

Plan Overview	Plan Providers - You Pay	Non-Plan Providers - You Pay
Deductible	\$2,000 single / \$4,000 family	Not Covered
Coinsurance	0% coinsurance after deductible	Not Covered
Office Visit Charge (Primary/Specialist)	\$25 copay / \$50 copay	Not Covered
Office Visit and Related Services	0% coinsurance after deductible	Not Covered
Preventive Services	\$0 copay	Not Covered
Deductible and Coinsurance Limit	Not Applicable	Not Covered
Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted)	\$3,000 single / \$6,000 family	Not Covered
<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	\$0 copay	Not Covered
Tier 2	\$25 copay	Not Covered
Tier 3	\$50 copay	Not Covered
Tier 4	30% coinsurance	Not Covered
Deductibles and/or Out of Pocket Maximums for Prescription Drugs	Rx Deductible: \$0 single / \$0 family Rx Max OOP: \$2,000 single / \$4,000 family	Not Covered
<b>Diagnostic Services</b>		
Diagnostic Services (Xrays/Labs)	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	\$75 copay and/or 0% coinsurance after deductible	\$75 copay and/or 0% coinsurance after in-network deductible
Emergency Room Services (Copay is waived if admitted)	\$150 copay and/or 0% coinsurance after deductible	\$150 copay and/or 0% coinsurance after in-network deductible
Ambulance	0% coinsurance after deductible	0% coinsurance after deductible
<b>Other Services</b>		
Mental Health Inpatient	0% coinsurance after deductible	Not Covered
Mental Health Day Treatment Programs	0% coinsurance after deductible	Not Covered
Mental Health Outpatient	\$25 copay	Not Covered
Durable Medical Equipment	0% coinsurance after deductible	Not Covered
Physical, Speech & Occupational Therapy	\$50 copay per therapy type per day	Not Covered
<b>Plan Design Attributes</b>		

This renewal plan includes prescription drug coverage that is creditable  
 Unless otherwise noted, all benefits are based on a Contract Year  
 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 [www.deancare.com](http://www.deancare.com).