

Plan Overview	Plan Providers - You Pay	Non-Plan Providers - You Pay
Deductible	\$100 single / \$200 family	\$400 single / \$800 family
Coinsurance	0% coinsurance after deductible	0% coinsurance after deductible
Office Visit Charge (Primary/Specialist)	\$5 copay; Waived for dependents through age 18	\$10 copay; Waived for dependents through age 18
Office Visit and Related Services	0% coinsurance after deductible	0% coinsurance after deductible
Preventive Services	\$0 copay	\$10 copay and/or 0% coinsurance after deductible
Deductible and Coinsurance Limit	\$100 single / \$200 family	Not Applicable
Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted)	\$250 single / \$500 family	\$400 single / \$800 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	\$10 copay	50% coinsurance
Tier 2	\$20 copay	50% coinsurance
Tier 3	\$40 copay	Not Covered
Tier 4	30% coinsurance	50% coinsurance
Deductibles and/or Out of Pocket Maximums for Prescription Drugs	Rx Deductible: \$0 single / \$0 family Rx Max OOP: \$500 single / \$1,500 family	Rx Deductible: \$0 single / \$0 family; Rx Max OOP: \$500 single / \$1,500 family
<b>Diagnostic Services</b>		
Diagnostic Services (Xrays/Labs)	0% coinsurance after deductible	0% coinsurance after deductible
CAT Scans/MRI/MRA	0% coinsurance after deductible	0% coinsurance after deductible
<b>Hospital &amp; Surgical Center</b>		
Inpatient Hospital	0% coinsurance after deductible	0% coinsurance after deductible
Outpatient Hospital	0% coinsurance after deductible	0% coinsurance after deductible
<b>Emergency Services</b>		
Urgent Care	\$5 copay; Waived for dependents through age 18 and/or 0% coinsurance after deductible	\$5 copay; Waived for dependents through age 18 and/or 0% coinsurance after in-network deductible
Emergency Room Services (Copay is waived if admitted)	\$50 copay and/or 0% coinsurance after deductible	\$50 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% coinsurance after deductible	0% coinsurance after deductible
Mental Health Day Treatment Programs	0% coinsurance after deductible	0% coinsurance after deductible
Mental Health Outpatient	\$5 copay; Waived for dependents through age 18	\$10 copay
Durable Medical Equipment	0% coinsurance after deductible	0% coinsurance after deductible
Physical, Speech & Occupational Therapy	\$5 copay per therapy type per day; Waived for dependents through age 18	\$10 copay per therapy type per day; Waived for dependents through age 18
<b>Plan Design Attributes</b>	In and Out-of-Network deductibles and coinsurance combined.	

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