Dean Health Plan

County of Rock
Effective Date: 01/01/2020

Plan 2 - 2
Product Type: POS
Plan Code: 52747/

Plan Overview	*Plan Providers - You Pay*	*Non-Plan Providers - You Pay*
Deductible	$500 single / $1500 family	$750 single / $2250 family
Coinsurance	10% coinsurance after deductible	35% coinsurance after deductible
Office Visit Charge (Primary/Specialist)	$15 copay / $15 copay	35% coinsurance after deductible / 35% coinsurance after deductible
Office Visit and Related Services	10% coinsurance after deductible	35% coinsurance after deductible
Preventive Services	$0 copay	35% coinsurance after deductible
Deductible and coinsurance Limit	$1500 single / $3000 family	$2250 single / $4300 family
Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted)	$3650 single / $7300 family	$3650 single / $7300 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
Tier 4	$150 copay	50% coinsurance
Diagnostic Services		
Diagnostic Services	10% coinsurance after deductible	35% coinsurance after deductible
CAT Scans/MRI/MRA	10% coinsurance after deductible	35% coinsurance after deductible
Hospital & Surgical Center		
Inpatient Hospital	10% coinsurance after deductible	35% coinsurance after deductible
Outpatient Hospital	10% coinsurance after deductible	35% coinsurance after deductible
Emergency Services		
Urgent Care	$30 copay and/or 10% coinsurance after deductible	$30 copay and/or 10% coinsurance after in-network deductible
Emergency Room Services (Copay is waived if admitted)	$300 copay and/or 10% coinsurance after deductible	$300 copay and/or 10% coinsurance after in-network deductible
Ambulance	10% coinsurance after deductible	10% coinsurance after in-network deductible
Other Services		
Mental Health Inpatient	10% coinsurance after deductible	35% coinsurance after deductible
Mental Health Day Treatment Programs	10% coinsurance after deductible	35% coinsurance after deductible
Mental Health Outpatient	$15 copay	35% coinsurance after deductible
Durable Medical Equipment	10% coinsurance after deductible	35% coinsurance after deductible
Physical, Speech & Occupational Therapy	$15 copay per therapy type per day	35% coinsurance after deductible
Plan Special Features		

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: 05/09/19