Wisconsin

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

Summary of Benefits

January 1, 2026 – December 31, 2026

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 toll-free at 1 (877) 234-0126 (TTY: 711).

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 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/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 protects 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, 2026 – December 31, 2026

	Essential HMO ($0)	Assurance HMO-POS ($50)	Balance HMO-POS ($119)	Complete HMO ($256)	Harmony HMO-POS ($0)
MONTHLY PREMIUM, DEDUCTIBLE, AND MAXIMUMS ON HOW MUCH YOU PAY FOR COVERED SERVICES					
Monthly Plan Premium	$0	$50	$119	$256	$0
Part B Premium Buy-Down	Not Applicable	Not Applicable	Not Applicable	Not Applicable	$20 per month
Medical Deductible	No deductible				
Maximum Out-Of-Pocket Responsibility *(does not include prescription drugs)*	In-Network: $6,750	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 ($50)	Balance HMO-POS ($119)	Complete HMO ($256)	Harmony HMO-POS ($0)
COVERED MEDICAL AND HOSPITAL BENEFITS					
Inpatient Hospital Coverage					
In-Network	$395 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 ($50)	Balance HMO-POS ($119)	Complete HMO ($256)	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 - $495 copay *	$0 - $450 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	$450 copay per stay	$400 copay per stay	$375 copay per stay	$350 copay per stay	$400 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 - $425 copay *	$0 - $375 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 ($50)	Balance HMO-POS ($119)	Complete HMO ($256)	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 - $45 copay	$0 - $40 copay	$0 - $35 copay	$0 - $25 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					
In-Network	$0 - $50 copay	$0 - $50 copay	$0 - $40 copay	$0 - $25 copay	$0 - $40 copay
Out-of-Network	Not covered	$50 copay	$40 copay	Not covered	$40 copay

	Essential HMO ($0)	Assurance HMO-POS ($50)	Balance HMO-POS ($119)	Complete HMO ($256)	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	$10 copay for basic imaging	$25 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 *	$140 copay for advanced imaging *	$225 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 ($50)	Balance HMO-POS ($119)	Complete HMO ($256)	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 *	$25 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 *
	X-Rays:	**X-Rays:**	**X-Rays:**	**X-Rays:**	**X-Rays:**
In-Network	$40 copay *	$40 copay *	$40 copay *	$30 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	**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	$45 copay	$40 copay	$35 copay	$25 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 per 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 ($50)	Balance HMO-POS ($119)	Complete HMO ($256)	Harmony HMO-POS ($0)
COVERED MEDICAL AND HOSPITAL BENEFITS					
	Hearing Aids:				
In-Network	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	$45 copay	$40 copay	$35 copay	$25 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
Dental Services - Preventive					
	Preventive exams:				
In-Network	$0 copay per visit for 2 visits every calendar year				
Out-of-Network	Not covered				
	Cleanings:				
In-Network	$0 copay per visit for 2 visits every calendar year				
Out-of-Network	Not covered				
	Fluoride treatment:				
In-Network	$0 copay for 1 every calendar year				
Out-of-Network	Not covered				
	Bitewing x-ray:				
In-Network	$0 copay per visit for 1 every calendar year				
Out-of-Network	Not covered				
Dental Services - Comprehensive					
	Diagnostic services:				
In-Network	$0 copay				
Out-of-Network	Not covered				

	Essential HMO ($0)	Assurance HMO-POS ($50)	Balance HMO-POS ($119)	Complete HMO ($256)	Harmony HMO-POS ($0)
COVERED MEDICAL AND HOSPITAL BENEFITS					
	Periodontal and denture maintenance:				
In-Network	50% of the total cost				
Out-of-Network	Not covered				
	Restorative (including fillings), extractions, and non-surgical periodontics:				
In-Network	50% of the total cost				
Out-of-Network	Not covered				
	Endodontics, prosthodontics and oral surgeries:				
In-Network	50% of the total cost				
Out-of-Network	Not covered				
Dental Services - Maximum annual limit (You are responsible for costs beyond the plan limit.)					
In-Network	$500 every calendar year	$600 every calendar year	$800 every calendar year	$1,500 every calendar year	$1,500 every calendar year
Out-of-Network	Not covered	Not covered	Not covered	Not covered	Not covered
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	$45 copay	$40 copay	$35 copay	$25 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 ($50)	Balance HMO-POS ($119)	Complete HMO ($256)	Harmony HMO-POS ($0)
COVERED MEDICAL AND HOSPITAL BENEFITS					
	Eyewear After Cataract Surgery: One pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens.	**Eyewear After Cataract Surgery:** One pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens.	**Eyewear After Cataract Surgery:** One pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens.	**Eyewear After Cataract Surgery:** One pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens.	**Eyewear After Cataract Surgery:** 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
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 $175 every year. You are responsible for costs beyond the plan limit.	Our plan pays up to a total of $175 every year. You are responsible for costs beyond the plan limit.	Our plan pays up to a total of $175 every year. You are responsible for costs beyond the plan limit.	Our plan pays up to a total of $175 every year. You are responsible for costs beyond the plan limit.	Our plan pays up to a total of $175 every year. You are responsible for costs beyond the plan limit.
Out-of-Network	Not covered	$0 copay	$0 copay	Not covered	$0 copay

	Essential HMO ($0)	Assurance HMO-POS ($50)	Balance HMO-POS ($119)	Complete HMO ($256)	Harmony HMO-POS ($0)
COVERED MEDICAL AND HOSPITAL BENEFITS					
Mental Health Services	**Outpatient Individual Therapy Visit:**	**Outpatient Individual Therapy Visit:**	**Outpatient Individual Therapy Visit:**	**Outpatient Individual Therapy Visit:**	**Outpatient Individual Therapy Visit:**
In-Network	$45 copay	$30 copay	$25 copay	$15 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
	Outpatient Group Therapy Visit:	**Outpatient Group Therapy Visit:**	**Outpatient Group Therapy Visit:**	**Outpatient Group Therapy Visit:**	**Outpatient Group Therapy Visit:**
In-Network	$35 copay	$20 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
	Inpatient Hospital:	**Inpatient Hospital:**	**Inpatient Hospital:**	**Inpatient Hospital:**	**Inpatient Hospital:**
In-Network	$350 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 *	$350 copay each day for days 1 through 6 and $0 copay for days 7 through 90 *
	$0 copay for up to an additional 60 lifetime reserve days.	$0 copay for up to an additional 60 lifetime reserve days.	$0 copay for up to an additional 60 lifetime reserve days.	$0 copay for up to an additional 60 lifetime reserve days.	$0 copay for up to an additional 60 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 *	40% of the total cost for days 1 through 7 and $0 copay for days 8 through 90 *	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.	$0 copay for up to an additional 60 lifetime reserve days.		$0 copay for up to an additional 60 lifetime reserve days.

	Essential HMO ($0)	Assurance HMO-POS ($50)	Balance HMO-POS ($119)	Complete HMO ($256)	Harmony HMO-POS ($0)
COVERED MEDICAL AND HOSPITAL BENEFITS					
Skilled Nursing Facility (SNF)					
In-Network	$0 copay for days 1 through 20, a $218 copay each day for days 21 through 52, and $0 copay for days 53 through 100 *	$0 copay for days 1 through 20, a $218 copay each day for days 21 through 44, and $0 copay for days 45 through 100 *	$0 copay for days 1 through 20, a $218 copay each day for days 21 through 41, and $0 copay for days 42 through 100 *	$0 copay for days 1 through 20, a $218 copay each day for days 21 through 34, and $0 copay for days 35 through 100 *	$0 copay for days 1 through 20, a $218 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 or Speech Therapy Visit:**	**Physical or Speech Therapy Visit:**
In-Network	$45 copay	$40 copay	$35 copay	$25 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:**	**Occupational Therapy Visit:**
In-Network			$40 copay	$45 copay	$35 copay
Out-of-Network			40% of the total cost	Not covered	40% of the total cost
Ambulance Services – Emergency	**Ground Ambulance:** $300 copay **Air Ambulance:** $475 copay				
Transportation					
In-Network	$0 copay for 24 one-way rides every calendar year				
Out-of-Network	Not covered				

	Essential HMO ($0)	Assurance HMO-POS ($50)	Balance HMO-POS ($119)	Complete HMO ($256)	Harmony HMO-POS ($0)
COVERED MEDICAL AND HOSPITAL BENEFITS					
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 ($50)	Balance HMO-POS ($119)	Complete HMO ($256)	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	Tiers 1, 2, & 6 = $0 Tiers 3, 4, & 5 = $615	Tiers 1, 2, & 6 = $0 Tiers 3, 4, & 5 = $380	Tiers 1, 2, & 6 = $0 Tiers 3, 4, & 5 = $300	Tiers 1, 2, & 6 = $0 Tiers 3, 4, & 5 = $100	NA

	Essential HMO ($0)	Assurance HMO-POS ($50)	Balance HMO-POS ($119)	Complete HMO ($256)	Harmony HMO-POS ($0)
PART D PRESCRIPTION DRUG BENEFITS					
insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines. You will start receiving coverage immediately.					
Initial Coverage Stage	You will stay in this stage until your yearly out-of-pocket drug costs reach $2,100. 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 ($50)	Balance HMO-POS ($119)	Complete HMO ($256)	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)	$5 copay	$11 copay	$14 copay	$15 copay	NA
Tier 3 (Preferred Brand)	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	NA
Tier 4 (Non-Preferred Drug)	45% coinsurance	45% coinsurance	45% coinsurance	45% coinsurance	NA

	Essential HMO ($0)	Assurance HMO-POS ($50)	Balance HMO-POS ($119)	Complete HMO ($256)	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 5 (Specialty Tier)	25% coinsurance	28% coinsurance	29% coinsurance	31% coinsurance	NA
Tier 6 (Part D Vaccines)	$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 ($50)	Balance HMO-POS ($119)	Complete HMO ($256)	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)	$7 copay	$7 copay	$7 copay	$7 copay	NA
Tier 2 (Generic)	$11 copay	$16 copay	$19 copay	$20 copay	NA
Tier 3 (Preferred Brand)	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	NA
Tier 4 (Non-Preferred Drug)	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	NA

	Essential HMO ($0)	Assurance HMO-POS ($50)	Balance HMO-POS ($119)	Complete HMO ($256)	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 5 (Specialty Tier)	25% coinsurance	28% coinsurance	29% coinsurance	31% coinsurance	NA
Tier 6 (Part D Vaccines)	$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 ($50)	Balance HMO-POS ($119)	Complete HMO ($256)	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)	$10 copay	$22 copay	$28 copay	$30 copay	NA
Tier 3 (Preferred Brand)	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	NA
Tier 4 (Non-Preferred Drug)	45% coinsurance	45% coinsurance	45% coinsurance	45% coinsurance	NA

	Essential HMO ($0)	Assurance HMO-POS ($50)	Balance HMO-POS ($119)	Complete HMO ($256)	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 5 (Specialty Tier)	NA	NA	NA	NA	NA
Tier 6 (Part D Vaccines)	NA	NA	NA	NA	NA
Insulin	You won't pay more than $105 for a three-month supply of each covered insulin product regardless of the cost-sharing tier.				NA

	Essential HMO ($0)	Assurance HMO-POS ($50)	Balance HMO-POS ($119)	Complete HMO ($256)	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 $2,100, the plan pays the full cost for your covered Part D drugs. You pay nothing.				NA

	Essential HMO ($0)	Assurance HMO-POS ($50)	Balance HMO-POS ($119)	Complete HMO ($256)	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	$30 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
Chiropractic Services 24 additional routine visits every calendar year					
In-Network	$15 copay	$15 copay	$15 copay	$15 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
Diabetic Testing Supplies					
In-Network	$0 copay for Abbott (FreeStyle® or Precision®) and Roche (Accu-Chek®) blood glucose monitors (BGMs) and related supplies and all other diabetic testing supplies	$0 copay for Abbott (FreeStyle® or Precision®) and Roche (Accu-Chek®) blood glucose monitors (BGMs) and related supplies and all other diabetic testing supplies	$0 copay for Abbott (FreeStyle® or Precision®) and Roche (Accu-Chek®) blood glucose monitors (BGMs) and related supplies and all other diabetic testing supplies	$0 copay for Abbott (FreeStyle® or Precision®) and Roche (Accu-Chek®) blood glucose monitors (BGMs) and related supplies and all other diabetic testing supplies	$0 copay for Abbott (FreeStyle® or Precision®) and Roche (Accu-Chek®) blood glucose monitors (BGMs) and related supplies and all other diabetic testing supplies

	Essential HMO ($0)	Assurance HMO-POS ($50)	Balance HMO-POS ($119)	Complete HMO ($256)	Harmony HMO-POS ($0)
ADDITIONAL BENEFITS AND SERVICES					
	when purchased at a retail pharmacy. 20% of the total cost for Abbott (FreeStyle or Precision) and Roche (Accu-Chek) BGMs and related supplies and all other diabetic testing supplies when received from a medical supplier.	when purchased at a retail pharmacy. 20% of the total cost for Abbott (FreeStyle or Precision) and Roche (Accu-Chek) BGMs and related supplies and all other diabetic testing supplies when received from a medical supplier.	when purchased at a retail pharmacy. 20% of the total cost for Abbott (FreeStyle or Precision) and Roche (Accu-Chek) BGMs and related supplies and all other diabetic testing supplies when received from a medical supplier.	when purchased at a retail pharmacy. 20% of the total cost for Abbott (FreeStyle or Precision) and Roche (Accu-Chek) BGMs and related supplies and all other diabetic testing supplies when received from a medical supplier.	when purchased at a retail pharmacy. 20% of the total cost for Abbott (FreeStyle or Precision) and Roche (Accu-Chek) BGMs and related supplies and all other diabetic testing supplies when received from a medical supplier.
Out-of-Network	Not covered	50% of the total cost for Abbott (FreeStyle or Precision) and Roche (Accu-Chek) BGMs and related supplies and all other diabetic testing supplies.	40% of the total cost for Abbott (FreeStyle or Precision) and Roche (Accu-Chek) BGMs and related supplies and all other diabetic testing supplies.	Not covered	40% of the total cost for Abbott (FreeStyle or Precision) and Roche (Accu-Chek) BGMs and related supplies and all other diabetic testing supplies.
Durable Medical Equipment (DME) and Related Supplies					
In-Network	$0 copay for Dexcom and Freestyle continuous glucose monitors (CGMs) purchased at a retail pharmacy. * 20% of the total cost for Dexcom and	$0 copay for Dexcom and Freestyle continuous glucose monitors (CGMs) purchased at a retail pharmacy. * 20% of the total cost for Dexcom and	$0 copay for Dexcom and Freestyle continuous glucose monitors (CGMs) purchased at a retail pharmacy. * 20% of the total cost for Dexcom and	$0 copay for Dexcom and Freestyle continuous glucose monitors (CGMs) purchased at a retail pharmacy. * 20% of the total cost for Dexcom and	$0 copay for Dexcom and Freestyle continuous glucose monitors (CGMs) purchased at a retail pharmacy. * 20% of the total cost for Dexcom and

	Essential HMO ($0)	Assurance HMO-POS ($50)	Balance HMO-POS ($119)	Complete HMO ($256)	Harmony HMO-POS ($0)
ADDITIONAL BENEFITS AND SERVICES					
	Freestyle CGMs received from a medical supplier and all other DME. *	Freestyle CGMs received from a medical supplier and all other DME. *	Freestyle CGMs received from a medical supplier and all other DME. *	Freestyle CGMs received from a medical supplier and all other DME. *	Freestyle CGMs received from a medical supplier and all other DME. *
Out-of-Network	Not covered	50% of the total cost for Dexcom and Freestyle CGMs and all other DME.	40% of the total cost for Dexcom and Freestyle CGMs and all other DME.	Not covered	40% of the total cost for Dexcom and Freestyle CGMs and all other DME.
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 (formerly Your Dean Wallet)	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.				
Home Health Agency Care					
In-Network	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay

	Essential HMO ($0)	Assurance HMO-POS ($50)	Balance HMO-POS ($119)	Complete HMO ($256)	Harmony HMO-POS ($0)
ADDITIONAL BENEFITS AND SERVICES					
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 $50 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 $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	$45 copay	$40 copay	$35 copay	$25 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 ($50)	Balance HMO-POS ($119)	Complete HMO ($256)	Harmony HMO-POS ($0)
ADDITIONAL BENEFITS AND SERVICES					
Pulmonary Rehabilitation Services					
In-Network	$30 copay	$30 copay	$25 copay	$25 copay	$25 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.

Arabic/العربية

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. Medica بشأن خطة الرعاية الصحية (الهاتف النصي: 711) 1-877-317-2410، اتصل على الرقم Dean Health 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 ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

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– နမ့ၢ်ကတိၤကညီကျိာ်နၤ့ဉ် တၢ်အိဉ်ဒီး ကျိာ်တၢ်ဆိဉ်ထွဲမၤစၢၤ လၢတလာ်ဘူဉ်လာ်စ့ၤလၢနဂီၢ်လီၤ. တၢ်အိဉ်ဒီး ပှၤနီၢ်ခိကွၢ်ဂီၤတဆူဉ်တကျၢၤအဂီၢ်
ပီးလီဒီးတၢ်တိစၢၤမၤစၢၤလၢအကြၢးအဘဉ် လၢကဟ့ဉ်တၢ်ဂ့ၢ်တၢ်ကျိၤ လၢတၢ်မၤနှ့ၢ်အီၤသ့တဖဉ် 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 နပှၤလၢဟ့ဉ်နၤတၢ်ကွၢ်ထွဲတကွၢ်.

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.