DeanHealthPlan by Medica

# VERONA AREA SCHOOL DISTRICT

Benefit Summary

Effective: 07/01/2026

**Plan Code:** HMO06668 / PHA05863 **Plan Type**: Copay **Network:** HMO **Contract:** Contract Year **Plan 1-0**

| **Plan Overview** | ***Plan Providers - You Pay*** | ***Non-Plan Providers - You Pay*** |
|---|---|---|
| Embedded Deductible* | $100 single / $300 family | Not Applicable |
| Coinsurance | 0% coinsurance after deductible | Not Applicable |
| Primary Office Visit Charge | $20 copay | Not Covered |
| Specialist Office Visit Charge | $20 copay | Not Covered |
| Preventive Services | $0 copay | Not Covered |
| Deductible & Coinsurance Limit | Not Applicable | Not Applicable |
| Maximum Out-of-Pocket** | $200 single / $600 family | Not Applicable |

**The plan begins making payments as soon as one family member has reached their individual deductible*
***Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted*

## Prescription Drugs, Insulin & Disposable Diabetic Supplies*

4 Tier Select

| | | | | |
|---|---|---|---|---|
| Rx Deductible | $0 single / $0 family | | | Not Applicable |
| Rx Maximum Out-of-Pocket | No Separate Rx Out-of-Pocket Max | | | No Separate Rx Out-of-Pocket Max |
| Mail Order | 90-day supply (Tiers 1 & 2) for 2 copays; 90-day supply (Tier 3) for 3 copays; Tier 4 Not Covered | | | |
| | **Tier 1** | **Tier 2** | **Tier 3** | **Tier 4** |
| In-Network | $10 copay | $25 copay | $50 copay | 30% coinsurance |
| Out-of-Network | Not Covered | Not Covered | Not Covered | Not Covered |

**Unless otherwise indicated, generic or brand name drugs can be found in any formulary tier*
**This new plan includes prescription drug coverage that is creditable*

| **Diagnostic Services** | ***Plan Providers - You Pay*** | ***Non-Plan Providers - You Pay*** |
|---|---|---|
| Diagnostic Services (Xrays/Labs) | 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 | $20 copay and/or 0% coinsurance after deductible | $20 copay and/or 0% coinsurance after deductible |
| Emergency Room Services* | $100 copay and/or 0% coinsurance after deductible | $100 copay and/or 0% coinsurance after deductible |
| Ambulance | 0% coinsurance after deductible | 0% coinsurance after deductible |

** copay is waived if admitted*

## Additional Plan Design Attributes

This 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 https://app.deancare.com/sites/sbc/employergroup