Dean Health Plan

HUSTISFORD SCHOOL DISTRICT

Effective Date: 07/01/2017

Product Type: POS

Plan Code: 44670/

Plan Overview	Plan Providers - You Pay	Non-Plan Providers - You Pay
Deductible	$1500 single / $3000 family	$3000 single / $6000 family
Coinsurance	0% coinsurance after deductible	20% coinsurance after deductible
Office Visit Charge (Primary/Specialist)	$30 copay / $30 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	$1500 single / $3000 family	$6000 single / $12000 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	$10 copay	50% coinsurance
Tier 2	$25 copay	50% coinsurance
Tier 3	$50 copay	Not Covered
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	$60 copay and/or 0% coinsurance after deductible	$60 copay and/or 0% coinsurance after in-network deductible
Emergency Room Services (Copay is waived if admitted)	$200 copay and 0% coinsurance after deductible	$200 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	$30 copay	20% coinsurance after deductible
Durable Medical Equipment	0% coinsurance after deductible	20% coinsurance after deductible
Physical, Speech & Occupational Therapy	$30 copay per therapy type per day	20% coinsurance after deductible
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: 05/10/17