Dean Health Plan

SCHOOL DISTRICT OF LODI | **Product Type: POS**

Effective Date: 09/01/2020 | **Plan Code: POS03368/PHA01791**

Plan Overview	*Plan Providers - You Pay*	*Non-Plan Providers - You Pay*
Deductible	$500 single / $1000 family	$1000 single / $2000 family
Coinsurance	0% coinsurance after deductible	20% coinsurance after deductible
Office Visit Charge (Primary/Specialist)	$25 copay ; Waived for dependents through age 18 / $25 copay ; Waived for dependents throug	$50 copay / $50 copay
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	$500 single / $1000 family	N/A
Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted)	$1500 single / $3000 family	$3000 single / $6000 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
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	$100 copay ; Waived for dependents through age 18 and/or 0% coinsurance after deductible	$100 copay ; Waived for dependents through age 18 and/or 0% coinsurance after in-network deductible
Emergency Room Services (Copay is waived if admitted)	$200 copay and/or 0% coinsurance after deductible	$200 copay and/or 0% coinsurance after in-network deductible
Ambulance	0% coinsurance after deductible	0% coinsurance after in-network deductible
Other Services		
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	$25 copay ; Waived for dependents through age 18	$50 copay
Durable Medical Equipment	0% coinsurance after deductible	20% coinsurance after deductible
Physical, Speech & Occupational Therapy	$25 copay per therapy type per day; Waived for dependents through age 18	$50 copay per therapy type per day
Plan Special Features	Out of Pocket Maximum Medical, $1500 Single, $3000 Family, Out of Pocket Maximum Prescription Drug, $2000 Single, $4000 Family	

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: 02/14/20