District HRA Plan

Dean Health Plan

Plan 2 - 0

SCHOOL DISTRICT OF FORT ATKINSON **Product Type: POS**

Effective Date: 09/01/2020 **Plan Code: POS03296/PHA01688**

Plan Overview	*Plan Providers - You Pay*	*Non-Plan Providers - You Pay*
Deductible	$2000 single / $4000 family	$4000 single / $8000 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	$2000 single / $4000 family	$8000 single / $16000 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	$5 copay	50% coinsurance
Tier 2	$10 copay	50% coinsurance
Tier 3	$25 copay	Not Covered
Tier 4	Not Covered	Not Covered
Diagnostic Services		
Diagnostic Services	0% coinsurance after deductible	20% coinsurance after deductible
CAT Scans/MRI/MRA	0% coinsurance after deductible	20% coinsurance after deductible
Hospital & Surgical Center		
Inpatient Hospital	0% coinsurance after deductible	20% coinsurance after deductible
Outpatient Hospital	0% coinsurance after deductible	20% coinsurance after deductible
Emergency Services		
Urgent Care	0% coinsurance after deductible	0% coinsurance after in-network deductible
Emergency Room Services (Copay is waived if admitted)	0% coinsurance after deductible	0% coinsurance after in-network deductible
Ambulance	0% coinsurance after deductible	0% coinsurance after in-network deductible
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	$0 copay	$0 copay
Durable Medical Equipment	0% coinsurance after deductible	20% coinsurance after deductible
Physical, Speech & Occupational Therapy	$0 copay per therapy type per day	20% coinsurance after deductible
Plan Special Features	Travel Immunizations. Full Time Student Amendment. Erectile Dysfunction drugs (Viagra, Levitra, Cialis) = 12 pills/month. Diabetic supplies and gluecometers covered at 100%.	

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: 03/12/20

District HSA plan

Dean Health Plan

Plan 1 - 0

SCHOOL DISTRICT OF FORT ATKINSON **Product Type: HMO HDHP**

Effective Date: 09/01/2020 **Plan Code: HMO04389/PHA01720**

Plan Overview	*Plan Providers - You Pay*	*Non-Plan Providers - You Pay*
Deductible	$3000 single / $6000 family	N/A
Coinsurance	0% coinsurance after deductible	N/A
Office Visit Charge (Primary/Specialist)	0% coinsurance after deductible / 0% coinsurance after deductible	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	N/A	N/A
Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted)	$3000 single / $6000 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	0% coinsurance after deductible	Not Covered
Tier 2	0% coinsurance after deductible	Not Covered
Tier 3	0% coinsurance after deductible	Not Covered
Tier 4	0% coinsurance after deductible	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	0% coinsurance after deductible	0% coinsurance after deductible
Emergency Room Services (Copay is waived if admitted)	0% coinsurance after deductible	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	0% coinsurance after deductible	Not Covered
Durable Medical Equipment	0% coinsurance after deductible	Not Covered
Physical, Speech & Occupational Therapy	0% coinsurance after deductible	Not Covered
Plan Special Features	HSA Qualified High Deductible Health Plan with Aggregate Deductible.	

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: 03/12/20