

Plan Overview	Plan Providers - You Pay	Non-Plan Providers - You Pay
Deductible	\$6,000 single / \$12,000 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)	\$6,000 single / \$12,000 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% 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
Tier 5	Not Covered	Not Covered
<b>Diagnostic Services</b>		
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
<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% 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
<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	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
<b>Plan Special Features</b>		

This renewal plan includes prescription drug coverage that is creditable  
 Unless otherwise noted, all benefits are based on a Calendar 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.prevea360.com](http://www.prevea360.com).