Dean Health Plan

SCHOOL DISTRICT OF WESTON

Effective Date: 07/01/2017

Product Type: HMO HRA

Plan Code: 44189/

Plan Overview	Plan Providers - You Pay	Non-Plan Providers - You Pay
Deductible	$1500 single / $3000 family	N/A
Coinsurance	20% coinsurance after deductible	N/A
Office Visit Charge (Primary/Specialist)	$40 copay ; Waived for dependents through age 18 / $40 copay ; Waived for dependents through age 18	Not Covered / Not Covered
Office Visit and Related Services	20% coinsurance after deductible	Not Covered
Preventive Services	$0 copay	Not Covered
Deductible and Coinsurance Limit	$3000 single / $6000 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	$10 copay	Not Covered
Tier 2	30% coinsurance up to max of $75 per Rx fill up to $1,500 per Contract Period; then $10 copay per prescription	Not Covered
Tier 3	50% coinsurance ($50 minimum up to max of $150 per prescription)	Not Covered
Diagnostic Services		
Diagnostic Services	20% coinsurance after deductible	Not Covered
CAT Scans/MRI/MRA	20% coinsurance after deductible	Not Covered
Hospital & Surgical Center		
Inpatient Hospital	20% coinsurance after deductible	Not Covered
Outpatient Hospital	20% coinsurance after deductible	Not Covered
Emergency Services		
Urgent Care	$40 copay ; Waived for dependents through age 18 and/or 20% coinsurance after deductible	$40 copay ; Waived for dependents through age 18 and/or 20% coinsurance after deductible
Emergency Room Services (Copay is waived if admitted)	$125 copay and 20% coinsurance after deductible	$125 copay and 20% coinsurance after deductible
Ambulance	20% coinsurance after deductible	20% coinsurance after deductible
Other Services		
Mental Health Inpatient	20% coinsurance after deductible	Not Covered
Mental Health Day Treatment Programs	20% coinsurance after deductible	Not Covered
Mental Health Outpatient	$0 copay	Not Covered
Durable Medical Equipment	20% coinsurance after deductible	Not Covered
Physical, Speech & Occupational Therapy	$40 copay per therapy type per day; Waived for dependents through age 18	Not Covered
Plan Special Features		

This plan is 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: 03/02/17