Plan 2 - 0

Dean Health Plan

SAUK PRAIRIE SCHOOL DISTRICT

Product Type: POS

Effective Date: 07/01/2017

Plan Code: POS03272/PHA01677

Plan Overview	Plan Providers - You Pay	Non-Plan Providers - You Pay
Deductible	$0 single / $0 family	$100 single / $200 family
Coinsurance	0% coinsurance after deductible	0% coinsurance after deductible
Office Visit Charge (Primary/Specialist)	$10 copay / $10 copay	0% coinsurance after deductible / 0% coinsurance after deductible
Office Visit and Related Services	0% coinsurance after deductible	0% coinsurance after deductible
Preventive Services	$0 copay	0% coinsurance after deductible
Deductible and Coinsurance Limit	$0 single / $0 family	$100 single / $200 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	$2 copay	50% coinsurance
Tier 2	$2 copay	50% coinsurance
Tier 3	Not Covered	Not Covered
Diagnostic Services		
Diagnostic Services	0% coinsurance after deductible	0% coinsurance after deductible
CAT Scans/MRI/MRA	0% coinsurance after deductible	0% coinsurance after deductible
Hospital & Surgical Center		
Inpatient Hospital	0% coinsurance after deductible	0% coinsurance after deductible
Outpatient Hospital	0% coinsurance after deductible	0% 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)	$50 copay and 0% coinsurance after deductible	$50 copay and 0% coinsurance after in-network deductible
Ambulance	$0 copay	$0 copay
Other Services		
Mental Health Inpatient	$0 copay per admission	$0 copay per admission
Mental Health Day Treatment Programs	$0 copay	$0 copay
Mental Health Outpatient	$10 copay	$10 copay
Durable Medical Equipment	0% coinsurance after deductible	50% coinsurance after deductible; not subject to out-of-pocket maximum
Physical, Speech & Occupational Therapy	$10 copay per therapy type per day	0% coinsurance after deductible
Plan Special Features	120 days per contract period (Skilled Nursing Facility)	

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: 03/03/17