

Plan Overview	Plan Providers - You Pay	Non-Plan Providers - You Pay
Deductible	\$1,500 single / \$3,000 family	Not Covered
Coinsurance	0% coinsurance after deductible	Not Covered
Office Visit Charge (Primary/Specialist)	0% coinsurance after deductible	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)	\$1,500 single / \$3,000 family	Not Covered
Prescription Drugs, Insulin & Disposable Diabetic Supplies	Unless otherwise indicated, generic or brand name drugs can be found in any formulary tier)	
Tier 1	0% coinsurance after deductible	Not Covered
Tier 2	0% coinsurance after deductible	Not Covered
Tier 3	0% coinsurance after deductible	Not Covered
Tier 4	0% coinsurance after deductible	Not Covered
Diagnostic Services		
Diagnostic Services (Xrays/Labs)	0% coinsurance after deductible / 0% coinsurance after deductible	Not Covered / 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	0% coinsurance after deductible	0% coinsurance after deductible
Emergency Room Services (Copay is waived if admitted)	0% coinsurance after deductible	0% coinsurance after deductible
Ambulance	0% coinsurance after deductible	0% coinsurance after deductible
Other Services		
Mental Health Inpatient	0% coinsurance after deductible	Not Covered
Mental Health Day Treatment Programs	0% coinsurance after deductible	Not Covered
Mental Health Outpatient	0% coinsurance after deductible	Not Covered
Durable Medical Equipment	0% coinsurance after deductible	Not Covered
Physical, Speech & Occupational Therapy	0% coinsurance after deductible	Not Covered
Plan Special Features		

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. 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.deanhealth.com.

Plan Overview	Plan Providers - You Pay	Non-Plan Providers - You Pay
Deductible	\$1,500 single / \$3,000 family	\$3,000 single / \$6,000 family
Coinsurance	0% coinsurance after deductible	20% coinsurance after deductible
Office Visit Charge (Primary/Specialist)	0% coinsurance after deductible	20% coinsurance after deductible
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	Not Applicable	Not Applicable
Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted)	\$1,500 single / \$3,000 family	\$6,000 single / \$12,000 family
Prescription Drugs, Insulin & Disposable Diabetic Supplies	Unless otherwise indicated, generic or brand name drugs can be found in any formulary tier	
Tier 1	0% coinsurance after deductible	20% coinsurance after deductible
Tier 2	0% coinsurance after deductible	20% coinsurance after deductible
Tier 3	0% coinsurance after deductible	Not Covered
Tier 4	0% coinsurance after deductible	20% coinsurance after deductible
Diagnostic Services		
Diagnostic Services (Xrays/Labs)	0% coinsurance after deductible / 0% coinsurance after deductible	20% 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	0% coinsurance after deductible	0% coinsurance after in-network deductible
Emergency Room Services (Copay is waived if admitted)	0% coinsurance after deductible	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	0% coinsurance after deductible	20% coinsurance after deductible
Durable Medical Equipment	0% coinsurance after deductible	20% coinsurance after deductible
Physical, Speech & Occupational Therapy	0% coinsurance after deductible	20% coinsurance after deductible
Plan Special Features		

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