Tier 3	0 % coinsurance after deductible	N/A

These benefits are a partial outline of health services under the Policy. Refer to your Schedule of Benefits for applicable limits to these health services. If differences exist between this Summary and the Certificate of Coverage, the Certificate governs.

Brodhead School District
Insurance Plan Co-Pays 2017-18

Health Insurance Plans

Family Plan Subscribers:	**Dean Health Plan**	**MercyCare Plan**
Per Month:	**$1,228.64**	**$1,380.30**
Hours worked:	Employee co-payment	Employee co-payment
1700 + (10% co-pay)	$122.86	$138.03
1350 - 1699 (20% co-pay)	$245.73	$276.06
1215-1349 (25% co-pay)	$307.16	$345.08
900-1214 (35% co-pay)	$430.02	$483.11
Teachers & Administrators (12.6%)	$154.81	$173.92

Single Plan Subscribers:	**Dean Health Plan**	**MercyCare Plan**
Per Month:	**$541.25**	**$608.10**
Hours worked:	Employee co-payment	Employee co-payment
1700 + (10% co-pay)	$54.13	$60.81
1350 - 1699 (20% co-pay)	$108.25	$121.62
1215-1349 (25% co-pay)	$135.31	$152.03
900-1214 (35% co-pay)	$189.44	$212.84
Teachers & Administrators (12.6%)	$68.20	$76.62

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