

# Dean Health Plan

SCHOOL DISTRICT OF ARGYLE

Product Type: POS

Effective Date: 07/01/2019

Plan Code: 52386/

Plan Overview	Plan Providers - You Pay	Non-Plan Providers - You Pay
Deductible	\$3000 single / \$6000 family	\$6000 single / \$12000 family
Coinsurance	0% coinsurance after deductible	10% coinsurance after deductible
Office Visit Charge (Primary/Specialist)	\$0 copay / \$0 copay	10% coinsurance after deductible / 10% coinsurance after deductible
Office Visit and Related Services	0% coinsurance after deductible	10% coinsurance after deductible
Preventive Services	\$0 copay	10% coinsurance after deductible
Deductible and Coinsurance Limit	\$3000 single / \$6000 family	\$12000 single / \$24000 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
<b>Prescription Drugs, Insulin &amp; Disposable Diabetic Supplies</b>	Unless otherwise indicated, generic or brand name drugs can be found in any formulary tier)	
Tier 1	\$6 copay	50% coinsurance
Tier 2	\$10 copay	50% coinsurance
Tier 3	50% coinsurance (\$50 minimum up to max of \$150 per prescription)	Not Covered
<b>Diagnostic Services</b>		
Diagnostic Services	0% coinsurance after deductible	10% coinsurance after deductible
CAT Scans/MRI/MRA	0% coinsurance after deductible	10% coinsurance after deductible
<b>Hospital &amp; Surgical Center</b>		
Inpatient Hospital	0% coinsurance after deductible	10% coinsurance after deductible
Outpatient Hospital	0% coinsurance after deductible	10% coinsurance after deductible
<b>Emergency Services</b>		
Urgent Care	\$0 copay and/or 0% coinsurance after deductible	\$0 copay and/or 0% coinsurance after in-network deductible
Emergency Room Services (Copay is waived if admitted)	\$100 copay and/or 0% coinsurance after deductible	\$100 copay and/or 0% coinsurance after in-network deductible
Ambulance	0% coinsurance after deductible	0% coinsurance after in-network deductible
<b>Other Services</b>		
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	50% coinsurance after deductible; not subject to out-of-pocket maximum
Physical, Speech & Occupational Therapy	0% coinsurance after deductible	10% coinsurance after deductible
<b>Plan Special Features</b>	PT/OT/ST & HH no visit limit. Travel Immunizations. Full Time Student Amendment.	

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](http://www.deancare.com).