

# Dean Health Plan

SCHOOL DISTRICT OF ARGYLE

Effective Date: 07/01/2020

Plan 2 - 1

Product Type: HMO

Plan Code: 60202/

Plan Component	Plan / Provider(s) and / or	Plan / Plan Provider(s) - Your Pay
Deductible	\$3000 single / \$6000 family	N/A
Coinsurance	0% coinsurance after deductible	N/A
Office Visit Charge (Primary/Specialist)	\$0 copay / \$0 copay	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	\$3000 single / \$6000 family	Unlimited
Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted)	\$7150 single / \$14300 family	N/A
<b>Prescription Drugs, Insulin &amp; Disposable Diabetic Supplies</b>	<i>Unless otherwise indicated, generic or brand name drugs can be found in any (community) drug</i>	
Tier 1	\$6 copay	Not Covered
Tier 2	\$10 copay	Not Covered
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	Not Covered
CAT Scans/MRI/MRA	0% coinsurance after deductible	Not Covered
<b>Hospital &amp; Surgical Center</b>		
Inpatient Hospital	0% coinsurance after deductible	Not Covered
Outpatient Hospital	0% coinsurance after deductible	Not Covered
<b>Emergency Services</b>		
Urgent Care	\$0 copay and/or 0% coinsurance after deductible	\$0 copay and/or 0% coinsurance after deductible
Emergency Room Services (Copay is waived if admitted)	\$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
<b>Other Services</b>		
Mental Health Inpatient	\$0 copay per admission	Not Covered
Mental Health Day Treatment Programs	\$0 copay	Not Covered
Mental Health Outpatient	\$0 copay	Not Covered
Durable Medical Equipment	0% coinsurance after deductible	Not Covered
Physical, Speech & Occupational Therapy	0% coinsurance after deductible	Not Covered
<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).

Date Prepared: 05/28/20