Plan 2 - 0

Dean Health Plan

DANE COUNTY - Retirees

Effective Date: 01/01/2019

Product Type: HMO

Plan Code: HMO03885/PHA01636

Plan Overview	Plan Providers - You Pay	Non-Plan Providers - You Pay
Deductible	$100 single / $200 family	N/A
Coinsurance	0% coinsurance after deductible	N/A
Office Visit Charge (Primary/Specialist)	$5 copay ; Waived for dependents through age 18 / $5 copay ; Waived for dependents through age 18	Not Covered / Not Covered
Office Visit and Related Services	0% coinsurance after deductible	Not Covered
Preventive Services	$0 copay	Not Covered
Deductible and Coinsurance Limit	$100 single / $200 family	N/A
Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Medical Copays unless otherwise noted)	$250 single / $500 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	$20 copay	Not Covered
Tier 3	$40 copay	Not Covered
Maximum Out-of-Pocket Prescription Copays	$500 single / $1500 family	Not Covered
Diagnostic Services		
Diagnostic Services	0% coinsurance after deductible	Not Covered
CAT Scans/MRI/MRA	0% coinsurance after deductible	Not Covered
Hospital & Surgical Center		
Inpatient Hospital	0% coinsurance after deductible	Not Covered
Outpatient Hospital	0% coinsurance after deductible	Not Covered
Emergency Services		
Urgent Care	$10 copay ; Waived for dependents through age 18 and/or 0% coinsurance after deductible	$10 copay ; Waived for dependents through age 18 and/or 0% coinsurance after deductible
Emergency Room Services (Copay is waived if admitted)	$50 copay and/or 0% coinsurance after deductible	$50 copay and/or 0% coinsurance after deductible
Ambulance	0% coinsurance after deductible	0% coinsurance after deductible
Other Services		
Mental Health Inpatient	0% coinsurance after deductible	Not Covered
Mental Health Day Treatment Programs	0% coinsurance after deductible	Not Covered
Mental Health Outpatient	$5 copay ; Waived for dependents through age 18	Not Covered
Durable Medical Equipment	0% coinsurance after deductible	Not Covered
Physical, Speech & Occupational Therapy	$5 copay per therapy type per day; Waived for dependents through age 18	Not Covered
Plan Special Features		

This renewal plan includes prescription drug coverage that is creditable
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: 09/28/18