HEALTH – HMO

Coverage Highlights	Dean Health Plan	MercyCare Health Plan
Your Annual Deductible		
Individual	$250	$250
Family	$500	$500
Plan Annual Deductible		
Individual	$5,000	$5,000
Family	$10,000	$10,000
Coinsurance		
Plan Pays	100%	100%
You Pay	0%	0%
Out-of-Pocket Max.		
Individual	$7,150	$7,150
Family	$14,300	$14,300
Covered Services		
Preventive Care	100%	100%
Office Visit	Deductible & Coinsurance	Deductible & Coinsurance
Diagnostic, X-Ray & Labs	Deductible & Coinsurance	Deductible & Coinsurance
Chiropractic Care	Deductible & Coinsurance	Deductible & Coinsurance
Urgent Care	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Room	$150 Copay and/or Deductible & Coinsurance	$150 Copay and/or Deductible & Coinsurance
Hospitalization	Deductible & Coinsurance	Deductible & Coinsurance
Prescription Drugs		
Tier 1	$10	$10
Tier 2	$30	$30
Tier 3	$60	$60

DENTAL – Delta Dental PPO & Premier Networks

Coverage Highlights	PPO Dentist	Premier Dentist
Deductible	Individual: $25 Family: $75	Individual: $75 Family: $225
Individual Annual Max.	$1,000	$1,000
Orthodontia Lifetime Max.	$1,500	$1,500
Preventive Care Oral exams, cleanings, fluoride, sealants, x-rays	100%	80%
Basic Services Root canals, filings, simple extractions, etc.	100%	80%
Major Services Crowns, inlays, onlays, dentures, etc.	80%	50%
Orthodontia Services Children up to age 19	50%	50%

HEALTH – POS

Coverage Highlights	Dean Health Plan		MercyCare Health Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible				
Individual	$500	$1,000	$500	$1,000
Family	$1,500	$3,000	$1,500	$3,000
Coinsurance				
Plan Pays	80%	60%	80%	60%
You Pay	20%	40%	20%	40%
Out-of-Pocket Max.				
Individual	$7,150	$14,300	$6,600	$13,200
Family	$14,300	$28,600	$13,200	$26,400
Covered Services				
Preventive Care	100%	Ded & Coins	100%	Ded & Coins
Office Visit	$25 Copay	Ded & Coins	$25 Copay	Ded & Coins
Diagnostic, X-Ray & Labs	Ded & Coins	Ded & Coins	Ded & Coins	Ded & Coins
Chiropractic Care	$25 Copay	Ded & Coins	$25 Copay	Ded & Coins
Urgent Care	$25 Copay Ded & Coins	$25 Copay Ded & Coins	$25 Copay Ded & Coins	$25 Copay Ded & Coins
Emergency Room	$100 Copay Ded & Coins	$100 Copay Ded & Coins	$100 Copay Ded & Coins	$100 Copay Ded & Coins
Hospitalization	Ded & Coins	Ded & Coins	Ded & Coins	Ded & Coins
Prescription				
Tier 1	$10	50%	$10	Not Covered
Tier 2	$30	50%	$30	Not Covered
Tier 3	$60	Not Covered	$60	Not Covered

VISION – Ameritas Network

Coverage Highlights	In-Network	Out-of-Network
Exam Once every 12 months	Covered in full	Up to $35
Lenses Once every 12 months	Varies on lens type	Varies on lens type
Frames Once every 24 months	$130	Up to $65
Contact Lenses Once every 12 months; in lieu of lenses/frames glasses	Varies on lens type	Varies on lens type