

# Dean Health Plan

MONONA GROVE SCHOOL DISTRICT

Product Type: POS

Effective Date: 01/01/2020

Plan Code: 53254/

Plan Overview	Plan Providers - You Pay	Non-Plan Providers - You Pay
Deductible	\$100 single / \$200 family	\$250 single / \$500 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	\$100 single / \$200 family	\$750 single / \$1500 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
<b>Prescription Drugs, Insulin &amp; Disposable Diabetic Supplies</b>	Unless otherwise indicated, generic or brand name drugs can be found in any formulary tier)	
Tier 1	\$5 copay	50% coinsurance
Tier 2	\$15 copay	50% coinsurance
Tier 3	\$35 copay	Not Covered
<b>Diagnostic Services</b>		
Diagnostic Services	0% coinsurance after deductible	20% coinsurance after deductible
CAT Scans/MRI/MRA	\$50 copay	20% coinsurance after deductible
<b>Hospital &amp; Surgical Center</b>		
Inpatient Hospital	0% coinsurance after deductible	20% coinsurance after deductible
Outpatient Hospital	0% coinsurance after deductible	20% coinsurance after deductible
<b>Emergency Services</b>		
Urgent Care	0% coinsurance after deductible	0% coinsurance after in-network deductible
Emergency Room Services (Copay is waived if admitted)	\$100 copay and/or 0% coinsurance after deductible	\$100 copay and/or 0% coinsurance after in-network deductible
Ambulance	0% coinsurance after deductible	0% coinsurance after in-network deductible
<b>Other Services</b>		
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	20% coinsurance up to \$2,000 limit	20% coinsurance after deductible
Physical, Speech & Occupational Therapy	0% coinsurance after deductible	20% coinsurance after deductible
<b>Plan Special Features</b>		

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](http://www.deancare.com).