Summary of Benefits

Plan Year 2022

Medicare Advantage Plans from Dean Health Plan

January 1, 2022 – December 31, 2022
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. See the Evidence of Coverage to get a complete list of services we cover. The Evidence of Coverage is available to view on deancare.com/medicareadvantagemembers. You can also request a printed copy of any of these materials by calling our Customer Care Center.

If you want to know more about the coverage and costs of Original Medicare, look in the current "Medicare & You" handbook. View it online at 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.

Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year. You must continue to pay your Part B premium.

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 1-877-232-7566 (TTY: 711).

Dean Health Plan, Inc. is a HMO/HMO-POS with a Medicare contract. Enrollment in Dean Health Plan, Inc. depends on contract renewal. Dean Health Plan markets under the names Dean Advantage and Prevea360 Medicare Advantage.

Hours of Operation

- From October 1 to March 31, you can call us 7 days a week from 8 am – 8 pm Central time.
- From April 1 to September 30, you can call us Monday through Friday from 8 am – 8 pm Central time.

Dean Advantage Phone Numbers and Website

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

Who can join?

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

What is the Service Area?

Dean Advantage Essential, Assurance, Balance, Complete and Harmony:

Our service area includes the following counties in Wisconsin: **Columbia, Dane, Dodge, Fond du Lac, Green, Iowa, Jefferson, Rock and Sauk**. You must live in one of these counties to be eligible to enroll.

Dean Advantage SSM Presence:

Our service area includes the following counties in Wisconsin: **Dodge and Fond du Lac**. You must live in one of these counties to be eligible to enroll.

Which doctors, hospitals and pharmacies can I use?

Dean Advantage has a network of doctors, hospitals, pharmacies and other providers. For some services you can use providers that are not in our network.

- You can see our plan's provider directory at our website, deancare.com/doctors.
- You can see our plan's pharmacy directory at our website deancare.com/medicareadvantagemembers.

Monthly Premium, Deductibles, and Limits on How Much You Pay for Covered Services

	Essential (HMO)	Assurance (HMO-POS) SSM Presence (HMO-POS)	Balance (HMO-POS)	Complete (HMO)	Harmony (HMO-POS)
Monthly Premium You must continue to pay your Medicare Part B premium	**$0**	**Assurance: $40** **SSM Presence: $0**	**$82**	**$251**	**$0**
Part B Buy Back Dean Health Plan provides a credit that will automatically be applied towards your Medicare Part B premium	Not Applicable	Not Applicable	Not Applicable	Not Applicable	$20
Medical Deductible	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Maximum Out-of-Pocket Responsibility If you reach the limit on out-of-pocket costs, you will keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. (Does not include prescription drugs)	$6,500 for in-network services	$4,500 for in-network and out-of-network services combined	$3,500 for in-network and out-of-network services combined	$2,000 for in-network services	$4,500 for in-network and out-of-network services combined

Covered Medical and Hospital Benefits

*Benefit may require prior authorization

	Essential (HMO)	Assurance (HMO-POS) SSM Presence (HMO-POS)		Balance (HMO-POS)		Complete (HMO)	Harmony (HMO-POS)	
	In Network	In Network	Out-of-Network	In Network	Out-of-Network	In Network	In Network	Out-of-Network
Inpatient Hospital Coverage* For Medicare-covered stays	$350 copay each day for days 1 - 5 $0 each day for days 6 to discharge	$350 copay each day for days 1 - 5 $0 each day for days 6 to discharge	$500 copay each day for days 1 - 7 $0 each day for days 8 to discharge	$350 copay each day for days 1 - 5 $0 each day for days 6 to discharge	$500 copay each day for days 1 - 7 $0 each day for days 8 to discharge	$350 copay each day for days 1 - 5 $0 each day for days 6 to discharge	$350 copay each day for days 1 - 5 $0 each day for days 6 to discharge	$500 copay each day for days 1 - 7 $0 each day for days 8 to discharge
Outpatient Hospital Coverage*								
Outpatient Hospital:	$300 copay	$300 copay	20% coinsurance	$300 copay	20% coinsurance	$300 copay	$300 copay	20% coinsurance
Ambulatory Surgery Center:	$300 copay	$300 copay	20% coinsurance	$300 copay	20% coinsurance	$300 copay	$300 copay	20% coinsurance
Procedure performed during office visit:	$0 - $50 copay	$0 - $40 copay	$60 copay	$0 - $25 copay	$50 copay	$0 - $10 copay	$0 - $35 copay	$75 copay
Doctor Visits								
Primary Care Providers:	$0 copay	$0 copay	$60 copay	$0 copay	$50 copay	$0 copay	$0 copay	$75 copay
Specialists:	$50 copay	$40 copay	$60 copay	$25 copay	$50 copay	$10 copay	$35 copay	$75 copay
Palliative Care:	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Preventive Care	$0 copay	$0 copay	$30 copay	$0 copay	$30 copay	$0 copay	$0 copay	$30 copay
Emergency Care In the U.S. (Waived if admitted)	$90 copay	$90 copay	$90 copay	$90 copay	$90 copay	$120 copay	$90 copay	$90 copay
Urgently Needed Services In the U.S.	$50 copay Your cost may be reduced based on level of treating provider	$40 copay Your cost may be reduced based on level of treating provider	$40 copay	$25 copay Your cost may be reduced based on level of treating provider	$25 copay	$10 copay Your cost may be reduced based on level of treating provider	$35 copay Your cost may be reduced based on level of treating provider	$35 copay

	Essential (HMO)	Assurance (HMO-POS) SSM Presence (HMO-POS)		Balance (HMO-POS)		Complete (HMO)	Harmony (HMO-POS)	
	In Network	In Network	Out-of-Network	In Network	Out-of-Network	In Network	In Network	Out-of-Network
Diagnostic Services / Labs / Imaging*								
Outpatient X-ray:	$30 copay	$20 copay	20% coinsurance	$15 copay	20% coinsurance	$10 copay	$30 copay	20% coinsurance
Laboratory Tests:	$0 copay	$0 copay	20% coinsurance	$0 copay	20% coinsurance	$0 copay	$0 copay	20% coinsurance
Radiation Therapy:	$35 copay	$35 copay	20% coinsurance	$35 copay	20% coinsurance	$35 copay	$35 copay	20% coinsurance
Diagnostic Procedures/Tests:	$10 copay	$10 copay	20% coinsurance	$10 copay	20% coinsurance	$10 copay	$10 copay	20% coinsurance
Diagnostic Mammograms:	$0 copay	$0 copay	20% coinsurance	$0 copay	20% coinsurance	$0 copay	$0 copay	20% coinsurance
Diagnostic Radiology:	$100 copay	$100 copay	20% coinsurance	$100 copay	20% coinsurance	$100 copay	$100 copay	20% coinsurance
Hearing Services								
Medicare-covered- exam to diagnose and treat hearing and balance issues:	$0 copay	$0 copay	$60 copay	$0 copay	$60 copay	$0 copay	$0 copay	$75 copay
Routine hearing exam:	$0 copay per exam for 1 exam every calendar year	$0 copay per exam for 1 exam every calendar year	Not Covered	$0 copay per exam for 1 exam every calendar year	Not Covered	$0 copay per exam for 1 exam every calendar year	$0 copay per exam for 1 exam every calendar year	Not Covered
Hearing aid fitting / evaluation:	$0 copay per fitting for 1 fitting every calendar year	$0 copay per fitting for 1 fitting every calendar year	Not Covered	$0 copay per fitting for 1 fitting every calendar year	Not Covered	$0 copay per fitting for 1 fitting every calendar year	$0 copay per fitting for 1 fitting every calendar year	Not Covered
Hearing aid allowance:	$0 copay	$0 copay		$0 copay		$0 copay	$0 copay	
	Our plan pays up to $750 both ears combined every calendar year for hearing aids	Our plan pays up to $750 both ears combined every calendar year for hearing aids	Not Covered	Our plan pays up to $750 both ears combined every calendar year for hearing aids	Not Covered	Our plan pays up to $750 both ears combined every calendar year for hearing aids	Our plan pays up to $750 both ears combined every calendar year for hearing aids	Not Covered
	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	

	Essential (HMO)	Assurance (HMO-POS) SSM Presence (HMO-POS)	
	In Network	In Network	Out-of-Network
Preventive Dental			
Preventive exams:	$0 copay per visit for 2 visits every calendar year	$0 copay per visit for 2 visits every calendar year	Not Covered
Cleanings:	$0 copay per visit for 2 visits every calendar year	$0 copay per visit for 2 visits every calendar year	Not Covered
X-Ray:	$0 copay per visit for 1 visit every calendar year	$0 copay per visit for 1 visit every calendar year	Not Covered
Comprehensive Dental			
Diagnostic services:	$0 copay	$0 copay	Not Covered
Gum disease maintenance and bridge/implants/dentures repairs:	$45 copay	$45 copay	Not Covered
Fillings, gum disease treatment, and extractions:	$95 copay	$95 copay	Not Covered
Root canals, bridges, implants, dentures, and crowns:	$595 copay	$595 copay	Not Covered
Dental Maximum Annual limit that Dean Health Plan will pay for preventive and comprehensive dental services You are responsible for costs beyond the plan limit	$1,500 every calendar year for dental services	$1,500 every calendar year for dental services	Not Covered

Balance (HMO-POS)		Complete (HMO)	Harmony (HMO-POS)	
In Network	Out-of-Network	In Network	In Network	Out-of-Network
$0 copay per visit for 2 visits every calendar year	Not Covered	$0 copay per visit for 2 visits every calendar year	$0 copay per visit for 2 visits every calendar year	Not Covered
$0 copay per visit for 2 visits every calendar year	Not Covered	$0 copay per visit for 2 visits every calendar year	$0 copay per visit for 2 visits every calendar year	Not Covered
$0 copay per visit for 1 visit every calendar year	Not Covered	$0 copay per visit for 1 visit every calendar year	$0 copay per visit for 1 visit every calendar year	Not Covered
$0 copay	Not Covered	$0 copay	$0 copay	Not Covered
$45 copay	Not Covered	$45 copay	$45 copay	Not Covered
$95 copay	Not Covered	$95 copay	$95 copay	Not Covered
$595 copay	Not Covered	$595 copay	$595 copay	Not Covered
$1,500 every calendar year for dental services	Not Covered	$1,500 every calendar year for dental services	$1,500 every calendar year for dental services	Not Covered

	Essential (HMO)	Assurance (HMO-POS) SSM Presence (HMO-POS)		Balance (HMO-POS)		Complete (HMO)	Harmony (HMO-POS)	
	In Network	In Network	Out-of-Network	In Network	Out-of-Network	In Network	In Network	Out-of-Network
Vision Services Medicare-covered exam to treat to diagnose and treat diseases and conditions of the eye:	$0 copay	$0 copay	$30 copay	$0 copay	$30 copay	$0 copay	$0 copay	$30 copay
Medicare-covered eyewear after cataract surgery:	$0 copay	$0 copay	Not Covered	$0 copay	Not Covered	$0 copay	$0 copay	Not Covered
Routine eye exam:	$0 copay per exam for 1 exam every calendar year	$0 copay per exam for 1 exam every calendar year	Not Covered	$0 copay per exam for 1 exam every calendar year	Not Covered	$0 copay per exam for 1 exam every calendar year	$0 copay per exam for 1 exam every calendar year	Not Covered
Eyewear: (eyeglasses, frames, lenses or contact lenses)	Our plan pays up to a total of $200 every calendar year You are responsible for costs beyond the plan limit	Our plan pays up to a total of $200 every calendar year You are responsible for costs beyond the plan limit	Not Covered	Our plan pays up to a total of $200 every calendar year You are responsible for costs beyond the plan limit	Not Covered	Our plan pays up to a total of $200 every calendar year You are responsible for costs beyond the plan limit	Our plan pays up to a total of $200 every calendar year You are responsible for costs beyond the plan limit	Not Covered
Mental Health Services: Hospital Care* For Medicare-covered stays	$350 copay each day for days 1 - 5 $0 each day for days 6 - 90	$350 copay each day for days 1 - 5 $0 each day for days 6 - 90	$500 copay each day for days 1 - 7 $0 each day for days 8 - 90	$350 copay each day for days 1 - 5 $0 each day for days 6 - 90	$500 copay each day for days 1 - 7 $0 each day for days 8 - 90	$350 copay each day for days 1 - 5 $0 each day for days 6 - 90	$350 copay each day for days 1 - 5 $0 each day for days 6 - 90	$500 copay each day for days 1 - 7 $0 each day for days 8 - 90
Mental Health Services: Outpatient Care Mental Health Specialty Services: Non-physician (Individual and Group)	$0 copay	$0 copay	$30 copay	$0 copay	$30 copay	$0 copay	$0 copay	$30 copay
Psychiatric Services: Physician (Individual and Group)	$10 copay	$10 copay	$30 copay	$10 copay	$30 copay	$10 copay	$10 copay	$30 copay

	Essential (HMO)	Assurance (HMO-POS) SSM Presence (HMO-POS)		Balance (HMO-POS)		Complete (HMO)	Harmony (HMO-POS)	
	In Network	In Network	Out-of-Network	In Network	Out-of-Network	In Network	In Network	Out-of-Network
Skilled Nursing Facility* Our plan covers up to 100 day per benefit period in a SNF: A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row	$0 each day for days 1 - 20 $184 each day for days 21 - 100	$0 each day for days 1 - 20 $184 each day for days 21 - 100	$150 each day for days 1 - 100	$0 each day for days 1 - 20 $184 each day for days 21 - 100	$150 each day for days 1 - 100	$0 each day for days 1 - 20 $184 each day for days 21 - 100	$0 each day for days 1 - 20 $184 each day for days 21 - 100	$150 each day for days 1 - 100
Therapy* Outpatient physical therapy, speech language pathology, and occupational therapy:	$40 copay per visit	$40 copay per visit	$60 copay per visit	$25 copay per visit	$60 copay per visit	$10 copay per visit	$35 copay per visit	$75 copay per visit
Ambulance For each one-way Medicare-covered trip	$275 copay	$275 copay	$275 copay	$275 copay	$275 copay	$275 copay	$275 copay	$275 copay
Transportation For rides to medical appointments	$0 copay per ride for 24 one-way rides every calendar year	$0 copay per ride for 24 one-way rides every calendar year	Not Covered	$0 copay per ride for 24 one-way rides every calendar year	Not Covered	$0 copay per ride for 24 one-way rides every calendar year	$0 copay per ride for 24 one-way rides every calendar year	Not Covered
Medicare Part B Drugs*								
Part B Drugs:	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Part B prescription drugs received in the pharmacy:	$0 copay - $47 copay	$0 copay - $47 copay	20% coinsurance	$0 copay - $47 copay	20% coinsurance	$0 copay - $47 copay	$0 copay - $47 copay	20% coinsurance

Medicare Part D Prescription Drug Coverage

	Essential (HMO)	Assurance (HMO-POS) SSM Presence (HMO-POS)	Balance (HMO-POS)	Complete (HMO)	Harmony (HMO-POS)
Part D Deductible	$250 Applies to Tier 3, Tier 4 and Tier 5	$150 Applies to Tier 3, Tier 4 and Tier 5	$100 Applies to Tier 3, Tier 4 and Tier 5	$0	Not Covered
PREFERRED RETAIL 30 day supply					
Tier 1 Preferred Generic	$0 copay	$0 copay	$0 copay	$0 copay	Not Covered
Tier 2 Generic	$5 copay	$5 copay	$5 copay	$5 copay	Not Covered
Tier 3 Preferred Brand	$40 copay	$40 copay	$40 copay	$40 copay	Not Covered
Tier 4 Non-Preferred Drugs	$90 copay	$90 copay	$90 copay	$90 copay	Not Covered
Tier 5 Specialty Drugs	28% coinsurance	30% coinsurance	31% coinsurance	33% coinsurance	Not Covered
Tier 6 Part D Vaccines	$0 copay	$0 copay	$0 copay	$0 copay	Not Covered
STANDARD RETAIL 30 day supply					
Tier 1 Preferred Generic	$7 copay	$7 copay	$7 copay	$7 copay	Not Covered
Tier 2 Generic	$12 copay	$12 copay	$12 copay	$12 copay	Not Covered
Tier 3 Preferred Brand	$47 copay	$47 copay	$47 copay	$47 copay	Not Covered
Tier 4 Non-Preferred Drugs	$100 copay	$100 copay	$100 copay	$100 copay	Not Covered
Tier 5 Specialty Drugs	28% coinsurance	30% coinsurance	31% coinsurance	33% coinsurance	Not Covered
Tier 6 Part D Vaccines	$0 copay	$0 copay	$0 copay	$0 copay	Not Covered
LONG TERM CARE 31 day supply	See Standard Retail Pharmacy (30 Day)		See Standard Retail Pharmacy (30 Day)		Not Covered
OUT-OF-NETWORK 29 day supply	See Standard Retail Pharmacy (30 Day)		See Standard Retail Pharmacy (30 Day)		Not Covered

	Essential (HMO)	Assurance (HMO-POS) SSM Presence (HMO-POS)	Balance (HMO-POS)	Complete (HMO)	Harmony (HMO-POS)
PREFERRED RETAIL 90 day supply					
Tier 1 Preferred Generic	$0 copay	$0 copay	$0 copay	$0 copay	Not Covered
Tier 2 Generic	$10 copay	$10 copay	$10 copay	$10 copay	Not Covered
Tier 3 Preferred Brand	$100 copay	$100 copay	$100 copay	$100 copay	Not Covered
Tier 4 Non-Preferred Drugs	$270 copay	$270 copay	$270 copay	$270 copay	Not Covered
Tier 5 Specialty Drugs	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Covered
Tier 6 Part D Vaccines	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Covered
STANDARD RETAIL 90 day supply					
Tier 1 Preferred Generic	$7 copay	$7 copay	$7 copay	$7 copay	Not Covered
Tier 2 Generic	$24 copay	$24 copay	$24 copay	$24 copay	Not Covered
Tier 3 Preferred Brand	$117.50 copay	$117.50 copay	$117.50 copay	$117.50 copay	Not Covered
Tier 4 Non-Preferred Drugs	$300 copay	$300 copay	$300 copay	$300 copay	Not Covered
Tier 5 Specialty Drugs	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Covered
Tier 6 Part D Vaccines	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Covered
Part D Coverage Stages					
Stage 1 Deductible	You pay in full until you reach your deductible. (Applies to Tier 3, Tier 4 and Tier 5 only)	You pay in full until you reach your deductible. (Applies to Tier 3, Tier 4 and Tier 5 only)	You pay in full until you reach your deductible. (Applies to Tier 3, Tier 4 and Tier 5 only)	There is no deductible. You begin in the initial coverage stage.	Not Covered
Stage 2 Initial Coverage	You pay copays or coinsurance, and we pay the remainder until together our spending reaches **$4,430**	You pay copays or coinsurance, and we pay the remainder until together our spending reaches **$4,430**	You pay copays or coinsurance, and we pay the remainder until together our spending reaches **$4,430**	You pay copays or coinsurance, and we pay the remainder until together our spending reaches **$4,430**	Not Covered
Stage 3 Coverage Gap	Above **$4,430**, you pay 25% of the cost for generics and brand drugs until your expenses reach **$7,050**	Above **$4,430**, you pay 25% of the cost for generics and brand drugs until your expenses reach **$7,050**	Above **$4,430**, you pay 25% of the cost for generics and brand drugs until your expenses reach **$7,050**	Above **$4,430**, you pay 25% of the cost for generics and brand drugs until your expenses reach **$7,050**	Not Covered
Stage 4 Catastrophic	Above **$7,050** you pay the greater of **5%** or **$3.95** for generics and **$9.85** for all other drugs and we pay the remainder	Above **$7,050** you pay the greater of **5%** or **$3.95** for generics and **$9.85** for all other drugs and we pay the remainder	Above **$7,050** you pay the greater of **5%** or **$3.95** for generics and **$9.85** for all other drugs and we pay the remainder	Above **$7,050** you pay the greater of **5%** or **$3.95** for generics and **$9.85** for all other drugs and we pay the remainder	Not Covered

Additional Benefits

	Essential (HMO)	Assurance (HMO-POS) SSM Presence (HMO-POS)		Balance (HMO-POS)		Complete (HMO)	Harmony (HMO-POS)	
	In Network	In Network	Out-of-Network	In Network	Out-of-Network	In Network	In Network	Out-of-Network
In-Home Support We partnered with Papa, a company that connects you with screened and trained Papa Pals who provide assistance with organization, light housework, technology and transportation.	$0 copay per visit for 10 visits every month	$0 copay per visit for 10 visits every month	Not Covered	$0 copay per visit for 10 visits every month	Not Covered	$0 copay per visit for 10 visits every month	$0 copay per visit for 10 visits every month	Not Covered
Over-the-Counter Allowance for Health and Wellness Products Shop online, in-store, or by catalog.	$50 quarterly allowance	$50 quarterly allowance	Not Covered	$50 quarterly allowance	Not Covered	$50 quarterly allowance	$50 quarterly allowance	Not Covered
Post Discharge Meals Mom's Meals delivered to your door after you are discharged from the hospital or a skilled nursing facility.	14 meals after an inpatient stay at no cost to you	14 meals after an inpatient stay at no cost to you	Not Covered	14 meals after an inpatient stay at no cost to you	Not Covered	14 meals after an inpatient stay at no cost to you	14 meals after an inpatient stay at no cost to you	Not Covered
Fitness Benefit Silver&Fit®	$0 copay	$0 copay	Not Covered	$0 copay	Not Covered	$0 copay	$0 copay	Not Covered
Routine Chiropractic	$15 copay for an additional 24 routine chiropractic visits every calendar year	$15 copay for an additional 24 routine chiropractic visits every calendar year	$60 copay for an additional combined 24 routine chiropractic visits every calendar year	$15 copay for an additional 24 routine chiropractic visits every calendar year	$50 copay for an additional combined 24 routine chiropractic visits every calendar year	$15 copay for an additional 24 routine chiropractic visits every calendar year	$10 copay for an additional 24 routine chiropractic visits every calendar year	$75 copay for an additional combined 24 routine chiropractic visits every calendar year
Acupuncture	You pay $50 copay per treatment for 12 treatments every calendar year	You pay $40 copay per treatment for 12 treatments every calendar year	Not Covered	You pay $25 copay per treatment for 12 treatments every calendar year	Not Covered	You pay $10 copay per treatment for 24 treatments every calendar year	You pay $35 copay per treatment for 12 treatments every calendar year	Not Covered

	Essential (HMO)	Assurance (HMO-POS) SSM Presence (HMO-POS)		Balance (HMO-POS)		Complete (HMO)	Harmony (HMO-POS)	
	In Network	In Network	Out-of-Network	In Network	Out-of-Network	In Network	In Network	Out-of-Network
Living Healthy Rewards for completing healthy activities like receiving a flu shot, going to the dentist and getting an annual physical	$150 every calendar year	$150 every calendar year	Not Covered	$150 every calendar year	Not Covered	$150 every calendar year	$150 every calendar year	Not Covered
Worldwide Emergency and Urgent Care Outside the US	$90 copay No Limit	$90 copay No Limit	$90 copay No Limit	$90 copay No Limit	$90 copay No Limit	$120 copay No Limit	$90 copay No Limit	$90 copay No Limit
Nurse Advice Line Nurses are available 24 hours a day, 365 days a year.	$0 copay	$0 copay	Not Covered	$0 copay	Not Covered	$0 copay	$0 copay	Not Covered
E-Visits See conditions treated and complete an online health interview at deancare.com/e-visit.	$0 copay	$0 copay	Not Covered	$0 copay	Not Covered	$0 copay	$0 copay	Not Covered