Wisconsin

Dean Advantage[SM] (HMO-POS and HMO) Plans

Summary of Benefits

January 1, 2027 – December 31, 2027

This is a summary of drug and health services covered by **Dean Advantage Essential (HMO), Dean Advantage Assurance (HMO-POS), Dean Advantage Balance (HMO-POS), Dean Advantage Complete (HMO),** and **Dean Advantage Harmony (HMO-POS).**

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the *Evidence of Coverage*.

You have choices about how to get your Medicare benefits

One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.

Another choice is to get your Medicare benefits by joining a Medicare Advantage plan (such as **Dean Advantage Essential (HMO)**, **Dean Advantage Assurance (HMO-POS)**, **Dean Advantage Balance (HMO-POS)**, **Dean Advantage Complete (HMO),** and **Dean Advantage Harmony (HMO-POS)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Dean Advantage** plans cover and what you pay. If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on www.medicare.gov.

If you want to know more about the coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About **Dean Advantage** Plans
- Monthly Premium, Deductible, and Maximums on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Part D Prescription Drug Benefits
- Additional Benefits and Services

This document is available in other formats such as braille and large print. This document may be available in a non-English language. For additional information, call us at 1 (877) 234-0126 (toll-free) (TTY: 711).

H9096-004-000, 001-000, 002-000, 005-000,
010-000
MCR61258-701026A H9096_61258_M

DeanHealthPlan by Medica

Things to Know About Dean Advantage Plans

Hours of Operation

- From Oct. 1 – March 31, you can call us from 8 a.m. – 8 p.m. CT, 7 days a week.
- From April 1 – Sept. 30, you can call us from 8 a.m. – 8 p.m. CT, Monday – Friday.

Dean Advantage Phone Numbers and Website

- If you are a member of this plan, call 1 (877) 232-7566 (toll-free) (TTY: 711).
- If you are not a member of this plan, call 1 (877) 234-0126 (toll-free) (TTY: 711).
- Our website: DeanCare.com/MedicareAdvantageMembers

Who Can Join?

To join **Dean Advantage** plans, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes the following counties in **Wisconsin**: Columbia, Dane, Dodge, Fond du Lac, Green, Iowa, Jefferson, Rock, and Sauk.

Which doctors, hospitals, and pharmacies can I use?

Dean Advantage plans have a network of doctors, hospitals, pharmacies, and other providers. For HMO, you must receive your care from a network provider. In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. For HMO-POS, you have coverage for most Medicare-covered services at out-of-network providers through the Point-of-Service (POS) benefit, but you may pay more. Coverage for emergency care is the same in network as it is out of network (within the U.S. and its territories) plus you have coverage worldwide. Covered services for HMO that need approval in advance to be covered as in-network services are marked by an asterisk (*). Covered services for HMO-POS that need approval in advance are marked by an asterisk (*).

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs. You may search for network providers and pharmacies on our website at DeanCare.com/MedicareAdvantageMembers. Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Dean Advantage Essential (HMO), Dean Advantage Assurance (HMO-POS), Dean Advantage Balance (HMO-POS), and **Dean Advantage Complete (HMO)** cover everything that Original Medicare covers – plus more. Our plans cover medical and hospital services, Part D outpatient prescription drugs, and protect you from unlimited out-of-pocket costs.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider. You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, DeanCare.com/MedicareAdvantageMembers. Or, call us and we will send you a copy of the formulary.

Dean Advantage Harmony (HMO-POS) covers everything that Original Medicare covers – plus more. Our plan covers medical and hospital services and protects you from unlimited out-of-pocket costs.

We cover Part B drugs such as chemotherapy and some drugs administered by your provider. You can see the complete plan formulary and any restrictions on our website, DeanCare.com/MedicareAdvantageMembers. Or, call us and we will send you a copy of the formulary.

SUMMARY OF BENEFITS

January 1, 2027 – December 31, 2027

	Essential HMO ($0)	Assurance HMO-POS ($60)	Balance HMO-POS ($139)	Complete HMO ($276)	Harmony HMO-POS ($0)
MONTHLY PREMIUM, DEDUCTIBLE, AND MAXIMUMS ON HOW MUCH YOU PAY FOR COVERED SERVICES					
Monthly Plan Premium	$0	$60	$139	$276	$0
Part B Premium Buy-Down	Not Applicable	Not Applicable	Not Applicable	Not Applicable	$60 per month
Medical Deductible	No deductible				
Maximum Out-Of-Pocket Responsibility *(does not include prescription drugs)*	In-Network: $7,150	In-Network: $5,000 In-Network and Out-of-Network combined: $5,000	In-Network: $4,200 In-Network and Out-of-Network combined: $4,200	In-Network: $2,750	In-Network: $5,000 In-Network and Out-of-Network combined: $5,000

	Essential HMO ($0)	Assurance HMO-POS ($60)	Balance HMO-POS ($139)	Complete HMO ($276)	Harmony HMO-POS ($0)
COVERED MEDICAL AND HOSPITAL BENEFITS					
Inpatient Hospital Coverage					
In-Network	$412 copay each day for days 1 through 6 $0 copay for days 7 through 90 $0 copay for additional	$400 copay each day for days 1 through 5 $0 copay for days 6 through 90 $0 copay for additional	$375 copay each day for days 1 through 5 $0 copay for days 6 through 90 $0 copay for additional	$350 copay each day for days 1 through 5 $0 copay for days 6 through 90 $0 copay for additional	$400 copay each day for days 1 through 6 $0 copay for days 7 through 90 $0 copay for additional

	Essential HMO ($0)	Assurance HMO-POS ($60)	Balance HMO-POS ($139)	Complete HMO ($276)	Harmony HMO-POS ($0)
COVERED MEDICAL AND HOSPITAL BENEFITS					
	Medicare-covered days. *	Medicare-covered days. *	Medicare-covered days. *	Medicare-covered days. *	Medicare-covered days. *
Out-of-Network	Not covered	50% of the total cost for days 1 through 7 $0 copay for days 8 through 90 $0 copay for additional Medicare-covered days.	40% of the total cost for days 1 through 7 $0 copay for days 8 through 90 $0 copay for additional Medicare-covered days.	Not covered	40% of the total cost for days 1 through 7 $0 copay for days 8 through 90 $0 copay for additional Medicare-covered days.
Outpatient Hospital Coverage	**Outpatient Hospital Services:**	**Outpatient Hospital Services:**	**Outpatient Hospital Services:**	**Outpatient Hospital Services:**	**Outpatient Hospital Services:**
In-Network	$0 - $595 copay *	$0 - $550 copay *	$0 - $400 copay *	$0 - $300 copay *	$0 - $425 copay *
Out-of-Network	Not covered	50% of the total cost	40% of the total cost	Not covered	40% of the total cost
	Outpatient Hospital Observation Services:	**Outpatient Hospital Observation Services:**	**Outpatient Hospital Observation Services:**	**Outpatient Hospital Observation Services:**	**Outpatient Hospital Observation Services:**
In-Network	$459 copay per stay	$450 copay per stay	$375 copay per stay	$350 copay per stay	$459 copay per stay
Out-of-Network	Not covered	50% of the total cost	40% of the total cost	Not covered	40% of the total cost
Ambulatory Surgery Center					
In-Network	$0 - $525 copay *	$0 - $475 copay *	$0 - $325 copay *	$0 - $225 copay *	$0 - $350 copay *
Out-of-Network	Not covered	50% of the total cost	40% of the total cost	Not covered	40% of the total cost

	Essential HMO ($0)	Assurance HMO-POS ($60)	Balance HMO-POS ($139)	Complete HMO ($276)	Harmony HMO-POS ($0)
COVERED MEDICAL AND HOSPITAL BENEFITS					
Doctor Visits	**Primary Care Provider:**	**Primary Care Provider:**	**Primary Care Provider:**	**Primary Care Provider:**	**Primary Care Provider:**
In-Network	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Out-of-Network	Not covered	50% of the total cost	40% of the total cost	Not covered	40% of the total cost
	Specialist:	**Specialist:**	**Specialist:**	**Specialist:**	**Specialist:**
In-Network	$0 - $60 copay	$0 - $50 copay	$0 - $35 copay	$0 - $20 copay	$0 - $40 copay
Out-of-Network	Not covered	50% of the total cost	40% of the total cost	Not covered	40% of the total cost
Preventive Care (e.g., Flu Vaccine, Diabetic Screenings)					
In-Network	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Out-of-Network	Not covered	50% of the total cost	40% of the total cost	Not covered	40% of the total cost
Emergency Care	$130 copay Copay is waived if you are admitted to a hospital within 1 day within the U.S. and its territories.	$130 copay Copay is waived if you are admitted to a hospital within 1 day within the U.S. and its territories.	$150 copay Copay is waived if you are admitted to a hospital within 1 day within the U.S. and its territories.	$150 copay Copay is waived if you are admitted to a hospital within 1 day within the U.S. and its territories.	$130 copay Copay is waived if you are admitted to a hospital within 1 day within the U.S. and its territories.
Urgently Needed Services	$50 copay	$50 copay	$40 copay	$25 copay	$40 copay

	Essential HMO ($0)	Assurance HMO-POS ($60)	Balance HMO-POS ($139)	Complete HMO ($276)	Harmony HMO-POS ($0)
COVERED MEDICAL AND HOSPITAL BENEFITS					
Diagnostic and Therapeutic Services/Labs/ Imaging					
	Diagnostic Tests and Procedures:	**Diagnostic Tests and Procedures:**	**Diagnostic Tests and Procedures:**	**Diagnostic Tests and Procedures:**	**Diagnostic Tests and Procedures :**
In-Network	$25 copay	$20 copay	$10 copay	$5 copay	$40 copay
Out-of-Network	Not covered	50% of the total cost	40% of the total cost	Not covered	40% of the total cost
	Lab Services:	**Lab Services:**	**Lab Services:**	**Lab Services:**	**Lab Services:**
In-Network	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Out-of-Network	Not covered	50% of the total cost	40% of the total cost	Not covered	40% of the total cost
	Diagnostic Radiology Services (e.g., MRI, CAT Scan):	**Diagnostic Radiology Services (e.g., MRI, CAT Scan):**	**Diagnostic Radiology Services (e.g., MRI, CAT Scan):**	**Diagnostic Radiology Services (e.g., MRI, CAT Scan):**	**Diagnostic Radiology Services (e.g., MRI, CAT Scan):**
In-Network	$25 copay for basic imaging	$25 copay for basic imaging	$15 copay for basic imaging	$50 copay for basic imaging	$150 copay for basic imaging
Out-of-Network	Not covered	50% of the total cost	40% of the total cost	Not covered	40% of the total cost
In-Network	$0 copay for diagnostic mammogram	$0 copay for diagnostic mammogram	$0 copay for diagnostic mammogram	$0 copay for diagnostic mammogram	$0 copay for diagnostic mammogram
Out-of-Network	Not covered	50% of the total cost	40% of the total cost	Not covered	40% of the total cost
In-Network	$250 copay for advanced imaging *	$170 copay for advanced imaging *	$140 copay for advanced imaging *	$95 copay for advanced imaging *	$325 copay for advanced imaging *
Out-of-Network	Not covered	50% of the total cost	40% of the total cost	Not covered	40% of the total cost

	Essential HMO ($0)	Assurance HMO-POS ($60)	Balance HMO-POS ($139)	Complete HMO ($276)	Harmony HMO-POS ($0)
COVERED MEDICAL AND HOSPITAL BENEFITS					
	Therapeutic Radiology Services:	**Therapeutic Radiology Services:**	**Therapeutic Radiology Services:**	**Therapeutic Radiology Services:**	**Therapeutic Radiology Services:**
In-Network	$40 copay *	$45 copay *	$45 copay *	$65 copay *	$85 copay *
Out-of-Network	Not covered	50% of the total cost	40% of the total cost	Not covered	40% of the total cost
	X-Rays:	**X-Rays:**	**X-Rays:**	**X-Rays:**	**X-Rays:**
In-Network	$40 copay	$40 copay	$40 copay	$0 copay	$50 copay
Out-of-Network	Not covered	50% of the total cost	40% of the total cost	Not covered	40% of the total cost
Hearing Services	**Exam to Diagnose and Treat Hearing and Balance Issues:**	**Exam to Diagnose and Treat Hearing and Balance Issues:**	**Exam to Diagnose and Treat Hearing and Balance Issues:**	**Exam to Diagnose and Treat Hearing and Balance Issues:**	**Exam to Diagnose and Treat Hearing and Balance Issues:**
In-Network	$75 copay	$40 copay	$35 copay	$20 copay	$40 copay
Out-of-Network	Not covered	50% of the total cost	40% of the total cost	Not covered	40% of the total cost
Hearing Services (Continued)	**Routine Hearing Exam:** Limited to 1 visit every calendar year.				
In-Network	$0 copay				
Out-of-Network	Not covered				
	Fitting Evaluation(s) for Hearing Aids: Limited to 1 fitting every calendar year.				
In-Network	$0 copay				
Out-of-Network	Not covered				

	Essential HMO ($0)	Assurance HMO-POS ($60)	Balance HMO-POS ($139)	Complete HMO ($276)	Harmony HMO-POS ($0)
COVERED MEDICAL AND HOSPITAL BENEFITS					
In-Network	**Hearing Aids:** Our plan pays up to $750 for both ears combined every calendar year for hearing aids. You are responsible for costs beyond the plan limit.				
Out-of-Network	Not covered				
Dental Services - Medicare-covered					
In-Network	$0 - $75 copay	$0 - $40 copay	$0 - $35 copay	$0 - $20 copay	$0 - $40 copay
Out-of-Network	$0 - $75 copay	$0 - $40 copay	$0 - $35 copay	$0 - $20 copay	$0 - $40 copay
Dental Services – Preventive (e.g., exams, routine cleanings, and certain x-rays)					
In-Network	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Out-of-Network	Not covered	50% of the total cost	50% of the total cost	Not covered	50% of the total cost
Dental Services – Comprehensive (e.g., crowns, bridges, root canals, and extractions) Orthodontic services are not covered.					
In-Network	50% of the total cost	50% of the total cost	50% of the total cost	50% of the total cost	50% of the total cost
Out-of-Network	Not covered	50% of the total cost	50% of the total cost	Not covered	50% of the total cost

	Essential HMO ($0)	Assurance HMO-POS ($60)	Balance HMO-POS ($139)	Complete HMO ($276)	Harmony HMO-POS ($0)
COVERED MEDICAL AND HOSPITAL BENEFITS					
Dental Services - Maximum annual limit (You are responsible for costs beyond the plan limit.)	$500 every calendar year	$600 every calendar year	$800 every calendar year	$1,500 every calendar year	$1,500 every calendar year
Vision Services	**Exam to Diagnose and Treat Diseases and Conditions of the Eye:**	**Exam to Diagnose and Treat Diseases and Conditions of the Eye:**	**Exam to Diagnose and Treat Diseases and Conditions of the Eye:**	**Exam to Diagnose and Treat Diseases and Conditions of the Eye:**	**Exam to Diagnose and Treat Diseases and Conditions of the Eye:**
In-Network	$75 copay	$40 copay	$35 copay	$20 copay	$40 copay
Out-of-Network	Not covered	50% of the total cost	40% of the total cost	Not covered	40% of the total cost
	Eyewear After Cataract Surgery:	**Eyewear After Cataract Surgery:**	**Eyewear After Cataract Surgery:**	**Eyewear After Cataract Surgery:**	**Eyewear After Cataract Surgery:**
	One pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens.	One pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens.	One pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens.	One pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens.	One pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens.
In-Network	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Out-of-Network	Not covered	$0 copay	$0 copay	Not covered	$0 copay
	Routine eye exam (1 exam each calendar year):	**Routine eye exam (1 exam each calendar year):**	**Routine eye exam (1 exam each calendar year):**	**Routine eye exam (1 exam each calendar year):**	**Routine eye exam (1 exam each calendar year):**
In-Network	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay

	Essential HMO ($0)	Assurance HMO-POS ($60)	Balance HMO-POS ($139)	Complete HMO ($276)	Harmony HMO-POS ($0)
COVERED MEDICAL AND HOSPITAL BENEFITS					
Out-of-Network	Not covered	$0 copay	$0 copay	Not covered	$0 copay
	Contact Lenses, Eyeglasses (Lenses and/or Frames), and Upgrades:	**Contact Lenses, Eyeglasses (Lenses and/or Frames), and Upgrades:**	**Contact Lenses, Eyeglasses (Lenses and/or Frames), and Upgrades:**	**Contact Lenses, Eyeglasses (Lenses and/or Frames), and Upgrades:**	**Contact Lenses, Eyeglasses (Lenses and/or Frames), and Upgrades:**
In-Network	Our plan pays up to a total of $125 every year.	Our plan pays up to a total of $150 every year.	Our plan pays up to a total of $175 every year.	Our plan pays up to a total of $175 every year.	Our plan pays up to a total of $175 every year.
	You are responsible for costs beyond the plan limit.	You are responsible for costs beyond the plan limit.	You are responsible for costs beyond the plan limit.	You are responsible for costs beyond the plan limit.	You are responsible for costs beyond the plan limit.
Out-of-Network	Not covered	$0 copay	$0 copay	Not covered	$0 copay
Mental Health Services	**Outpatient Group Therapy Visit:**	**Outpatient Group Therapy Visit:**	**Outpatient Group Therapy Visit:**	**Outpatient Group Therapy Visit:**	**Outpatient Group Therapy Visit:**
In-Network	$40 copay	$30 copay	$15 copay	$10 copay	$20 copay
Out-of-Network	Not covered	50% of the total cost	40% of the total cost	Not covered	40% of the total cost
	Outpatient Individual Therapy Visit:	**Outpatient Individual Therapy Visit:**	**Outpatient Individual Therapy Visit:**	**Outpatient Individual Therapy Visit:**	**Outpatient Individual Therapy Visit:**
In-Network	$50 copay	$40 copay	$25 copay	$10 copay	$30 copay
Out-of-Network	Not covered	50% of the total cost	40% of the total cost	Not covered	40% of the total cost
	Inpatient Hospital:	**Inpatient Hospital:**	**Inpatient Hospital:**	**Inpatient Hospital:**	**Inpatient Hospital:**
In-Network	$392 copay each day for days 1 through 6 and $0 copay for days 7 through 90 *	$350 copay each day for days 1 through 5 and $0 copay for days 6 through 90 *	$350 copay each day for days 1 through 5 and $0 copay for days 6 through 90 *	$350 copay each day for days 1 through 5 and $0 copay for days 6 through 90 *	$392 copay each day for days 1 through 6 and $0 copay for days 7 through 90 *
	$0 copay for up to an additional 60	$0 copay for up to an additional 60	$0 copay for up to an additional 60	$0 copay for up to an additional 60	$0 copay for up to an additional 60

	Essential HMO ($0)	Assurance HMO-POS ($60)	Balance HMO-POS ($139)	Complete HMO ($276)	Harmony HMO-POS ($0)
COVERED MEDICAL AND HOSPITAL BENEFITS					
	lifetime reserve days.	lifetime reserve days.	lifetime reserve days.	lifetime reserve days.	lifetime reserve days.
Out-of-Network	Not covered	50% of the total cost for days 1 through 7 and $0 copay for days 8 through 90 $0 copay for up to an additional 60 lifetime reserve days.	40% of the total cost for days 1 through 7 and $0 copay for days 8 through 90 $0 copay for up to an additional 60 lifetime reserve days.	Not covered	40% of the total cost for days 1 through 7 and $0 copay for days 8 through 90 $0 copay for up to an additional 60 lifetime reserve days.
Skilled Nursing Facility (SNF)					
In-Network	$0 copay for days 1 through 20, a $221 copay each day for days 21 through 52, and $0 copay for days 53 through 100 *	$0 copay for days 1 through 20, a $221 copay each day for days 21 through 44, and $0 copay for days 45 through 100 *	$0 copay for days 1 through 20, a $221 copay each day for days 21 through 41, and $0 copay for days 42 through 100 *	$0 copay for days 1 through 20, a $221 copay each day for days 21 through 34, and $0 copay for days 35 through 100 *	$0 copay for days 1 through 20, a $221 copay each day for days 21 through 44, and $0 copay for days 45 through 100 *
Out-of-Network	Not covered	50% of the total cost	40% of the total cost	Not covered	40% of the total cost
Outpatient Rehabilitation Services	**Physical, Speech, or Occupational Therapy Visit:**	**Physical, Speech, or Occupational Therapy Visit:**	**Physical or Speech Therapy Visit:**	**Physical, Speech, or Occupational Therapy Visit:**	**Physical or Speech Therapy Visit:**
In-Network	$60 copay	$50 copay	$35 copay	$20 copay	$40 copay
Out-of-Network	Not covered	50% of the total cost	40% of the total cost	Not covered	40% of the total cost
			Occupational Therapy Visit:		**Occupational Therapy Visit:**
In-Network			$40 copay		$35 copay
Out-of-Network			40% of the total cost		40% of the total cost

	Essential HMO ($0)	Assurance HMO-POS ($60)	Balance HMO-POS ($139)	Complete HMO ($276)	Harmony HMO-POS ($0)
COVERED MEDICAL AND HOSPITAL BENEFITS					
Ambulance Services – Emergency	**Ground Ambulance:** $300 copay **Air Ambulance:** $475 copay	**Ground Ambulance:** $300 copay **Air Ambulance:** $475 copay	**Ground Ambulance:** $300 copay **Air Ambulance:** $475 copay	**Ground Ambulance:** $300 copay **Air Ambulance:** $475 copay	**Ground Ambulance:** $325 copay **Air Ambulance:** $500 copay
Transportation	$0 copay for 24 one-way rides every calendar year				
In-Network					
Out-of-Network	Not covered				
Medicare Part B Drugs Part B rebatable drugs may be subject to a lower coinsurance. For Part B insulin furnished through an external insulin pump, you will pay up to a $35 copay per a one-month supply.					
In-Network	20% of the total cost *	20% of the total cost *	20% of the total cost *	20% of the total cost *	20% of the total cost *
Out-of-Network	Not covered	50% of the total cost	40% of the total cost	Not covered	40% of the total cost

	Essential HMO ($0)	Assurance HMO-POS ($60)	Balance HMO-POS ($139)	Complete HMO ($276)	Harmony HMO-POS ($0)
PART D PRESCRIPTION DRUG BENEFITS					
Deductible Stage You pay the full cost of your drugs until you reach this amount. The deductible does not apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines. You will start receiving coverage immediately.	Tiers 1, 2, 3, & 6 = $0 Tiers 4 & 5 = $700	Tiers 1, 2, & 6 = $0 Tiers 3, 4, & 5 = $350	Tiers 1, 2, & 6 = $0 Tiers 3, 4, & 5 = $315	Tiers 1, 2, & 6 = $0 Tiers 3, 4, & 5 = $105	NA
Initial Coverage Stage	You will stay in this stage until your yearly out-of-pocket drug costs reach $2,400. In this stage you will pay up to a $35 copay for a one-month (30-day) supply or up to a $105 copay for a three-month (90-day) supply for insulin.				NA

	Essential HMO ($0)	Assurance HMO-POS ($60)	Balance HMO-POS ($139)	Complete HMO ($276)	Harmony HMO-POS ($0)
PREFERRED RETAIL COST SHARING					
Tiers	**1-month (30-day) supply**	**1-month (30-day) supply**	**1-month (30-day) supply**	**1-month (30-day) supply**	**1-month (30-day) supply**
Tier 1 (Preferred Generic)	$0 copay	$0 copay	$0 copay	$0 copay	NA
Tier 2 (Generic)	$10 copay	$12 copay	$11 copay	$10 copay	NA
Tier 3 (Preferred Brand)	17% coinsurance	17% coinsurance	17% coinsurance	17% coinsurance	NA
Tier 4 (Non-Preferred Drug)	31% coinsurance	31% coinsurance	31% coinsurance	31% coinsurance	NA
Tier 5 (Specialty Tier)	25% coinsurance	29% coinsurance	29% coinsurance	32% coinsurance	NA
Tier 6 (Select Care)	$0 copay	$0 copay	$0 copay	$0 copay	NA
Insulin	You won’t pay more than $30 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.				NA

	Essential HMO ($0)	Assurance HMO-POS ($60)	Balance HMO-POS ($139)	Complete HMO ($276)	Harmony HMO-POS ($0)
STANDARD RETAIL COST SHARING					
Tiers	**1-month (30-day) supply**	**1-month (30-day) supply**	**1-month (30-day) supply**	**1-month (30-day) supply**	**1-month (30-day) supply**
Tier 1 (Preferred Generic)	$8 copay	$8 copay	$8 copay	$8 copay	NA
Tier 2 (Generic)	$17 copay	$20 copay	$18 copay	$17 copay	NA
Tier 3 (Preferred Brand)	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	NA
Tier 4 (Non-Preferred Drug)	32% coinsurance	32% coinsurance	32% coinsurance	32% coinsurance	NA
Tier 5 (Specialty Tier)	25% coinsurance	29% coinsurance	29% coinsurance	32% coinsurance	NA
Tier 6 (Select Care)	$0 copay	$0 copay	$0 copay	$0 copay	NA
Insulin	You won’t pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.				NA

	Essential HMO ($0)	Assurance HMO-POS ($60)	Balance HMO-POS ($139)	Complete HMO ($276)	Harmony HMO-POS ($0)
STANDARD MAIL-ORDER COST SHARING					
Tiers	**3-month (90-day) supply**	**3-month (90-day) supply**	**3-month (90-day) supply**	**3-month (90-day) supply**	**3-month (90-day) supply**
Tier 1 (Preferred Generic)	$0 copay	$0 copay	$0 copay	$0 copay	NA
Tier 2 (Generic)	$20 copay	$24 copay	$22 copay	$20 copay	NA
Tier 3 (Preferred Brand)	17% coinsurance	20% coinsurance	17% coinsurance	17% coinsurance	NA
Tier 4 (Non-Preferred Drug)	31% coinsurance	31% coinsurance	31% coinsurance	31% coinsurance	NA
Tier 5 (Specialty Tier)	NA	NA	NA	NA	NA
Tier 6 (Select Care)	$0 copay	$0 copay	$0 copay	$0 copay	NA
Insulin	You won’t pay more than $90 for a three-month supply of each covered insulin product regardless of the cost-sharing tier.				NA

	Essential HMO ($0)	Assurance HMO-POS ($60)	Balance HMO-POS ($139)	Complete HMO ($276)	Harmony HMO-POS ($0)
PART D COVERAGE STAGES					
Catastrophic Coverage Stage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $2,400, the plan pays the full cost for your covered Part D drugs. You pay nothing.				NA

	Essential HMO ($0)	Assurance HMO-POS ($60)	Balance HMO-POS ($139)	Complete HMO ($276)	Harmony HMO-POS ($0)
ADDITIONAL BENEFITS AND SERVICES					
Annual Physical Exam					
In-Network	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Out-of-Network	Not covered	50% of the total cost	40% of the total cost	Not covered	40% of the total cost
Cardiac Rehabilitation Services					
In-Network	$35 copay	$35 copay	$30 copay	$20 copay	$40 copay
Out-of-Network	Not covered	50% of the total cost	40% of the total cost	Not covered	40% of the total cost
Chiropractic Services 24 additional routine visits every calendar year					
In-Network	$15 copay	$15 copay	$15 copay	$10 copay	$15 copay
Out-of-Network	Not covered	50% of the total cost	40% of the total cost	Not covered	40% of the total cost

	Essential HMO ($0)	Assurance HMO-POS ($60)	Balance HMO-POS ($139)	Complete HMO ($276)	Harmony HMO-POS ($0)
ADDITIONAL BENEFITS AND SERVICES					
Diabetic Testing Supplies	**Medicare-covered Abbott FreeStyle® (InsuLinx, Lite, or Precision Neo) and Roche Accu-Chek® diabetic testing supplies and blood glucose monitors (BGMs) and Abbott FreeStyle Libre and Dexcom continuous glucose monitors (CGMs):**	**Medicare-covered Abbott FreeStyle® (InsuLinx, Lite, or Precision Neo) and Roche Accu-Chek® diabetic testing supplies and blood glucose monitors (BGMs) and Abbott FreeStyle Libre and Dexcom continuous glucose monitors (CGMs):**	**Medicare-covered Abbott FreeStyle® (InsuLinx, Lite, or Precision Neo) and Roche Accu-Chek® diabetic testing supplies and blood glucose monitors (BGMs) and Abbott FreeStyle Libre and Dexcom continuous glucose monitors (CGMs):**	**Medicare-covered Abbott FreeStyle® (InsuLinx, Lite, or Precision Neo) and Roche Accu-Chek® diabetic testing supplies and blood glucose monitors (BGMs) and Abbott FreeStyle Libre and Dexcom continuous glucose monitors (CGMs):**	**Medicare-covered Abbott FreeStyle® (InsuLinx, Lite, or Precision Neo) and Roche Accu-Chek® diabetic testing supplies and blood glucose monitors (BGMs) and Abbott FreeStyle Libre and Dexcom continuous glucose monitors (CGMs):**
In-Network	$0 copay for CGMs when obtained at a retail pharmacy or 20% of the total cost when obtained from a medical supplier and for Dean-approved non-preferred manufacturer exceptions. *	$0 copay for CGMs when obtained at a retail pharmacy or 20% of the total cost when obtained from a medical supplier and for Dean-approved non-preferred manufacturer exceptions. *	$0 copay for CGMs when obtained at a retail pharmacy or 20% of the total cost when obtained from a medical supplier and for Dean-approved non-preferred manufacturer exceptions. *	$0 copay for CGMs when obtained at a retail pharmacy or 20% of the total cost when obtained from a medical supplier and for Dean-approved non-preferred manufacturer exceptions. *	$0 copay for CGMs when obtained at a retail pharmacy or 20% of the total cost when obtained from a medical supplier and for Dean-approved non-preferred manufacturer exceptions. *
	$0 copay for BGMs, test strips, and diabetic testing supplies when obtained at a retail pharmacy or 20% of the total cost when obtained from a medical supplier and	$0 copay for BGMs, test strips, and diabetic testing supplies when obtained at a retail pharmacy or 20% of the total cost when obtained from a medical supplier and	$0 copay for BGMs, test strips, and diabetic testing supplies when obtained at a retail pharmacy or 20% of the total cost when obtained from a medical supplier and	$0 copay for BGMs, test strips, and diabetic testing supplies when obtained at a retail pharmacy or 20% of the total cost when obtained from a medical supplier and	$0 copay for BGMs, test strips, and diabetic testing supplies when obtained at a retail pharmacy or 20% of the total cost when obtained from a medical supplier and

	Essential HMO ($0)	Assurance HMO-POS ($60)	Balance HMO-POS ($139)	Complete HMO ($276)	Harmony HMO-POS ($0)
ADDITIONAL BENEFITS AND SERVICES					
	for Dean-approved non-preferred manufacturer exceptions.	for Dean-approved non-preferred manufacturer exceptions.	for Dean-approved non-preferred manufacturer exceptions.	for Dean-approved non-preferred manufacturer exceptions.	for Dean-approved non-preferred manufacturer exceptions.
Out-of-Network	Not covered	$0 copay for CGMs when obtained at a retail pharmacy or 50% of the total cost when obtained from a medical supplier and for Dean-approved non-preferred manufacturer exceptions. *	$0 copay for CGMs when obtained at a retail pharmacy or 40% of the total cost when obtained from a medical supplier and for Dean-approved non-preferred manufacturer exceptions. *	Not covered	$0 copay for CGMs when obtained at a retail pharmacy or 40% of the total cost when obtained from a medical supplier and for Dean-approved non-preferred manufacturer exceptions. *
		$0 copay for BGMs when obtained at a retail pharmacy or 50% of the total cost when obtained from a medical supplier and for Dean-approved non-preferred manufacturer exceptions.	$0 copay for BGMs when obtained at a retail pharmacy or 40% of the total cost when obtained from a medical supplier and for Dean-approved non-preferred manufacturer exceptions.		$0 copay for BGMs when obtained at a retail pharmacy or 40% of the total cost when obtained from a medical supplier and for Dean-approved non-preferred manufacturer exceptions.
		50% of the total cost for test strips and diabetic testing supplies and for Dean-approved	40% of the total cost for test strips and diabetic testing supplies and for Dean-approved		40% of the total cost for test strips and diabetic testing supplies and for Dean-approved

	Essential HMO ($0)	Assurance HMO-POS ($60)	Balance HMO-POS ($139)	Complete HMO ($276)	Harmony HMO-POS ($0)
ADDITIONAL BENEFITS AND SERVICES					
		non-preferred manufacturer exceptions.	non-preferred manufacturer exceptions.		non-preferred manufacturer exceptions.
Durable Medical Equipment (DME) and Related Supplies					
In-Network	20% of the total cost *	20% of the total cost *	20% of the total cost *	20% of the total cost *	20% of the total cost *
Out-of-Network	Not covered	50% of the total cost	40% of the total cost	Not covered	40% of the total cost
eVisits					
In-Network	$0 copay				
Out-of-Network	Not covered				
Health and Wellness Education Programs					
	Nurse Advice Line:				
In-Network	$0 copay				
Out-of-Network	Not covered				
	One Pass™ Fitness Program:				
In-Network	$0 annual fee				
Out-of-Network	Not covered				
Health+ by Medica card	Use this card to pay for eyewear benefits at a licensed eyewear provider that accepts Visa®. This card can also be used to purchase OTC health and wellness products at participating retailers, online, or over the phone. Allowances are added the first month you are enrolled in the plan. All allowance amounts expire as stated in the benefit, at the end of the plan year, or when you leave the plan.				

	Essential HMO ($0)	Assurance HMO-POS ($60)	Balance HMO-POS ($139)	Complete HMO ($276)	Harmony HMO-POS ($0)
ADDITIONAL BENEFITS AND SERVICES					
Home Health Agency Care					
In-Network	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Out-of-Network	Not covered	50% of the total cost	40% of the total cost	Not covered	40% of the total cost
In-Home Support Services					
In-Network	$0 copay for 120 hours every calendar year				
Out-of-Network	Not covered				
Meals					
In-Network	$0 copay for 2 meals per day for 7 days after an inpatient stay				
Out-of-Network	Not covered				
Over-the-Counter (OTC) Drugs and Supplies					
In-Network	You are eligible for a $20 allowance quarterly by using the Health+ by Medica card at participating retailers, online, or over the phone.	You are eligible for a $20 allowance quarterly by using the Health+ by Medica card at participating retailers, online, or over the phone.	You are eligible for a $25 allowance quarterly by using the Health+ by Medica card at participating retailers, online, or over the phone.	You are eligible for a $35 allowance quarterly by using the Health+ by Medica card at participating retailers, online, or over the phone.	You are eligible for a $40 allowance quarterly by using the Health+ by Medica card at participating retailers, online, or over the phone.
Out-of-Network	Not covered	Not covered	Not covered	Not covered	Not covered
Podiatry Services					
In-Network	$60 copay	$50 copay	$35 copay	$20 copay	$40 copay
Out-of-Network	Not covered	50% of the total cost	40% of the total cost	Not covered	40% of the total cost

	Essential HMO ($0)	Assurance HMO-POS ($60)	Balance HMO-POS ($139)	Complete HMO ($276)	Harmony HMO-POS ($0)
ADDITIONAL BENEFITS AND SERVICES					
Pulmonary Rehabilitation Services					
In-Network	$30 copay	$30 copay	$25 copay	$20 copay	$35 copay
Out-of-Network	Not covered	50% of the total cost	40% of the total cost	Not covered	40% of the total cost
Smoking and nicotine use cessation or reduction program					
In-Network	$0 copay for 5 visits per calendar year				
Out-of-Network	Not covered				
Worldwide Emergency Care	$125 copay	$125 copay	$140 copay	$140 copay	$110 copay

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-952-3455 (TTY: 711) for Medica, call 1-877-317-2410 (TTY: 711) for Dean Health Plan/Prevea360 Health Plan, or speak to your provider.

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia de idiomas. También están disponibles de forma gratuita asistencia y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-952-3455 (TTY: 711) para Medica, llame al 1-877-317-2410 (TTY: 711) para Dean Health Plan/Prevea360 Health Plan o hable con su proveedor de atención médica.

Vietnamese/Việt: LƯU Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-952-3455 (TTY: 711) đối với Medica, gọi theo số 1-877-317-2410 (TTY: 711) đối với Dean Health Plan/Prevea360 Health Plan hoặc trao đổi với nhà cung cấp dịch vụ của quý vị.

Chinese Traditional: 注意：如果您說中文，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-952-3455 (TTY: 711) 聯絡 Medica，致電 1-877-317-2410 (TTY: 711) 聯絡 Dean Health Plan/Prevea360 Health Plan，或與您的提供者討論。

Hmong/Lus Hmoob: LUS CEEV: Yog hais tias koj hais Lus Hmoob ces muaj kev pab txhais lus pub dawb rau koj. Muaj khoom siv thiab muaj kev saib xyuas pab uas tsim nyog los npaj kom muaj cov ntaub ntawv uas siv tau dawb. Hu rau 1-800-952-3455 (TTY: 711) rau Medica, hu rau 1-877-317-2410 (TTY: 711) rau Dean Health Plan/Prevea360 Health Plan, los sis tham rau koj tus kws kuaj mob.

German/Deutsch: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-952-3455 (TTY: 711) für Medica bzw. 1-877-317-2410 (TTY: 711) für Dean Health Plan/Prevea360 Health Plan oder sprechen Sie mit Ihrem Gesundheitsdienstleister.

Cushitic-Oromo: XIYYEEFFANNOO: Ingiliffaa dubbattu taanaan, tajaajilli deggersa afaan bilisaa ni jira. Tajaajilli deggersa bu'ura dhiheessii odeeffannoo kaffaltii tokko malee ni jira. Lakkoofsa bilbilaa 1-800-952-3455 (TTY: 711) Tajaajila Fayyaaf, lakkoofsa Medica 1-877-317-2410 (TTY: 711), Dean Health Plan/Prevea360 Health Plan, ykn dhiheessaa keessan dubbisaa.

العربية/Arabic

كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. تنبيه: (الهاتف النصي: 711) للتواصل مع 1-800-952-3455اتصل على الرقم المعلومات بتنسيقات يمكن الوصول إليها مجانًا. Dean Health Plan، اتصل على الرقم 1-877-317-2410 (الهاتف النصي: 711) بشأن خطة الرعاية الصحية Medica Plan/Prevea360 Health Plan

Korean/한국어: 주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. Medica 의 경우 1-800-952-3455(TTY: 711)번으로, Dean Health Plan/Prevea360 Health Plan 의 경우 1-877-317-2410(TTY: 711)번으로 전화하시거나, 서비스 제공업체에 문의하십시오.

Russian/Русский: Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-952-3455 (TTY: 711) относительно Medica, позвоните по телефону 1-877-317-2410 (TTY: 711) относительно Dean Health Plan/Prevea360 Health Plan или обратитесь к своему поставщику услуг.

Laos/ ລາວ: ຂໍ້ຄວນເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ນອກຈາກນີ້ ຈະມີເຄື່ອງຊ່ວຍເສີມ ແລະ
ບໍລິການແບບທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້ໂດຍບໍ່ເສຍຄ່າ. ໂທຫາເບີ 1-800-952-3455 (TTY: 711) ສຳລັບ Medica, ໂທ 1-877-317-2410 (TTY: 711) ສຳລັບ Dean Health Plan/Prevea360 Health Plan ຫຼື ຕິດຕໍ່ຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

French/ Français: ATTENTION : si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-952-3455 (TTY : 711) pour Medica, appelez le 1-877-317-2410 (TTY : 711) pour le régime de santé Dean Health Plan/Prevea360, ou parlez à votre prestataire de santé.

Serbo-Croatian: PAŽNJA: Ako govorite srpski, dostupne su vam besplatne usluge tumača. Odgovarajuća dodatna pomagala i usluge za pružanje informacija u pristupačnim formatima su takođe dostupne besplatno. Za Medica zdravstveno osiguranje pozovite 1-800-952-3455 (TTY: 711), za Dean/Prevea360 zdravstveno osiguranje pozovite 1-877-317-2410 (TTY: 711) ili razgovarajte sa svojim pružaocem usluga.

Tagalog: PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-952-3455 (TTY: 711) para sa Medica, tumawag sa 1-877-317-2410 (TTY: 711) para sa Dean Health Plan/Prevea360 Health Plan, o makipag-usap sa iyong tagapagbigay ng serbisyo.

Karen/ထၢနှာ်လီၤဖဲအံၤ: ဟ်သူဉ်ဟ်သး– နမ့ၢ်ကတိၤကညီကျိာ်နၫ် တၢ်အိဉ်ဒီး ကျိာ်တၢ်ဆိဉ်ထွဲမၤစၢၤ လၢတလာ်ဘူဉ်လာ်စ့ၤလၢနဂီၢ်လီၤ. တၢ်အိဉ်ဒီး ပှၤနီၢ်ခိက့ၢ်ဂီၤတဆူဉ်တကျၢၤအဂီၢ်
ပီးလီဒီးတၢ်တိစၢၤမၤစၢၤလၢအကြၢးအဘဉ် လၢကဟ့ဉ်တၢ်ဂ့ၢ်တၢ်ကျိၤ လၢတၢ်မၤနှ်အီၤသ့တဖဉ် လၢတလာ်ဘူဉ်လာ်စ့ၤ လၢနဂီၢ်လီၤ. ကိး 1-800-952-3455 (TTY: 711) လၢ Medica အဂီၢ်, ကိး 1-877-317-2410 (TTY: 711) လၢ Dean Health Plan/Prevea360 Health Plan အဂီၢ်, မ့တမ့ၢ် ကတိၤတၢ်ဒီး နပှၤလၢဟ့ဉ်နၤတၢ်ကွၢ်ထွဲတက့ၢ်.

Amharic/ አማርኛ:- ማሳሰቢያ፡- አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። ለMedica በ1-800-952-3455 (TTY: 711) ይደውሉ፣ ለDean የጤና እቅድ/Prevea360 የጤና እቅድ በ1-877-317-2410 (TTY: 711) ይደውሉ ወይም ለእርስዎን አቅራቢ የሆነውን ያነጋግሩ።

This page intentionally left blank.

This page intentionally left blank.

This page intentionally left blank.

DeanHealthPlan by Medica.

Dean Health Plan is an HMO and an HMO-POS plan with a Medicare contract. Enrollment in Dean Health Plan depends on contract renewal.

Health+ by Medica card: Card can only be used for Qualified Purchases indicated by your plan provider everywhere Visa® debit cards are accepted. Card is issued by Sutton Bank, pursuant to a license from Visa U.S.A. Inc. Please contact your Program Sponsor directly for a full list of Qualified Purchases. Visa is a registered trademark of Visa, U.S.A. Inc. All other trademarks and service marks belong to their respective owners. No Cash or ATM Access. Terms and conditions apply, contact your Plan Provider for details.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our Member Services number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.

© 2026 Dean Health Plan, Inc.