Plan 3 - 0

Dean Health Plan

DODGEVILLE SCHOOL DIST

Effective Date: 07/01/2016

Product Type: HMO

Plan Code: HMO03245/PHA01061

Plan Overview	Plan Providers - You Pay	Non-Plan Providers - You Pay
Deductible	$250 single / $500 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	$250 single / $500 family	N/A
Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted)	$6600 single / $13200 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	$5 copay	Not Covered
Tier 2	$10 copay	Not Covered
Tier 3	$25 copay	Not Covered
Diagnostic Services		
Diagnostic Services	0% coinsurance after deductible	Not Covered
CAT Scans/MRI/MRA	$50 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)	$100 copay and 0% coinsurance after deductible	$100 copay and 0% coinsurance after 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	$10 copay	Not Covered
Durable Medical Equipment	0% coinsurance after deductible	Not Covered
Physical, Speech & Occupational Therapy	$10 copay per therapy type per day	Not Covered
Plan Special Features		

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: 03/10/16

Dean Health Plan

DODGEVILLE SCHOOL DIST

Effective Date: 07/01/2016

Product Type: POS

Plan Code: POS02753/PHA01062

Plan Overview	Plan Providers - You Pay	Non-Plan Providers - You Pay
Deductible	$250 single / $500 family	$500 single / $1000 family
Coinsurance	0% coinsurance after deductible	20% coinsurance after deductible
Office Visit Charge (Primary/Specialist)	$10 copay / $10 copay	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	$250 single / $500 family	$1000 single / $2000 family
Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted)	$6600 single / $13200 family	$13200 single / $26400 family
Prescription Drugs, Insulin & Disposable Diabetic Supplies	Unless otherwise indicated, generic or brand name drugs can be found in any formulary tier)	
Tier 1	$5 copay	50% coinsurance
Tier 2	$10 copay	50% coinsurance
Tier 3	$25 copay	Not Covered
Diagnostic Services		
Diagnostic Services	0% coinsurance after deductible	20% coinsurance after deductible
CAT Scans/MRI/MRA	$50 copay	$50 copay
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	$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)	$100 copay and 0% coinsurance after deductible	$100 copay and 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	$10 copay	20% coinsurance after deductible
Durable Medical Equipment	0% coinsurance after deductible	20% coinsurance after deductible
Physical, Speech & Occupational Therapy	$10 copay per therapy type per day	20% coinsurance after deductible
Plan Special Features		

This plan is NOT auto-linked to an HRA administrator

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