Dean Health Plan, Inc.

www.deancare.com

Customer Care Center 800-279-1301

DeanHealthPlan by Medica

2024

A Health Maintenance Organization (Basic Option)

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 8, FEHB Facts for details. This plan is accredited. See Section 1, How This Plan Works, page 12.

IMPORTANT
- Rates: Back Cover
- Changes for 2024: Page 16
- Summary of Benefits: Page 98

Serving: South Central Wisconsin
Enrollment in this plan is limited. You must live or work in the following counties: Dane, Dodge, Fond du Lac, Green, Rock or Sauk; and utilize the Dean Focus provider network for all services. See Section 1, Service Area, page 14 for requirements.

Enrollment codes for this Plan:

AG1 Basic Option – Self Only
AG3 Basic Option – Self Plus One
AG2 Basic Option – Self and Family

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

Important Notice from Dean Health Plan About
Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that Dean Health Plan's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1 percent per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 800-772-1213, (TTY: 800-325-0778).

Potential Additional Premium for Medicare's High Income Members
Income-Related Monthly Adjustment Amount (IRMAA)

The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is an amount you may pay in addition to your FEHB premium to enroll in and maintain Medicare prescription drug coverage. This additional premium is assessed only to those with higher incomes and is adjusted based on the income reported on your IRS tax return. You do not make any IRMAA payments to your FEHB plan. Refer to the Part D-IRMAA section of the Medicare website to see if you would be subject to this additional premium.

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.

Call 800-MEDICARE 800-633-4227, TTY 877-486-2048.

Table of Contents

Introduction

This brochure describes the benefits of the Basic Option under Dean Health Plan, Inc. contract (CS 1966) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer Care Center may be reached at 800-279-1301 or through our website: www.deancare.com. The address for Dean Health Plan's administrative office is:

Physical Address
Dean Health Plan, Inc.
1277 Deming Way
Madison, WI 53717

Mailing Address
Dean Health Plan, Inc.
P.O. Box 56099
Madison, WI 53705

This brochure is the official statement of benefits. No verbal statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2024, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2024, and changes are summarized in Section 2, Changes for 2024, page 16. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee and each covered family member, “we” means Dean Health Plan.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM’s Office of the Inspector General investigates all allegations of fraud, waste and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the phone or to people you do not know, except for your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claims history for accuracy to ensure we have not been billed for services you did not receive.

- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 800-279-1301 and explain the situation.
  - If we do not resolve the issue:

CALL THE HEALTH CARE FRAUD HOTLINE
877-499-7295
OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/
The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.
You can also write to:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise) or
  - Your child age 26 or over (unless they are was disabled and incapable of self-support prior to age 26). A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks.

Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you take notes, ask questions and understand answers.

2. Keep and bring a list of all the medications you take.

- Bring the actual medication or give your doctor and pharmacist a list of all the medications and dosage that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medication is what the doctor ordered. Ask the pharmacist about the medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Don’t assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital or clinic is best for your health needs.

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the healthcare you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, “Who will manage my care when I am in the hospital?”
- Ask your surgeon:
  - "Exactly what will you be doing?"

- "About how long will it take?"
- "What will happen after surgery?"
- "How can I expect to feel during recovery?"

- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.
- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.
- www.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medications.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these conditions may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events".

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error.

Plan Providers agree that they will comply with terms of the Wisconsin Hospital Association's "Wisconsin Hospitals, Physicians Vow to Eliminate Rare, Serious Errors-Resolution Aimed at Improving Patient Safety, Quality", adopted April 2008.

Plan Providers agree to notify all applicable reporting agencies of any Serious Reportable Adverse Events, including but not limited to, root cause analysis and corrective action taken. Plan Providers further agree that when a Serious Reportable Adverse Event occurs, Dean Health Plan and Members shall not be required to pay for the cost of medical care related to the event.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

  We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage (MEC). Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

- **Where you can get information about enrolling in the FEHB Program**

  See www.opm.gov/healthcare-insurance for enrollment information as well as:

  - Information on the FEHB Program and plans available to you
  - A health plan comparison tool
  - A list of agencies that participate in Employee Express
  - A link to Employee Express
  - Information on and links to other electronic enrollment systems

  Also, your employing or retirement office can answer your questions, give you other plans' brochures and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

  - When you may change your enrollment
  - How you can cover your family members
  - What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire
  - What happens when your enrollment ends
  - When the next Open Season for enrollment begins

  We do not determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

  Once enrolled in your FEHB Program Plan, you should contact your carrier directly for address updates and questions about your benefit coverage.

- **Enrollment types available for you and your family**

  Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee and one or more eligible family members. Family members include your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

  If you have a Self Only enrollment, you may change to a Self Plus One or Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event.

The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form. Benefits will not be available to your spouse until you are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Contact your employing or retirement office if you want to change from Self Only to Self Plus One or Self and Family. If you have a Self and Family enrollment, you may contact us to add a family member.

Your employing or retirement office will not notify you when a family member is no longer eligible to receive benefits. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26. We will send written notice to you 60 days before we proactively disenroll your child on midnight of their 26th birthday unless your child is eligible for continued coverage because they are incapable of self-support due to a physical or mental disability that began before age 26.

If you or one of your family members are enrolled in one FEHB plan, you are they cannot be enrolled in or covered as a family member in another FEHB plan.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/payroll office, or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including your spouse by a valid common-law marriage from a state that recognizes common-law marriages) and children as described below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member, as described below.

Natural children, adopted children, and stepchildren
Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children
Coverage: Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.

Children incapable of self-support
Coverage: Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.

Married children
Coverage: Married children (but NOT their spouse or their own children) are covered until their 26th birthday.

Children with or eligible for employer-provided health insurance
Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

- **Children's Equity Act**

OPM implements the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll in Self Plus One or Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, the lowest-cost nationwide plan option as determined by OPM.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that does not serve the area in which your children live, unless you provide documentation that you have other coverage for the children.

If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be processed according to the 2024 benefits of your prior plan or option**. If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan's 2023 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31-days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment; or
- You are a family member no longer eligible for coverage.

Any person covered under the 31-day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31-day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

- **Upon divorce**

If you are an enrollee, and your divorce or annulment is final, your ex-spouse cannot remain covered as a family member under your Self Plus One or Self and Family enrollment.

You must contact us to let us know the date of the divorce or annulment and have us remove your ex-spouse. We may ask for a copy of the divorce decree as proof. In order to change enrollment type, you must contact your employing or retirement office. A change will not automatically be made.

If you were married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC).

If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get information about your coverage choices. You can also visit OPM's website at www.opm.gov/healthcare-insurance/healthcare/plan-information. We may request that you verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, if you are a covered dependent child and you turn 26, etc.

You may not elect TCC if you are fired from your Federal or Tribal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must contact us in writing within 31-days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must contact us in writing within 31-days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, a waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions. When you contact us we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 800-279-1301 or visit our website at www.deancare.com.

- **Health Insurance Marketplace** If you would like to purchase health insurance through the ACA's Health Insurance Marketplace, please visit www.Healthcare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How This Plan Works

This Plan is a (health maintenance organization (HMO) plan). OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. Dean Health Plan holds the following accreditation: Excellent accreditation by the National Committee for Quality Assurance (NCQA) www.ncqa.org. To learn more about this plan's accreditation, please visit the following website: www.deancare.com/our-company/quality. We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. We are solely responsible for the selection of these providers in your area. Dean Health Plan offers a current and complete listing of physicians, clinics, pharmacies and more at www.deancare.com/find-a-doc/ or contact us for a copy of our most recent provider directory. Important contact information such as phone numbers and locations are listed on our website. When searching for providers from our website, you will want to be sure to select "DEAN FOCUS" as your plan type for the Basic Option network providers.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments and coinsurance described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the Plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

General Features - Basic Option Plan

- No Deductible
- No Coinsurance
- Virtual Visit - $0 Copayment
- Primary Care Provider Office Visit - $40 Copayment
- Specialist Office Visit - $80 Copayment
- Allergy Testing and Treatment - $80 Copayment
- Chiropractic Care - $40 Copayment
- Hearing Examinations - $40 Copayment
- Hearing Aid - $300 Copayment
- Routine Vision Exam - $40 Copayment
- Diagnostic services - $0 Copayment
  - X-Rays and Readings
  - Laboratory Services and Readings
  - Vision Care Services
  - Readings of MRI/MRA, CAT Scans, PET Scans
- MRI/MRA/CT Scan, PET Scans - $480 Copayment
- Urgent Care - $40 Copayment
- Emergency Room - $300 Copayment
- Ambulance - $300 Copayment
- Inpatient Hospital Facility Charge - $1,000 Copayment per day up to a maximum of $3,000 per contract year
- Outpatient Hospital Facility Charge - $1,000 Copayment per occurrence up to a maximum of $3,000 per contract year

- Physician Charges and Related Services - $0 Copayment
- Skilled Nursing Facility - $80 Copayment per day
- Durable Medical Equipment - $0 Copayment
- Physical/Speech/Occupational Therapies - $80 Copayment per therapy type per day
- Catastrophic Protection Maximum - $6,000 Self Only enrollment or $12,000 Self Plus One and Self and Family enrollment
- Prescription Drugs - Retail (Up to a 30 day supply)
  - Tier 1 - $20 Copayment
  - Tier 2 - $45 Copayment
  - Tier 3 - $70 Copayment
  - Tier 4 - $150 Copayment
- Prescription Drugs - Mail Order (90 day supply)
  - Tier 1 - $40 Copayment
  - Tier 2 - $90 Copayment
  - Tier 3 - $210 Copayment
  - Tier 4 - Not available
- Preventive care services are generally covered with no cost-sharing and are not subject to copayments or annual limits when received from a network plan provider.*

*Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available (USPSTF) is available online at: www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations

HHS: www.healthcare.gov/coverage/preventive-care-benefits/

Preventive care services

Preventive care services are generally covered with no cost sharing and are not subject to copayments, deductibles or annual limits when received from a network provider.

Annual deductible

The annual deductible must be met before Plan benefits are paid for care other than preventive services.

We Have Open Access Benefits

Our HMO offers Open Access benefits. This means you can receive covered services from your primary care provider or by another participating provider in the Focus network without a referral.

How We Pay Providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your cost sharing (copayments, coinsurance, deductibles, and non-covered services and supplies).

Catastrophic Protection

We protect you against catastrophic out-of-pocket expenses for covered services. The IRS limits annual out-of-pocket expenses for covered services, including deductibles and copayments, to no more than $9,100 for Self Only enrollment, and $18,200 for a Self Plus One or Self and Family. The out-of-pocket limit for this Plan may differ from the IRS limit, but cannot exceed that amount.

Your rights and responsibilities

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Dean Health Plan, Inc. has been in business since 1983
- Dean Health Plan, Inc. is a for-profit HMO

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this plan. You can view the complete list of these rights and responsibilities by visiting our website, Dean Health Plan www.deancare.com. You can also contact us to request that we mail a copy to you.

If you want more information about us, call 800-279-1301, or write to Dean Health Plan, Attention Customer Care Center, P. O. Box 56099, Madison WI 53705. You may also visit our website at www.deancare.com.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website at www.deancare.com/app/files/public/3484/pdf-aboutus-plan-privacy_deanhealthplan.pdf to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

To enroll in this Plan, you must live in or work in our service area. This is where our providers practice. The Basic Option service area is limited to our narrow Focus network. The Focus network is our narrow network, consisting of only six service area counties which include Dane, Dodge, Fond du Lac, Green, Rock, and Sauk counties in Wisconsin.

Except in the case of an emergency, medical services must be obtained from a Focus Plan network provider in these counties to ensure coverage. Visit our Focus Map for an overview of this service area. To verify if your provider is part of this network, go to www.deancare.com/doctors. Under "Select Plan Type" select "Dean Focus". Search by specialty, name, location, gender and/or language.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits (See Section 5(d). Emergency Services/Accidents). We will not pay for any other healthcare services out of our service area unless the services have prior Plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Qualified dependent children who live outside the service area may, if approved by Dean Health Plan, see certain providers outside the service area and still have claims paid at an in-network rate. To locate these providers or for more details, call our Customer Care Center at 800-279-1301.

Section 2. Changes for 2024

Do not rely only on these change descriptions, this Section is not an official statement of benefits. For that go to Section 5 benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes:

- There are no program-wide changes.

Changes to this Plan

- **Your share of the premium rate** will stay the same for Self Only, Self Plus One and for Self and Family. (See back cover.)
- **Infertility (Services) -** Adding coverage for artificial insemination; up to six cycles annually. Member pays 50% of the allowed amount of covered services. See Section 5(a) - Infertility Services for additional detail.
- **Infertility (Drugs) -** Adding coverage for outpatient infertility IVF drugs; up to three cycles annually. Member pays 50% copayment of the allowed amount per unit or refill, regardless of the tier the covered formulary drug is on. See Section 5 (f) - Prescription Drug Benefits for additional detail.
- **Prescription Drugs ($6 for 6) -** Select unique generic medications for conditions such as diabetes, high blood pressure, mood disorders and bone health available to members for $6 for a 6-month supply at all participating in-network SSM Health retail pharmacies and Costco retail pharmacy. See Section 5(f) - Prescription Drug Benefits for additional detail.
- **Hospice Respite Care -** Adding a respite care benefit to the hospice benefit. Respite care is limited to not more than five consecutive days for the duration of hospice care. $80 copayment per visit. See Section 5(c) - Hospice Care for additional detail.
- **Durable Medical Equipment (Breast Pumps) -** Expanding the available selection of breast pumps supplied through SSM Health at Home to include the below option. The pumps are covered at 100% under the Women's Preventive benefit. See Section 5(a) - Maternity Care for additional detail.
  - Spectra S2 Plus Double Electric Breast Pump
  - Spectra S1 Plus Double Electric Premier Rechargeable Breast Pump
  - Zomee Fit Wearable Rechargeable Breast Pumps
- **COVID-19 (Post Pandemic) -** Returning all COVID-19 related services to be consistent with similar services (i.e. office visits, urgent care, emergency room, lab, x-ray, etc. will all return to the appropriate cost share for each option).
  - COVID-19 vaccines and booster shots will continue to be covered with no member cost share, but only for In-network providers.
  - COVID-19 lab testing - Normal cost-sharing requirements will apply for COVID-19 tests ordered by an In-network medical provider. There is no charge for lab testing for this plan (No change.)
  - Over the Counter (OTC) tests will be removed from Plan coverage, consistent with other over the counter items. Members will pay the full cost for over-the-counter COVID-19 tests.
  - With the exception of a potential emergency care issue, there is no out-of-network benefit for COVID-19 related services and drugs.
- **Gender Affirming Care and Services -** Extending Gender Affirming Care and Services benefit to cover all medically necessary Gender Affirming Care Services, including facial gender affirming care surgeries. See Section 5(b) - Reconstructive Surgery for additional detail. The member cost shares remain the same as follows:
  - PCP - $40 copayment, Specialist - $80 copayment, Outpatient Facility - $1,000 copayment per occurrence up to a maximum of $3,000 per contract year, Inpatient Facility - $1,000 copayment per day up to a maximum of $3,000 per contract year, Inpatient Physician - $0 copayment.

Section 3. How You Get Care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800-279-1301 or write to us at:

P.O. Box 56099, Madison WI 53705

You may also request replacement cards through our online member portal DeanConnect at www.deancare.com/deanconnect.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments. You will not have to file claims. You can receive covered services from a participating provider without a required referral from your primary care provider or by another participating provider in the network.

- **Balance Billing Protection**

FEHB Carriers must have clauses in their in-network (participating) providers agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or for non-elective services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in network contracted amount. If an in-network provider bills you for covered services over your normal cost share (deductible, copayment, coinsurance) contact your Carrier to enforce the terms of its provider contract.

- **Plan providers**

Plan providers are physicians and other healthcare professionals in our service area that we contract with to provide covered services to our members. Services by Plan Providers are covered when acting within the scope of their license or certification under applicable state law. We credential Plan providers according to NCQA and Dean Health Plan standards.

Benefits are provided under this Plan for the services of covered providers, in accordance with Section 2706(a) of the Public Health Service Act. Coverage of practitioners is not determined by your state's designation as a medically underserved area.

We list Plan providers in the provider directory, which we update monthly. The list is also on our website at www.deancare.com.

The plan recognizes that transgender, non-binary, and other gender diverse members require health care delivered by healthcare providers experienced in gender affirming health. Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex or gender.

This plan provides Care Coordinators for complex conditions and can be reached at 800-279-1301 or visit our website at www.deancare.com for assistance.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update daily. The provider directory can be found on our website at www.deancare.com/find-a-doc.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care provider. This decision is important since your primary care provider provides or arranges for most of your health care. When you enroll, you (and your family members) must choose a primary care provider. Each member of your family may select a different primary care provider. A provider who specializes in only one area of medicine would not be able to treat all of your basic health care needs.

- **Primary care**

Primary care providers specialize in different areas, and each specialty has its own benefits. A basic summary might help you narrow your search:

- **Family Medicine (with or without Obstetrics)** focuses on healthcare for individuals and families of all ages. This includes routine and preventive care, treatment of acute and chronic illness, and coordination of your overall care. Some Family Medicine physicians also include Obstetrics (the care of women during pregnancy and childbirth).
- **Internal Medicine** focuses on adult patients and the aging process. Internists generally see patients over 18 years old. They also frequently care for patients with multiple ongoing health conditions. They provide preventative care, age-related screenings and health guidance.
- **Pediatrics** is a specialty which treats children from birth to their late teens. While pediatricians see healthy children for primary care, they also help children who have special or difficult health conditions. Pediatricians provide ongoing screenings, immunizations and preventative care throughout childhood.

You can also visit www.deancare.com/members/new-to-dhp for the most up-to-date listing of providers and view our Tips for Choosing a Primary Care Provider.

Dean Health Plan members are free to switch to a different primary care provider (PCP) at any time. If you are changing to another PCP within the same clinic, you may ask that clinic's staff for assistance. Otherwise you may call the Customer Care Center at 800-279-1301.

- **Specialty care**

Written referrals are not required when seeing a Dean Health Plan provider.

Here are some other things you should know about specialty care:

- Your primary care provider will create your treatment plan. The physician may have to get an authorization or approval from us beforehand. If you are seeing a specialist when you enroll in our Plan, talk to your primary care provider. If they decide to refer you to a specialist, ask if you can see your current specialist.

If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care provider, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for other than cause;
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program plan; or
  - reduce our service area and you enroll in another FEHB plan;

- If you receive care from an Out-of-Network Provider that is not available from a Network Provider and have an approved Prior Authorization to see this Out-of-Network Provider, payment for covered charges will be based on the actual charges, and not the Maximum Allowable Fee. We have no liability or responsibility for the quality of care provided by an Out-of-Network Provider. Prior Authorization is required both to determine medical appropriateness and whether services can be provided by Network Providers.

You may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

If you are in the third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days. Services provided by an Out-of-Network Provider require Prior Authorization.

- **Hospital care**

Your Plan primary care provider or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our Customer Care Center immediately at 800-279-1301. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

Since your primary care provider arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under *Other services*.

If you choose an out-of-network provider, it is up to you to secure a prior authorization. Failure to do so may result in a penalty of 100% of cost. Your out-of-network provider must contact our Customer Care Center to submit a prior authorization request. Dean Health Plan will then review the request and provide a written decision to both you and your provider within 15 business days. Make sure you wait until you receive this approval before receiving the recommended services to avoid penalty.

A good rule to remember is that any time you seek services with an out-of-network or non-participating provider, you will need to obtain a prior authorization from an in-plan provider.

If you fail to obtain a Prior Authorization for any Medically Necessary covered service which requires an authorization, you, the Member, will be responsible for 100% of the total cost of services. It is the responsibility of the Member to ensure that Prior Authorization has been obtained for all services, including facility Confinements and/or surgery.

- **Inpatient hospital admission**

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

Your health care provider must get prior authorization from us before we will cover certain procedures or services. Examples of procedures and services that need prior authorization are listed below. **This is not an all-inclusive list**. You should contact the Customer Care Center at 800-279-1301 or TTY 711 to verify whether a procedure or service needs prior authorization.

Examples of Procedures/Services Requiring Prior Authorization:

- Certain organ and blood and marrow transplant services - this Prior Authorization must be obtained before the transplant workup is initiated
- In-network benefits for services from non-network providers, with the exception of emergency services
- Certain reconstructive or restorative surgery procedures
- Certain drugs, biologics and biosimilars
- Certain home health care services
- Certain durable medical equipment
- Certain outpatient surgical procedures
- Certain imaging services
- Non-emergency licensed air ambulance transportation
- Skilled nursing facility services

The Process for Obtaining Prior Authorization:

If your health care provider recommends that you have a service or procedure that needs prior authorization, your health care provider should submit a prior authorization request form to Us. It is the member's responsibility to make sure that your health care provider requests prior authorization. We must receive the prior authorization request at least 15 business days before the date of your service or procedure. We will notify you in writing of our decision.

Your health care provider may decide that it is medically necessary for you to 1) get additional services beyond what we originally authorized, or 2) receive care for longer than the length of time we originally authorized. If this happens, your health care provider must contact Us to request an extension of the original authorization. You and your health care provider will be notified of whether we approve or deny your extension request.

Prior authorization does not guarantee coverage and/or payment if you have already reached a benefit maximum or your coverage has been terminated.

Professionally Administered Drugs - Covered Expenses:

- Medically Necessary Professionally Administered Drugs that are administered, in conjunction with a covered benefit such as an office visit or home health care visit, by a physician acting within the scope of the provider's license, on an outpatient basis in a hospital, physician's office or in your home.
- Prior Authorization (approval in advance) is required before you receive certain biologics, biosimilars and professionally administered drugs. Certain biologics, biosimilars and Professionally Administered Drugs may be subject to Step Therapy. In certain cases, it is possible to get an exception to Step Therapy requirements. To obtain more information about the Step Therapy exception process call Customer Care Center at the number on the back of your ID card.

- If you require certain Professionally Administered Drugs, We may direct you to a designated Health Care Provider with whom We have an arrangement to provide those certain Professionally Administered Drugs. Such designated Health Care Providers may include an outpatient pharmacy, specialty pharmacy, home health care agency, home infusion provider, hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy. If you or your provider administering the Professionally Administered Drugs are directed to a designated Health Care Provider and you or your provider choose not to obtain your Professionally Administered Drug from that designated Health Care Provider, benefits may not available under this Policy for that professionally administered drug.

Non-Covered Professionally Administered Drug Expenses:

- Professionally Administered Drugs provided by an Out-of-Network Network Provider.

- **How to request precertification for an admission or get prior authorization for other services**

First, your physician, your hospital, you, or your representative, must call us at 800-279-1301 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of days requested for hospital stay.

- **Non-urgent care claims**

For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether or not it is an urgent care claim by applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 800-279-1301. You may also call OPM's FEHB 3 at 202-606-0755 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 800-279-1301. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must phone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity care**

You do not need precertification of a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, your physician or the hospital must contact us for precertification of additional days for your baby.

Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

What happens when you do not follow the precertification rules when using non-network facilities

Failure to Obtain Authorization for Non-Plan Providers: If you fail to obtain Prior Authorization for any service requiring such an authorization, you, the Member, will be responsible for 100% of the total cost of services received from any Non-Plan Provider. It is the responsibility of the Member to ensure that Prior Authorization has been obtained for all services.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below. If your claim is in reference to a contraceptive, call 800-279-1301.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent claim**

  Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

  In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

  1. Precertify your hospital stay or, if applicable, arrange for the healthcare provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
  2. Ask you or your provider for more information.
     - You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.
     - If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
  3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

  In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

  Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by phone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

  After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your Costs for Covered Services

This is what you will pay out-of-pocket for covered care:

Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., copayments) for the covered care you receive.
Coinsurance	Coinsurance is the percentage of covered expenses that a member is required to pay each time covered services are provided, subject to any maximums specified in this brochure. Coinsurance amounts are applied toward the catastrophic protection out-of-pocket maximum expense in most circumstances. Coinsurance does not begin until you have met your calendar year deductible. This Basic Option does not have coinsurance amounts.
Copayments	A copayment is a specified dollar amount that you may be required to pay each time covered services are provided, subject to any maximums specified in this policy. Copayment amounts are applied to our contracted fee or Maximum Allowable Fee, and apply at the benefit level. Copayment amounts are applied toward the out-of-pocket expense maximum. **Example:** **Primary Care Provider copayment**: When you see your primary care provider or chiropractor you pay a copayment of $40 per office visit. **Specialist Provider copayment**: When you see a specialty provider you pay a copayment of $80 per office visit.
Deductible	A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible. Note: If you change plans during Open Season, you do not have to start a new deductible under your prior plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan. This Basic Option does not have a deductible.
Differences between our Plan allowance and the bill	The maximum amount payable based upon the average charge for the same service provided. You should also see section Important Notice About Surprise Billing – Know Your Rights below that describes your protections against surprise billing under the No Surprises Act.

Your catastrophic protection out-of-pocket maximum

After your out-of-pocket expenses, including any applicable deductibles, copayments and coinsurance total $6,000 for Self Only, or $12,000 for a Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. ***The maximum annual limitation on cost sharing listed under Self Only of $6,000 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.***

Example Scenario: Your plan has a $6,000 Self Only maximum out-of-pocket limit and a $12,000 Self Plus One or Self and Family maximum out-of-pocket limit. If you or one of your eligible family members has out-of-pocket qualified medical expenses of $6,000 or more for the calendar year, any remaining qualified medical expenses for that individual will be covered fully by your health plan. With a Self and Family enrollment out-of-pocket maximum of $12,000, a second family member, or an aggregate of other eligible family members, will continue to accrue out-of-pocket qualified medical expenses up to a maximum of $6,000 for the calendar year before their qualified medical expenses will begin to be covered in full.

However, copayments and coinsurance, if applicable for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and coinsurance for these services:

- Premiums
- Non-Covered Services
- Benefit Reduction Amounts
- Services provided by out-of-network providers that have not been prior authorized

Be sure to keep accurate records and receipts of your copayments and coinsurance to ensure the plan's calculation of your out-of-pocket maximum is reflected accurately.

Carryover

If you changed to this Plan during Open Season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your prior plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your prior plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your prior plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your prior plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Important Notice About Surprise Billing – Know Your Rights

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" for out-of-network emergency services; out-of-network non-emergency services provided with respect to a visit to a participating health care facility; and out-of-network air ambulance services. Plan providers are physicians and other healthcare professionals in our service area that we contract with to provide covered services to our members.

A surprise bill is an unexpected bill you receive for

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating providers of air ambulance services.

Balance billing happens when you receive a bill from the non-participating provider, facility, or air ambulance service for the difference between the nonparticipating provider's charge and the amount payable by your health plan.

Your health plan must comply with the NSA protections that hold you harmless from surprise bills.

For specific information on surprise billing, the rights and protections you have, and your responsibilities go to www.deancare.com/Members/No-surprises or contact the health plan at 800-279-1301.

The Federal Flexible Spending Account Program - FSAFEDS

Healthcare FSA (HCFSA) – Reimburses you for eligible out-of-pocket healthcare expenses (such as copayments, deductibles, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you, your tax dependents, and your adult children (through the end of the calendar year in which they turn 26).

FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

Section 5. Basic Option Benefits

Section Summary of Benefits for the Basic Option of Dean Health Plan, Page 96, is a benefits summary of the Basic option.

Section 5. Basic Option Benefit Overview

This Plan offers a Basic Option. The benefit package is described in Section 5.

Section 5 is divided into subsections. Please read 'Important Things You Should Keep in Mind' at the beginning of the subsections. Also, read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about the Basic Option benefits, contact us at 800-279-1301 or on our website at www.deancare.com/federalemployee.

The Basic option offers unique features.

Basic Option Plan Overview - The Basic Option is a simple, copayment only health plan. This plan provides upfront cost transparency. $0 deductible; 0% coinsurance; $40 primary care provider office visit copayment or $80 Specialist office visit copayment; $40 urgent Care copayment; $300 emergency room copayment. $1,000 copayment per day up to a maximum of $3,000 per contract year for inpatient hospital facility charges. $1,000 copayment per occurrence up to a maximum of $3,000 per contract year for outpatient hospital facility charges. This plan includes several services covered with $0 copayment, such as:

- Virtual Visits
- Preventive Care
- Diagnostic Services
  - X-Rays and Readings
  - Laboratory Services and Readings
  - Readings of MRI/MRA, CT Scans, PET Scans
- Durable Medical Equipment

The calendar year catastrophic limit is $6,000 self only or $12,000 self and family maximum out-of-pocket.

The Basic Option is offered with our limited Focus network. The Focus network is our narrow network, consisting of six counties: Dane, Dodge, Fond du Lac, Green, Rock and Sauk. Except in the case of an emergency, medical services must be obtained from a Focus Plan network provider in these counties to ensure coverage. Visit our **Focus Map** for an overview of this service area. To verify if your provider is part of this network, go to www.deancare.com/find-a-doctor. Under "Dean Health Plan Product Type", select "DEAN FOCUS". Search by specialty, name, location, gender and/or language.

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- There is no calendar year deductible.
- There is no calendar year coinsurance.
- Be sure to read Section 4, Your Costs for Covered Services, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).

Benefit Description	You pay
Diagnostic and treatment services	**Basic**
Professional services of physicians • In physician's office • Advance care planning	$40 copayment per visit - Primary Care Provider $80 copayment per visit - Specialist
Professional services of physicians • In an urgent care center • Office medical consultation • Second surgical opinion	$40 copayment per visit - Primary Care Provider $80 copayment per visit - Specialist $40 copayment per visit - Urgent Care Center
• During a hospital stay • In a skilled nursing facility	$0 additional copayment (See Section 5 (b) for Skilled Nursing and/or hospital stay copayments.)
Telemedicine Services	**Basic**
Telemedicine Services • This term is the umbrella term that includes a wide range of technologies that support Telehealth and Virtual Care/Virtual Visits • Not all conditions may be available or appropriate for treatment by a Telehealth Services provider, and you may be referred to another more appropriate care setting. Covered Expenses • Telehealth; an interactive audio and/or video telecommunications system that permits real-time communication between the provider at the practice location and the Member at a different location. - Coverage of a service provided via Telehealth is subject to the same benefits and limitations as if the service is provided face-to-face (e.g., allowable providers, prior authorization, copayment, deductible, coinsurance).	Telehealth Visit • $40 Copayment per visit - Primary Care Provider • $80 Copayment per visit - Specialist Virtual Visit • Nothing

Telemedicine Services - continued on next page

Benefit Description	You pay
Telemedicine Services (cont.)	**Basic**
• Virtual Care/Virtual Visit (member completes a computer based questionnaire and receives a treatment plan from a provider). - Complete an online health interview. Answer a series of questions about how you are feeling and the symptoms you are experiencing - just as you would during an in-office visit. A provider from SSM Health reviews your responses and creates a treatment plan, which may include a prescription if necessary. You'll be notified when the results are available. For more information, visit deancare.com/virtualvisit. Non-Covered Telemedicine Services Expenses • All other benefits not otherwise listed in the Policy. • Virtual visit with a provider that is not contracted with Us will not be covered. Please Note: • Virtual visit with a provider that is not contracted with Us will not be covered. • Not all conditions may be treated or appropriate for treatment through a virtual visit provider. You may be referred to another more appropriate care setting.	Telehealth Visit • $40 Copayment per visit - Primary Care Provider • $80 Copayment per visit - Specialist Virtual Visit • Nothing
Lab, X-ray and other diagnostic tests	**Basic**
Diagnostic services associated with an office visit or urgent care visit • X-rays and readings • Laboratory services and readings • Hearing services • Vision care services • Readings - MRI/MRA, CT scans, PET scans	Nothing
Other Diagnostic Services Covered Expenses: • Electroencephalogram (EEG) • Electrocardiogram (EKG) • Endoscopy • Duplex scan • Pulmonary stress test • Sleep study • Nerve conduction studies • Neuropsychological testing • Swallow study • Ultrasounds	Nothing
• CT Scan • MRI • PET Scan	$480 copayment per visit Outpatient services only

Lab, X-ray and other diagnostic tests - continued on next page

Benefit Description	You pay
Lab, X-ray and other diagnostic tests (cont.)	**Basic**
Genetic Counseling and Testing We cover genetic counseling, occurring in an office, clinic, or telephonically. Genetic testing services received in an office or outpatient hospital setting. Covered Expenses: • Genetic counseling, pre-test or post-test. • Genetic testing. - When the test will directly affect treatment decisions or frequency of screening for a disease, or when results of the test will affect reproductive choices.	Nothing
Not covered: • *Genetic Counseling and testing services provided by an Out-of-Network provider.* • *Genetic testing when performed in the absence of symptoms or high-risk favors for a heritable disease.* • *Genetic testing when knowledge of genetic status will not affect treatment decisions, frequency of screening for the disease, or reproductive choices.* • *Genetic testing that has been performed in response to direct to consumer marketing and not under the direction of your physician.* *Note: BRCA testing, if appropriate, is covered as a women's preventive health service.*	*All charges*
Preventive care, adult	**Basic**
Routine physical once annually. The following preventive services are covered at the time interval recommended at each of the links below. • Immunizations such as pneumococcal, influenza, shingles, tetanus/Tdap and human papillomavirus (HPV). For a complete list of immunizations go to the Centers for Disease Control (CDC) website at www.cdc.gov/vaccines/schedules/. • Screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV and colorectal cancer screening. For a complete list of screenings go to the U.S. Preventive Services Task Force (USPSTF) website at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • Individual counseling on prevention and reducing health risks. • Preventive care benefits for women such as pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care benefits for women go to the Health and Human Services (HHS) website at www.healthcare.gov/preventive-care-women/. • To build your personalized list of preventive services go to https://health.gov/myhealthfinder.	Nothing
Routine mammogram	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**Basic**
Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. *Note: Preventive services are defined as health care services that might include screenings, check-ups, and patient counseling to **prevent** illnesses, disease, or other health problems. The Affordable Care Act (ACA) outlines preventive services which are offered at no cost sharing to the member.* *Additionally, in order to be covered under the plan, preventive services must:* • *Be performed by or ordered by a Primary Care Provider or Obstetrician/ Gynecologist; and* • *Be expenses for care to evaluate or assess health and well being and screen for possible detection of unrevealed illness on a regular basis; and* • *Be provided by a Plan Provider; and* • *Not be performed for the primary reason of diagnosing or treating an illness or injury.* *Dean Health Plan follows the United States Preventive Service's Task Force (USPSTF) recommendations for preventive services. We allow services that receive an "A" or "B" rating. We do cover certain services under the ACA (preventive services) related to pregnancy at no member cost share.* *You may review the Health Resources and Services Administration (HRSA) guidelines available at www.hrsa.gov/womensguidelines/ and related federal guidance for additional detail.* *Laboratory and diagnostic studies may be subject to other plan benefits (diagnostic or treatment benefits) if determined not to be part of a preventive visit. When a Member has symptoms or a history of an illness or injury, laboratory and diagnostic studies relating to that illness or injury are no longer considered part of a preventive visit.* *Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.* • *Medical Nutrition Therapy and Intensive Behavioral Therapy for the prevention of obesity related comorbidities as recommended under the U.S. Preventive Services Task Force (USPSTF) A and B recommendations.*	Nothing
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for work-related exposure.*	*All charges*

Benefit Description	You pay
Preventive care, children	**Basic**
Well-child visits, examinations and immunizations as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. Pediatric Vision (eye glasses) – One pair of eyeglasses per contract year. Immunizations such as Tdap, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/index.html. Covered Pediatric Vision Expenses: • Single vision, conventional (lined) bifocal, and conventional (lined) Bifocal lenses • Polycarbonate lenses are covered for children (monocular or patients with prescriptions > +/-6.00 diopters) • Frame • Scratch resistant coating • Ultraviolet protective coating Lenses include choice of glasses or plastic lenses. One pair of replacement glasses per year. Non-Covered Pediatric Vision Expenses: • Blended segment lenses • Intermediate vision lenses • Standard progressives • Premium progressives (Varilux®, etc.) • Photochromic glass lenses • Plastic photosensitive lenses (Transitions®) • Polarized lenses • Standard anti-reflective (AR) coating • Premium AR coating • Contact lenses Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible. You may also find a complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) online at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-brecommendations HHS: www.healthcare.gov/coverage/preventive-care-benefits/ CDC: www.cdc.gov/vaccines/schedules/index.html Women's preventive services: www.healthcare.gov/preventive-care-women For additional information: health.gov/myhealthfinder	Nothing

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	**Basic**
Note: For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to www.aap.org/en/practice-management/bright-futures	Nothing
Travel immunizations	**Basic**
Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention.	Nothing
Maternity care	**Basic**
Complete maternity (obstetrical) care, such as: • Delivery* • Postnatal care	$40 copayment - Primary Care Provider or $80 copayment - Specialist per office visit* *Delivery subject to inpatient hospital facility copayment. See Section 5(c). for charges associated with the facility (i.e. hospital, surgical center, etc.)
• Prenatal and Postpartum care • Screening for gestational diabetes for pregnant women • Breastfeeding support, supplies and counseling for each birth - The health plan covers the purchase of one covered breast pump per birth with no prior authorization required. The pump is covered at 100% per the women's preventive benefit. • Screening and counseling for prenatal and postpartum depression Note: Here are some things to keep in mind: • Hospital services are covered under Section 5(c). • New members under this certificate who are in their third trimester as of their effective date and are seeing an out-of-network provider are allowed to continue receiving care with their Out-of-Network Provider for the duration of their pregnancy and until their first postpartum checkup. Services provided by an out-of-network provider require prior authorization. • You do not need to pre-certify your vaginal delivery; see See Section 3, How You Get Care, page 17 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery, (you do not need to pre- certify the normal length of stay). We will extend your inpatient stay for you or your baby if medically necessary. See Section 3, How You Get Care, page 17 for other circumstances. • We cover routine nursery care of the newborn child during the covered portion of the mother maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.	Nothing

Maternity care - continued on next page

Benefit Description	You pay
Maternity care (cont.)	**Basic**
• Dean Health Plan follows the United States Preventive Service's Task Force (USPSTF) recommendations for preventive services. We allow services that receive an "A" or "B" rating. We do cover certain services under the ACA (preventive services) related to pregnancy at no member cost share. • You may review the Health Resources and Services Administration (HRSA) guidelines available at www.hrsa.gov/ womensguidelines/ and related federal guidance for additional detail. • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b). Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.	Nothing
Not covered: • *Amniocentesis, CVS (Chorionic Villi Sampling), or noninvasive pre-natal testing when performed exclusively for sex determination.* • *Birthing classes (e.g. Lamaze).* • *Elective abortions.* • *Services, Drugs, or supplies related to abortions, except when: 1) an individual suffers from a physical disorder, physical injury, or physical illness that would place the individual in danger of death unless an abortion is performed; 2) the pregnancy is the result of an act of rape or incest.* • *Home or intentional out of hospital deliveries (e.g. free standing birthing centers).* • *Maternity services received outside the service area during the last 30 days of the pregnancy except for emergency and urgent care services.* • *Treatment, services or supplies for a non-Member traditional surrogate or gestational carrier.*	*All charges*
Family planning	**Basic**
Contraceptive counseling on an annual basis A range of voluntary family planning services, limited to: • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo-Provera) • Intrauterine devices (IUDs) • Diaphragms • Tubal ligation Note: We cover oral contraceptives under the prescription drug benefit.	Nothing
• Vasectomy (in an office setting)	$40 copayment per visit - Primary Care Provider $80 copayment per visit - Specialist

Family planning - continued on next page

Benefit Description	You pay
Family planning (cont.)	**Basic**
Not covered: • *Reversal of voluntary surgical sterilization*	*All charges*
Infertility services	**Basic**
Diagnosis of infertility	See Section 5(a) for covered labs, diagnostic test and x-rays. See Section 5(b) for covered surgical services. See Section 5(f) for covered prescription drugs.
Physician, hospital and ambulatory surgical center services for the treatment of infertility, such as: • Artificial insemination up to six cycles annually: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) • Other Services, such as: - Chromotubation - Fimbrioplasty - Salpingostomy - Labs - Injectable drugs billed on medical claims • Fertility drugs (See Prescription Drugs in Section 5(f)) Note: **Fertility Treatment** is the treatment or procedure intended to assist conception, undergone as the result of infertility or for any other reason. **Infertility** is a disease of the reproductive system defined by the failure to achieve a pregnancy by any means including artificial insemination after 12 months or more of attempts to conceive for individuals under age 35; and 6 months for individuals age 35 and older. Infertility may also be established through evidence of medical history and diagnostic testing. The diagnosis of infertility and certain services for fertility treatment in connection with the voluntary planning of conceiving a child are covered. Coverage includes benefits for professional, hospital and ambulatory surgical center services. Services for the diagnosis of infertility and fertility treatment must be received from or under the direction of a physician. All services, supplies, drugs and associated expenses for fertility treatment are not covered. See Section 5(f). Prescription Drug Benefits for coverage of fertility treatment drugs.	50% of the allowed amount of covered services. Member pays 100% of all artificial insemination charges that exceed the six cycle annual limit.

Infertility services - continued on next page

Benefit Description	You pay
Infertility services (cont.)	**Basic**
Prior authorization (approval in advance) is required before you receive certain biologics, biosimilars and professionally administered drugs. Certain biologics, biosimilars and professionally administered drugs may be subject to step therapy. In certain cases, it is possible to get an exception to step therapy requirements. To obtain more information about the step therapy exception process, call the Dean Health Plan Customer Care Center at the number listed on the front of this certificate. To determine if Dean Health Plan requires prior authorization for a particular service or treatment, please call the Dean Health Plan Customer Care Center at the number listed on the front of this certificate. Please see Section 3. How You Get Care for more information about prior authorization requirements and processes.	50% of the allowed amount of covered services. Member pays 100% of all artificial insemination charges that exceed the six cycle annual limit.
Not covered: *Consultation, treatment, or procedures for Assisted Reproductive Technology (ART).* ***Assisted Reproductive Technology (ART):*** All treatments or procedures that include the handling of human eggs, sperm, and/or embryos to help an individual become pregnant. ART includes, but is not limited to, gamete intrafallopian transfer (GIFT), uterine embryo lavage, embryo transfer, in vitro fertilization (IVF), pronuclear state transfer (PROST),tubal embryo transfer (TET), zygote intrafallopian transfer (ZIFT), low tubal ovum transfer, intracytoplasmic sperm injection, cryopreservation (e.g., egg, embryo, sperm), and other third party-assisted ART methods (e.g., sperm donation, egg donation, Traditional Surrogates and Gestational Carriers, embryo donation).	*All charges*
Allergy care	**Basic**
• Testing and Treatment • Allergy injections	$80 copayment per visit (Treatment) Nothing (Testing Allergy Injections)
Allergy Serum	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*
Treatment therapies	**Basic**
• Chemotherapy • Dialysis - hemodialysis and peritoneal dialysis • Intravenous (IV)/infusion therapy - home IV and antibiotic therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed in Section 5(b), Organ/Tissue Transplants, page 52.	Nothing
• Respiratory and inhalation therapy • Cardiac and pulmonary rehabilitation services for cardiac disease and lung disease as medically necessary. Phase II treatment must begin within 90 days of surgery. • Cognitive rehabilitation therapy	$80 copayment per visit

Treatment therapies - continued on next page

Benefit Description	You pay
Treatment therapies (cont.)	**Basic**
• Proton beam radiation therapy • Intensity-modulated radiation therapy (IMRT) Note: Growth hormone therapy (GHT) is covered under the prescription drug benefit. We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary.	$80 copayment per visit
• Applied behavior analysis (ABA) therapy for autism spectrum disorder	$40 copayment per day per therapy type
Therapies & Rehabilitation services	**Basic**
Autism ***Please contact our Customer Care Center for coordination of care assistance.*** Covered Expenses: • Services specifically related to a primary verified diagnosis of autism spectrum disorder, which includes autism disorder, Asperger's syndrome and pervasive development disorder not otherwise specified. Verified diagnosis must be conducted by a provider skilled in testing and in the use of empirically validated tools specific for autism spectrum disorders. For the diagnosis to be valid, the evidence must meet the criteria for autism spectrum disorder in the most recent Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. These services include: - **Diagnostic testing**, if testing tool is appropriate to the age of the Member and determined through the use of empirically validated tools specific for autism spectrum disorders. Dean Health Plan reserves the right to require a second opinion with a provider mutually agreeable to the Member and Dean Health Plan. - **Intensive level services.** The Member is eligible for 4 years of intensive level services. Any previous intensive-level services received by the Member will be counted against this requirement under this Policy, regardless of payor. Intensive level services must be consistent with the following: • Evidence based • Provided by a qualified provider as defined by state law • Based on a treatment plan developed by a qualified provider or professional as defined by state law that includes an average of 20 or more hours per week over a six-month period of time with specific cognitive, social, communicative, self-care or behavioral goals that are clearly defined, directly observed and continually measured. Treatment plans shall require that the Member be present and engaged in the intervention. • Provided in an environment most conducive to achieving the goals of the Members treatment plan	$40 office visit copayment per visit will apply where applicable (i.e. Autism intensive/non-intensive physician and facility charges)

Therapies & Rehabilitation services - continued on next page

Benefit Description	You pay
Therapies & Rehabilitation services (cont.)	**Basic**
• Includes training and consultation, participation in team meetings and active involvement of the Member's family and treatment team for implementation of the therapeutic goals developed by the team. • Commences after an insured is 2 years of age and before the insured is 9 years of age. • Services must be assessed for progress and documented throughout the course of treatment. • The Member must be directly observed by the qualified provider at least once every two months. **Non-intensive level services.** The Member is eligible for non-intensive level services, including direct or consultative services, that are evidence-based and are provided by a qualified provider or qualified paraprofessional if one of following conditions apply: • After the completion of intensive level services and designed to sustain and maximize gains made during intensive-level treatment. • To a Member who has not and will not receive intensive-level but for whom non-intensive level services will improve the member's condition. Non-intensive level services must be consistent with the following: • The services are based upon a treatment plan and includes specific therapy goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that the Member be present and engaged in the intervention. • Implemented by qualified providers, qualified supervising providers, qualified professionals, qualified therapists or qualified paraprofessionals as defined by state law. • Provides treatment and services in an environment most conducive to achieving the goals of the Member's treatment plan. • Provides training and consultation, participation in team meetings and active involvement of the Member's family in order to implement therapeutic goals developed by the team • Provides supervision for qualified professionals and paraprofessionals in the treatment team. • Services must be assessed for progress and documented throughout the course of treatment.	$40 office visit copayment per visit will apply where applicable (i.e. Autism intensive/non-intensive physician and facility charges)
Not covered Autism Expenses:* • *Animal-based therapy including hippotherapy* • *Auditory integration training* • *Chelation therapy* • *Child care fees* • *Cost for the facility or location of for the use of the facility or location when treatment, therapy or services are provided outside a Member's home.* • *Cranial sacral therapy* • *Custodial or respite care*	*All charges*

Therapies & Rehabilitation services - continued on next page

Benefit Description	You pay
Therapies & Rehabilitation services (cont.)	**Basic**
• *Hyperbaric oxygen therapy* • *Provider travel expenses* • *Special diets and supplements* • *Therapy, treatment or services to a Member residing in a residential treatment center, inpatient treatment or day treatment facilities* • *Prescription drugs and durable medical equipment*** **Please also see General Exclusions* ***These items may be covered under the normal terms and conditions of the policy and are not covered under the Autism benefit. Please see Section 5(f). Prescription drug benefits, if applicable, and/or Section 5(a). Medical services and supplies provided by physician and other health care professionals (Durable Medical Equipment) for more information.*	*All charges*
Physical and Occupational therapies	**Basic**
Outpatient visits if significant improvement can be expected within two months for the services of each of the following: • Qualified physical therapists • Occupational therapists Note: We only cover therapy when a provider: • orders the care; • identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • indicates the length of time the services are needed. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.	$80 copayment per day per therapy type
Biofeedback when prior authorization is obtained.	$80 copayment per day per therapy type
Habilitative Services • Physical therapy, occupational therapy and speech therapy. • Counseling. • Behavioral health services. • Habilitative services for Developmental delay. • Cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings. Note: Certain services require Prior Authorization. Please contact the Customer Care Center for a current list of services that require Prior Authorization.	$80 copayment per visit

Physical and Occupational therapies - continued on next page

Benefit Description	You pay
Physical and Occupational therapies (cont.)	**Basic**
Not covered: • *Custodial care* • *Daycare* • *Recreational care* • *Respite care* • *Vocational training* • *Exercise programs*	*All charges*
Speech therapy	**Basic**
Outpatient visits when medically necessary Note: Inpatient speech therapy is billed by the hospital and included under the inpatient hospital service/authorization.	$80 copayment per day per therapy type
Hearing services (testing, treatment, and supplies)	**Basic**
• Hearing services to determine if correction is needed • Treatment related to illness or injury, including diagnostic hearing tests performed by an M.D., D.O., or audiologist	$40 copayment per visit (Test & Examination) Nothing (Treatment)
• One hearing aid per ear every 36 months • One adult hearing aid per ear, including repairs, ear molds and hearing aid dispensing fees. The hearing aid must be repaired by/purchased from SSM Health Dean Medical Group, or other authorized providers. Please contact the Customer Care Center with questions regarding authorized providers, or reference our website at www.deancare.com. • Infants and children through age 18 who are certified as deaf or hearing impaired by a physician or audiologist are eligible for bilateral hearing aids. Benefits are available per benefit period. The benefit period is 36 consecutive months from the date the benefit is first used. • Cochlear implants for children and adults, including procedures for implantation and post-cochlear implant aural therapy. For therapy benefits please refer to Section 5(a) Orthopedic and prosthetic devices for benefits for devices.	$300 copayment (Hearing Assistive Devices) Cochlear Implants subject to inpatient hospital facility copayment. See Section 5(c). for charges associated with the facility (i.e. hospital, surgical center, etc.).
Note: • For routine hearing screening performed during a child's preventive care visit, see Section 5(a) Preventive care, children.	$300 copayment (Hearing Assistive Devices) Cochlear Implants subject to inpatient hospital facility copayment. See Section 5(c). for charges associated with the facility (i.e. hospital, surgical center, etc.).
Not covered: • *Batteries and chargers for hearing aids* • *Hearing aids that are available over-the-counter*	*All charges*

Benefit Description	You pay
Vision services (testing, treatment, and supplies)	**Basic**
• Routine vision exam (limited to one per contract year) • Non-routine vision exam • Vision care services - An initial lens (eyeglass lens or contact lens) following surgical repair of the eye. • For purposes of this benefit, reasons for surgical repair include treatment for cataracts or diseases of the cornea surface. - Therapeutic contact lenses for the treatment of the following diseases of the ocular surface, when these contact lenses will result in significantly better visual and/or improved binocular function when compared to eyeglasses, such as the following conditions: • Keratoconus; • Pathological myopia; • Aphakia; • Anisometropia; • Aniridia; • Corneal disorders; • Post-traumatic disorder; • Irregular astigmatism; • High ametropia; • Bullous keratopathy - Diagnostic vision services	Exam and Testing - $40 copayment per visit with primary care provider; $80 copayment per visit with specialist Vision Treatment or Supplies - Nothing
Not covered: • *Eyeglasses, contact lenses or fitting of contact lenses* • *Radial keratotomy and other refractive surgery*	*All charges*
Foot care	**Basic**
• Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$80 copayment per visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above.* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery).*	*All charges*

Benefit Description	You pay
Orthopedic and prosthetic devices	**Basic**
• Artificial limbs and eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Lenses following cataract removal; or therapeutic contact lenses/bandages as well as the fitting as determined by Us. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. • Prescription support stockings. Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical and anesthesia services. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services. Durable medical equipment may require prior authorization as stated in our medical policies. Your plan doctor will obtain the prior authorization. Bone anchored hearing aids do not require a prior authorization.	Nothing
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics (that are not custom made)* • *Heel pads and heel cups* • *Lumbosacral supports* • *Non-prescription elastic support or anti-embolism stockings* • *Prosthetic replacements provided less than 3 years after the last one we covered*	*All charges*
Durable medical equipment (DME)	**Basic**
Durable medical equipment may require prior authorization as stated in our medical policies. Your plan doctor will obtain the prior authorization. Rental of a ventilator or other mechanical equipment or purchase of such equipment at the option of Dean Health Plan. • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches, splints, trusses, orthopedic braces and appliances • Walkers • Insulin pumps	Nothing

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	**Basic**
• TENS unit • Oxygen therapy and other inhalation therapy and related items for home use • Speech generating devices	Nothing
Not covered: • *Repairs and replacement of durable medical equipment/supplies unless they are prior authorized by Us.* • *Non-prescription elastic support or anti-embolism stockings* • *Shoes or orthotics that are not custom made and can be purchased over the counter.* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.* • *Medical supplies and durable medical equipment for comfort, personal hygiene, and convenience, regardless of the Medical Necessity of such items.* *Examples include, but are not limited to: air conditioners, air cleaners, humidifiers, physical fitness equipment, Health Care Provider equipment except as covered by our Medical policy, disposable supplies, alternative communication devices, and self-help devices not medical in nature.* • *Home testing and monitoring supplies and related equipment except those used in connection with the treatment of diabetes,* • *Equipment, models or devices that have features over and above that which is medically necessary. Coverage will be limited to the standard model as determined by Us.* • *Any durable medical equipment or supplies used for work, athletic or job enhancement.*	*All charges*
Medical Foods and Enteral Therapy Durable medical equipment may require prior authorization as stated in Our medical policies. Your plan doctor will obtain the prior authorization. • Medical foods to be covered without regard to age, mode of administration (oral vs. nasogastric tube), narrow arbitrary limitations to specific diseases (e.g. PKU), or whether it is the sole source of nutrition for that individual for those members with diagnosis of cystic fibrosis, amino acid, organic acid, fatty acid, metabolic and absorption disorders as well as other conditions when prescribed to treat the member's condition and as described in Our medical policy. • Amino acid based elemental oral formula is covered for members up to five (5) years of age with IgE mediated allergies to food proteins, food protein-induced enterocolitis syndrome, eosinophilic esophagitis and other conditions when prescribed to treat the member’s condition and as described in Our medical policy. • Synthetic or semi-synthetic enteral feeding is covered with Prior Authorization for members when this feeding supplies the member's sole source of nutrition, is to be delivered via naso-gastric, jejunostomy or gastrostomy tube, and criteria are met as described in Our medical policy.	Nothing

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	**Basic**
Note: Medical supplies and equipment are covered when prescribed by your plan physician for treatment of a diagnosed illness or injury. The supplies or equipment must be purchased from a plan durable medical equipment provider. Oral nutrition is covered when mandated by law or covered under Our medical policy for a specific condition. Items available at grocery stores are not considered medical foods and therefore are not covered.	Nothing
Not covered: • *Oral nutrition is not considered a medical item. We do not cover nutritional support that is taken orally (i.e., by mouth), unless mandated by law or covered under Our medical policy for a specific condition. Examples include, but are not limited to, over-the-counter nutritional supplements, infant formula and donor breast milk.*	*All charges*
Home health services	**Basic**
• Home healthcare ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L. V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	$80 copayment per visit
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship, or giving oral medication* • *Private duty nursing or nursing aide*	*All charges*
Chiropractic	**Basic**
• Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	$40 copayment per visit
Not covered: • *Maintenance and long term therapies.*	*All charges*
Osteopathic manipulative treatment	$80 copayment per visit
Alternative treatments	**Basic**
Acupuncture - by a doctor of medicine or osteopathy, or licensed or certified acupuncture practitioner. Note: Limited to 10 visits per member per contract year. Please visit our website at www.deancare.com for a list of participating acupuncturists.	$80 copayment per visit
Not covered: • *All other forms of alternative medicine not otherwise listed in the policy.*	*All charges*

Benefit Description	You pay
Educational classes and programs	**Basic**
Tobacco cessation As part of your health benefits, Dean Health Plan provides coverage of tobacco cessation medications. You can receive any of the tobacco cessation medications listed on the drug formulary with no member cost-sharing. To take advantage of this benefit you must obtain a prescription from your doctor and may enroll in the Dean Health Plan Quit for Life® program. The Quit For Life® Program is completely free to Dean Health Plan commercial members 18 years and older. Using a mix of medication and phone-based coaching, it can help you down the path to quit smoking and overcome physical, psychological and behavioral addictions to nicotine dependence. A highly trained Quit Coach® helps you gain the knowledge, skills and behavioral strategies to quit for life. Free of Cost - the program includes: • up to five outbound coaching calls and unlimited access to a Quit Coach for the duration of the program; • a printed workbook that helps guide you through the quitting process; • an opportunity to receive twelve weeks of the NRT patch or gum at no cost, mailed directly to your home. The Quit For Life® Program uses four essential practices to quit: 1. Quit At Your Own Pace: Quit on your own terms, but get the help you need, when you need it. 2. Conquer Your Urges to Smoke: Gain the skills you need to control cravings, urges and situations involving alcohol. 3. Use Medications So They Really Work: Learn how to supercharge your quit attempt with the proper use of nicotine substitutes or medications. 4. Don't Just Quit, Become a Nonsmoker: Once you've stopped using tobacco, learn to never again have that "first" cigarette. Enroll Now! Enrollment in The Quit for Life® Program is easy! Call 866-QUIT4LIFE (866-784-8454) or enroll online at www.deancare.com/quitforlife.	Nothing
Diabetic Education • Diabetic education • Diabetic self-management training classes	Nothing
Not covered • *Educational services, except for diabetic education* • *Group counseling*	*All charges*
Nutritional Counseling and Education Visits Nutritional counseling services by a registered dietician when both of the following are true:	$80 copayment per visit

Educational classes and programs - continued on next page

Benefit Description	You pay
Educational classes and programs (cont.)	**Basic**
• Patient self-management is an important component of the treatment for a disease. • There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.	$80 copayment per visit
Not covered: • *Food or medical food formulated to be consumed or administered internally under the supervision of a physician intended for specific dietary management.* • *Nutritional supplements or vitamins.*	*All charges*

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- There is no calendar year deductible.
- There is no calendar year coinsurance.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other healthcare professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay
Surgical procedures	**Basic**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Insertion of internal prosthetic devices. See 5(a) - Orthopedic and prosthetic devices for device coverage information. • Cochlear implant procedures • Voluntary sterilization (e.g., vasectomy) • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	Nothing See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.). See Section 5(a) diagnostic and treatment services for surgical services provided in an office setting.
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot (see Foot care)* • *Sexual dysfunction treatment.*	*All charges*

Benefit Description	You pay
Medical Weight Management Services and Bariatric Surgery	**Basic**
Services listed in this subsection will not be paid unless you: 1. Obtain Prior Authorization to participate in the Dean Comprehensive Weight Management Program ("Program"); and 2. Meet the criteria listed within the appropriate Dean Health Plan Medical Policy. Please contact Our Customer Care Center at 800-279-1301 (TTY: 711) for the criteria. Prior Authorization may only be granted after you have consulted with a Program provider. Only certain Dean Health Plan providers qualify as Program providers. Contact our Customer Care Center at 800-279-1301 (TTY: 711) for a listing of plan providers. Any surgery must be performed at SSM Health St. Mary's Hospital - Madison or the SSM Health Surgery Center in Madison, Wisconsin. Covered Expenses: • Medical weight management services received through the Program. • Surgical treatment of severe obesity (bariatric surgery) • Bariatric surgery for the treatment of morbid obesity. • Follow-up care services.	Nothing See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.). See Section 5(a) for surgical services provided in an office setting.
Not covered: • *Treatments, services or procedures that are not Medically Necessary nor approved by Us.* • *Diet supplements.* • *Low-calorie foods and beverages.* • *Weight loss books and materials obtained through the Program or other outside sources.* • *Body sculpting procedures related to weight loss.*	*All charges*
Reconstructive surgery	**Basic**
We adhere to WPATH Standards for gender affirming care and services, including facial feminization. There are no exclusions for WPATH Standards. • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. • Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts - treatment of any physical complications, such as Lymphedemas - breast prostheses and surgical bras and replacements (see Prosthetic devices)	Nothing See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.). See Section 5(a) for surgical services provided in an office setting.

Reconstructive surgery - continued on next page

Benefit Description	You pay
Reconstructive surgery (cont.)	**Basic**
• Gender Affirming Surgeries. Gender transitions surgeries include, but are not limited to, the following with prior authorization: - **For female to male transition:** surgeries and procedures such as: Mastectomy, Hysterectomy, Vaginectomy, Salpingo-Oophorectomy, Breast reduction, Nipple – Areola Reconstruction, Metoidioplasty, Phalloplasty, Urethroplasty/ Urethromeatoplasty, Scrotoplasty, Placement of Testicular and Penile (erectile) Prosthesis, secondary sex characteristics - **For male to female transition:** surgeries and procedures such as: Penectomy, Orchiectomy, Breast Augmentation Mammoplasty and Implants, Repair of Introitus, Coloproctostomy, Vaginoplasty, Colovaginoplasty, Clitoroplasty, Labiaplasty, secondary sex characteristics Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Nothing See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.). See Section 5(a) for surgical services provided in an office setting.
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury*	*All charges*
Oral and maxillofacial surgery	**Basic**
• Surgery consult and/or evaluation. • Surgical procedures as follows: - Removal of impacted teeth - Removal of tumors and cysts that are not related to non-bony impacted teeth. - Treatment for accidental injuries of the jaw, cheeks, lips, tongue, roof, and floor of mouth. - Apicoectomy. - Removal of exostoses of the jaw and hard palate when not performed to facilitate denture placement. - Treatment of fractured facial bones. - External/ internal incision and drainage of facial abscess of soft tissues. - Cutting of accessory sinuses, salivary glands or ducts. - Reducing dislocations; alveoloplasty. - Lingual frenectomy. - Vestibuloplasty. - Residual root removal Medically Necessary Anesthesia and Facility Charges for Dental Procedures Charges for medical facilities (e.g. hospital, ambulatory surgery center (ASC)) and general anesthesia services for dental care will be covered if the member is a child under the age of five. Charges for medical facilities and general anesthesia services will be covered in the ASC or hospital location if the member is five years and older if any of the following applies: • The Member has a chronic disability that;	$80 copayment per visit (surgery consult and/or evaluation) $80 copayment per visit (all other services)

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay
Oral and maxillofacial surgery (cont.)	**Basic**
• Is attributable to a behavioral or physical impairment or combination of behavioral and physicial impairments; • Is likely to continue indefinitely; and • Results in substantial functional limitation in self-care, language, learning mobility, capacity for independent living or economic self-sufficiency; or • The Member has a medical condition requiring hospitalization or general anesthesia for dental care. Temporomandibular Joint Disorders (TMJ) Coverage is limited to diagnostic procedures, including diagnostic casts, diagnostic study models and bite adjustments, and Medically Necessary surgical or non-surgical treatment for the correction of temporomandibular joint disorders (TMJ), if the following apply: • Under the accepted standards of the profession of the Health Care Provider rendering the service, the procedure or device is reasonable and appropriate for the diagnosis or treatment of this condition. • The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction. • Orthognathic surgery only for the treatment of TMD, when prior authorized by Us.	$80 copayment per visit (surgery consult and/or evaluation) $80 copayment per visit (all other services)
Not covered: *Expenses for Oral Surgery* • *All charges or costs exceeding a benefit maximum.* • *All dental services, except those listed as covered in Section 5(g). Dental Benefits subsection.* • *Surgery performed to correct functional deformities of the mandible or maxilla.* • *Correction of malocclusion.* • *Orthognathic surgery; except for the treatment of TMJ.* • *Orthodontic care, periodontic care, or general dental care.* • *Restoration. Examples include but are not limited to crowns and root canals.* • *Tooth damage due to eating, chewing or biting.* *Not covered Expenses for Hospitalization for Dental Procedures:* • *Hospitalization costs for services not listed in this Section, except those listed in the Hospital and Dental Services subsections, for which Prior Authorization is required.* • *Any non-hospital or non-ambulatory surgery center facility charges* • *Any charges related to dental procedures unless listed as a Covered Expense elsewhere in this Certificate.* *Expenses for Temporomandibular Joint Disorders (TMJ):* • All dental services, except those listed as covered in this TMJ subsection.	*All charges*

Benefit Description	You pay
Organ/tissue transplants	**Basic**
These **solid organ transplants** are covered. These solid organ transplants are subject to medical necessity and experimental/investigational review by the Plan. See other services under Section 3, You need prior approval for certain services, page 18. Solid organ transplants are limited to: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-pancreas • Liver • Lung: single/bilateral/lobar • Pancreas These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to Other services in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	Nothing See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.). See Section 5(a) for surgical services provided in an office setting.
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hematopoietic Stem Cell Transplant (HSCT) - Hemoglobinopathy - Infantile malignant osteopetrosis	Nothing See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.). See Section 5(a) for surgical services provided in an office setting.

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**Basic**
- Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast Cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Hematopoietic Stem Cell Transplant (HSCT) - Medulloblastoma - Multiple myeloma - Neuroblastoma - Pineoblastoma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors	Nothing See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.). See Section 5(a) for surgical services provided in an office setting.
Mini-transplants performed in a clinical trial setting (nonmyeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed)	Nothing See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.). See Section 5(a) for surgical services provided in an office setting.

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**Basic**
- Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	Nothing See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.). See Section 5(a) for surgical services provided in an office setting.
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Multiple myeloma - Multiple sclerosis - Sickle Cell anemia Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Chronic lymphocytic leukemia • Chronic myelogenous leukemia • Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL)	Nothing See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.). See Section 5(a) for surgical services provided in an office setting.

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**Basic**
• Multiple myeloma • Multiple sclerosis • Myelodysplasia/Myelodysplastic Syndromes • Myeloproliferative disorders (MSDs) • Sickle cell anemia • Autologous Transplants for - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin lymphomas - Breast Cancer - Childhood rhabdomyosarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Systemic lupus erythematosus - Systemic sclerosis Note: Coverage for organ-procurement costs is limited to costs directly related to the procurement of an organ from a cadaver or compatible living donor. Organ-procurement costs include the following: organ transportation, compatibility testing, hospitalization, and surgery (when a live donor is involved).	Nothing See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.). See Section 5(a) for surgical services provided in an office setting.
National Transplant Program (NTP)	Nothing See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.). See Section 5(a) for surgical services provided in an office setting.
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*

Benefit Description	You pay
Anesthesia	**Basic**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Provider office	Nothing

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- There is no calendar year deductible.
- There is no calendar year coinsurance.
- Observation: In a hospital facility, Observation care is a set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment and reassessment. Treatment can frequently include surgical services to resolve an urgent, unforeseen condition. An Observation stay is considered an outpatient service and is paid as an outpatient benefit. It is an alternative to an inpatient hospital admission to allow reasonable and necessary time to evaluate and render medically necessary services to a member and determine if they may require an inpatient stay or follow-up care in another setting.
- Be sure to read Section 4, Your costs for covered services for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay
Note: When the calendar year deductible does not apply we indicate - "Deductible does not apply"	
Inpatient hospital	**Basic**
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$1,000 copayment per day up to a maximum of $3,000 per contract year
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	$1,000 copayment per day up to a maximum of $3,000 per contract year

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	**Basic**
Note: Inpatient dental procedures – limited benefit. Hospitalization for certain procedures is covered when a Plan doctor determines there is a need for hospitalization for reasons totally unrelated to the dental procedure; the Plan will cover the hospitalization, but not the cost of the professional dental services. Conditions for which hospitalization would be covered include hemophilia and heart disease; the need for anesthesia, by itself, is not a condition. The Plan will not cover the cost of the professional dental services. If you request a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$1,000 copayment per day up to a maximum of $3,000 per contract year
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as phone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	**Basic**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	$1,000 copayment per occurrence up to a maximum of $3,000 per contract year
Extended care benefits/Skilled nursing care facility benefits	**Basic**
Extended care benefit: The plan provides a comprehensive range of benefits for up to 30 days per confinement when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. All necessary services are covered, including: • Bed, board and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor	$80 copayment per day
Not covered: Custodial care	*All charges*

Benefit Description	You pay
Hospice care	**Basic**
Hospice Care • Inpatient hospice • Hospice services while at a skilled nursing facility • Home-based hospice • Respite care is a form of hospice service that give your uncompensated primary caregivers (i.e. family members or friends) rest or relief when necessary to maintain a terminally ill Member at home. • Respite care is limited to five consecutive days per plan year. • Respite care is available once per plan year. • Respite services managed through credentialed hospice provider.	$80 copayment per visit
Not covered: • *Independent nursing, homemaker services* • *Respite care for more than five consecutive days*	*All charges*
End of life care	**Basic**
Dean Health Plan partners with Vital Decisions Living Well Program, offering telephonic health care counseling to individuals and their families who are experiencing serious illness. The phone counseling is offered at no cost to the member and can be extremely beneficial by supporting participants in making important health decisions. The Living Well Program, which is a voluntary, patient-centered service, will: help individuals identify their quality of life preferences and values; assist patients in actively and effectively communicating their priorities to family and physicians and ensure that more effective shared decision making occurs.	Nothing
Palliative care	**Basic**
Palliative Care • Palliative care team may include providers such as doctors, nurses, or social workers. • These services are coordinated by a palliative care provider and must be Medically Necessary. • Prior Authorization may be required for in-home palliative care services. Please contact the Customer Care Center for information on which services require prior authorization. **Covered Expenses:** • Outpatient visits with palliative care providers. • In-home visits with a palliative care provider or team member for member-facing issues associated with advanced life-limiting illnesses. Must be prior authorized. • Licensed skilled nursing. • Licensed medical social worker.	Nothing
Non-covered Expenses for Palliative Care: • *Custodial Care or any service that is not required to be provided by a skilled/ licensed provider.* • *Services provided by volunteers.* • *Residential Care.*	*All charges*

Palliative care - continued on next page

Benefit Description	You pay
Palliative care (cont.)	**Basic**
• *Housekeeping or homemaking services.* • *Home care services provided by a family member or someone that resides with the Member.*	*All charges*
Ambulance	**Basic**
Ambulance • Ambulance transportation must be provided by an established state-licensed ambulance service and comply with all local and federal laws. • Out-of-network air ambulance services are covered at the in-network level. **Ground Ambulance Services** • Ground ambulance transportation to or from a hospital in urgent or emergency situations when medical attention is required along the way. • Non-urgent or non-emergency ground ambulance transportation situations in the following circumstances: - The Member needs to be transported from one acute inpatient facility setting to another inpatient facility care setting. - The Member is transported from an acute facility to another acute care site because Medically Necessary services are not available in the hospital the Member was admitted. The Member will be transported back to the original facility upon completion of services. - The Member is a mother whose baby requires transfer to a higher level of care, and the mother requires an inpatient level of post-partum care and has been accepted for admission at the receiving facility. - Other non-urgent or non-emergency ground ambulance transportation involving transport between higher level of care to lower level of care or transport between lower levels of care, when the Member requires medical care en route, may require Prior Authorization. - Please contact Our Customer Care Center about services that require Prior Authorization. • Ground ambulance services when transportation is not provided, in the following circumstances: - Transportation is unplanned; - Services are provided by qualified medical professionals from the ambulance provider; and - Services are deemed Medically Necessary to treat the injury or medical condition that prompted the call for the ambulance.	$300 copayment

Ambulance - continued on next page

Benefit Description	You pay
Ambulance (cont.)	**Basic**
Air and Water Ambulance Transportation • Ambulance transportation to transfer a Member to a hospital or from one hospital to another hospital is covered if all of the following requirements are met: - The Member needs to be transported due to an emergency situation and requires medical attention along the way; - Using any other method of transportation, including ground ambulance transportation, would endanger the Member's health; - The transferring hospital cannot provide the hospital or skilled nursing care the Member's illness or injury requires; and - The facility which receives the transported Member is the nearest one with appropriate facilities. *Not covered:* • Non-emergency or non-urgent ground or air ambulance services or transportation, unless the transportation or service is listed as a Covered Expense under Ground Ambulance Transportation in the Section or is Prior Authorized by Us. • Charges for, or in connection with, any other form of travel, unless otherwise stated in this Section. • Member's condition does not meet medical criteria for ambulance services or transportation. • Any ambulance transportation or services initiated for convenience or non-medical reasons.	$300 copayment

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- There is no calendar year deductible.
- There is no calendar year coinsurance.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

Emergencies within our service area:

If you are in an emergency situation please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 phone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member should notify the Plan within 48 hours or when medically feasible. It is your responsibility to ensure that the Plan has been notified, unless it was not reasonably possible to notify the Plan within that time.

If you need to be hospitalized in a non-Plan facility, the Plan should be notified within 48 hours following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in a non-Plan facility and if the Plan believes your care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

Any follow up care recommended by non-Plan providers must be prior authorized by the Plan, or provided by Plan providers.

Plan pays reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers; this is called maximum allowable fee. This is the maximum allowable amount payable based upon the average charge for the same service provided by other providers of a similar type, training, and experience, the same or similar geographical area and should not exceed the fees that the provider would charge any other payor for the same service. Other factors such as but not limited to, complexity, degree of skill or type of provider may also determine a maximum allowable fee.

Emergencies outside our service area:

Benefits are available for any medically necessary health services that is immediately required because of injury or unforeseen illness. If you need to be hospitalized, the Plan should be notified within 48 hours following your admission, unless it was not reasonably possible to notify the Plan within that time. If the Plan believes you can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Any follow up care recommended by non-Plan providers must be prior authorized by the Plan, or provided by Plan providers.

Plan pays reasonable charges for emergency care services to the extent the services would have been covered if received from Plan providers; this is called maximum allowable fee. This is the maximum allowable amount payable based upon the average charge for the same service provided other providers of a similar type, training, and experience, the same or similar geographical area and should not exceed the fees that the provider would charge any other payor for the same service. Other factors such as but not limited to, complexity, degree of skill or type of provider may also determine a maximum allowable fee.

Benefit Description	You pay
Emergency within our service area	**Basic**
Emergency care at a doctor's office • With primary care provider	$40 copayment per visit $80 copayment per visit
Emergency care at a doctor's office • With specialist	Nothing
Emergency care at a doctor's office • Related services	
Emergency care at an urgent care center • With primary care provider or specialist	$40 copayment per visit Nothing
Emergency care at an urgent care center • Related services	
Emergency care as an outpatient at a hospital; including doctors' services Note: The ER copayment is waived if admitted for observation or inpatient directly from the emergency visit.	$300 copayment per visit
Not covered: Elective care or non-emergency care	*All charges*
Emergency outside our service area	**Basic**
Emergency care at a doctor’s office • With primary care provider	$40 copayment per visit $80 copayment per visit
Emergency care at a doctor’s office • With specialist	Nothing
Emergency care at a doctor’s office • Related service	
Emergency care at an urgent care center • With primary care provider or specialist	$40 copayment per visit Nothing
Emergency care at an urgent care center • Related services	
Emergency care as an outpatient at a hospital; including doctors' services Note: The ER copayment is waived if admitted for observation or inpatient directly from the emergency visit. *Not covered:*	$300 copayment per visit *All charges*

Emergency outside our service area - continued on next page

Benefit Description	You pay
Emergency outside our service area (cont.)	**Basic**
Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers. *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area.* *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area.*	*All charges*
Ambulance	**Basic**
Professional ambulance service when medically appropriate (ground or air). Note: See 5(c) for non-emergency service. Non-transport service is covered if medically appropriate.	$300 copayment per visit

Section 5(e). Behavioral Health and Substance Use Disorder Benefits

Important things you should keep in mind about these benefits:

- Court-ordered services may not be covered if those services are NOT performed by a Plan Provider, unless the services are a result of an Emergency Detention or received on an emergency basis.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary and with a plan provider unless otherwise authorized.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

YOU MUST GET PREAUTHORIZATION FOR CERTAIN SERVICES. Prior authorization must come from Us. Please contact the Customer Care Center for a current list of services that require prior authorization.

Benefit Description	You pay
Professional services	**Basic**
When part of a treatment plan we approve, we cover professional services by licensed professional behavioral health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. Diagnosis and treatment of psychiatric conditions, behavioral health illness, or behavioral health disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of substance use disorders, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	$40 copayment per visit (Outpatient)/Includes Telehealth Visits $1,000 copayment per day; limited to $3,000 per individual per contract year (Inpatient)

Benefit Description	You pay
Diagnostics	**Basic**
• Outpatient diagnostic tests provided and billed by a licensed behavioral health and substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	Nothing
Inpatient hospital or other covered facility	**Basic**
Inpatient behavioral health services means medically oriented treatment, psychotherapy and other behavioral health services provided by a licensed professional in a state licensed or certified hospital or behavioral health residential facility on a 24 hour per day basis to enable a person with a behavioral health disorder or a behavioral health disorder in combination with other impairments to function successfully. • Medically Necessary services provided at an in- network inpatient, behavioral health inpatient/residential facility. • Medically Necessary services at a substance use disorder residential/inpatient treatment programs for alcohol and/or drug dependent persons services provided by a licensed professional in a state licensed or certified facility. • Medically Necessary inpatient detoxification services are considered medical and, therefore, are NOT applied to this benefit. Please see the "Detoxification Services" provision under the Hospital subsection for more information on this coverage.	$1,000 copayment per day up to a maximum of $3,000 per contract year
Outpatient hospital or other covered facility	**Basic**
Partial hospitalization or day treatment programs are more intensive than outpatient services and less intensive than inpatient services. The services must be in a licensed behavioral health or substance use disorder partial hospitalization or day treatment facility with services by a licensed behavioral health or substance use disorder treatment services provider. • Medically Necessary outpatient services, including group, family and individual therapy in an office or clinic setting with a behavioral health or substance use disorder treatment in-network Provider. For Full-Time Students attending school in Wisconsin, but outside the service area: • A clinical assessment by an Out-of-Network Provider and 5 visits for outpatient behavioral health or substance use disorder treatment with an approved Prior Authorization. We retain the right to choose the provider. Further treatment may be approved upon review of Our Quality and Care Management division. Medically Necessary and prior authorized services for the following treatments and programs: • Behavioral health or substance use disorder treatment for adults, adolescents, and children in a partial hospitalization or day treatment program. • Services for persons with chronic behavioral health illness provided through a community program. These programs provide services to people with chronic behavioral health illnesses that, due to history or prognosis, require repeated acute treatment or prolonged periods of inpatient care. Benefits are payable only for charges directly related to treatment of behavioral health illness. • Intensive outpatient programs for the treatment of drug and alcohol use disorders. Treatment must be provided by specialists in addiction medicine.	$40 copayment per visit

Outpatient hospital or other covered facility - continued on next page

Benefit Description	You pay
Outpatient hospital or other covered facility (cont.)	**Basic**
• Intensive outpatient programs for the treatment of behavioral health disorders. • Coordinated emergency behavioral health services for persons who are experiencing a behavioral health crisis or who are in a situation likely to turn into a behavioral health crisis if support is not provided. Services are provided by a program certified for the period of time the person is experiencing a behavioral health crisis until the person is stabilized or referred to other providers for stabilization. Certified emergency behavioral health service plans shall provide timely notice to Us to facilitate coordination of services for persons who are experiencing, or are in a situation likely to turn into, a behavioral health crisis. Note: To qualify for coverage under behavioral health and substance use disorder treatment care, the care must be Medically Necessary and prior authorized by Us. • Medical Necessity will be reviewed by our Quality and Care Management division. To qualify, the treatment program must be staffed by a multi-disciplinary team, which should include registered nurses, occupational therapists, social workers, psychologists, physicians or other health care professionals. The treatment must be provided by substance use disorder treatment or behavioral health credentialed professionals and the treatment program must include a quality assurance program to review quality of care. • Prior Authorization will be approved if Our Quality and Care Management division determines that the Member requires more intensive treatment than is available through outpatient services and that the care is the most appropriate level of care for the Member. Prior Authorization does not guarantee payment if the services would not otherwise be covered according to the provisions of this Certificate.	$40 copayment per visit
Not covered: • *Biofeedback.* • *Family counseling for non-medical reasons.* • *Wilderness and camp programs, boarding school, academy-vocational programs and group homes.* • *Halfway houses.* • *Hypnotherapy.* • *Long-term or maintenance therapy.* • *Marriage counseling.* • *Phototherapy.*	*All charges*

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Federal law prevents the pharmacy from accepting unused medications.
- Your prescribers must obtain prior approval/authorization for certain prescription drugs and supplies before coverage applies. Prior approval/authorization must be renewed periodically.
- Certain prescription drugs included in our formulary require prior authorization. The drug prior authorization process can be initiated by your plan physician or your plan pharmacy by filling out a Drug Prior Authorization Request form. A copy of this request including the determination will then be mailed to you, your plan pharmacy, and plan physician.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy, national plan pharmacy or by mail for a maintenance medication.
- **We use a formulary**. Prescription drugs are included in our formulary by our plan Pharmacy and Therapeutics Committee to ensure that our members receive safe, effective treatment at a reasonable cost. The committee is staffed by providers from many different specialties. Drugs recently approved by the Food and Drug Administration are not automatically included in the formulary but may be added after the committee determines therapeutic advantages of the drug and it's medically appropriate application. In addition, certain drug products are excluded when therapeutic alternatives are available. If your physician prescribes a drug that is not on our formulary, the physician must obtain prior authorization from the Plan in order for the prescription to be covered under Plan benefits. In some cases, the physician will need to prescribe an alternative formulary drug if an alternative is available that is equally effective for the patient for treatment of the specific condition. To order a listing of the drugs that require prior authorization or are excluded, call our Customer Care Center at 800-279-1301 or visit our website at www.deancare.com.
- **Why use generic drugs?** Generic drugs contain the same active ingredients and are equivalent in strength and dosage to the original brand name product. Generic drugs cost you and your plan less money than a name-brand drug.
- **When you have to file a claim**. If you receive a prescription outside of the area or a situation arises where the pharmacy cannot process a prescription under the plan, you may submit an itemized receipt and completed Pharmacy Claims Member Reimbursement Form to us for reimbursement for all covered prescription drugs. Send the completed form and the receipt to: Dean Health Plan, P.O. Box 56099, Madison, WI 53705-7674.
- **A generic equivalent will be dispensed if it is available**, unless your physician specifically requires a name brand. If you receive a name brand drug when a FDA approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic. The Dispensed as Written penalty charges are not applied to your deductible or out-of-pocket maximum.

- **These are the dispensing limitations.** Certain drugs have Quantity Limits. Please refer to the formulary for these limits. Certain Drugs on Our formulary are only covered under Our Partial Fill Program. Our Partial Fill Program requires you to fill certain prescriptions for 15-day supplies for the first three months. You will pay half of the monthly cost-share. We assign Drugs to the specialty Drug category based upon the need to provide exceptional management such as: Prior Authorization; clinical oversight and monitoring; special handling; cost; and disease management and/or case management. Some specialty Drugs require Prior Authorization. Specialty Drugs must be obtained from Our Network specialty pharmacies. Certain specialty Drugs may be subject to the Partial Fill Program. Medications classified as specialty Drugs are identified on the formulary. If it is determined that you are receiving certain prescription drugs in a quantity or manner that may harm your health, benefits for these medications will be restricted to medications that are both prescribed by one specific network physician and dispensed by one specific network pharmacy. Failure to receive these medications in this manner will result in a denial of coverage. We will notify you regarding the specific physician and pharmacy assigned for you. The use of physician samples or manufacturer discount programs does not count toward historical drug utilization to guarantee drug coverage. All criteria, including Prior Authorization, Step Therapy, and any other requirements, must be met in order to obtain coverage of the drug. Prescription drugs prescribed by a Plan or referral doctor and obtained at a plan pharmacy will be dispensed for up to a 30 day supply or 100 unit supply, whichever is less; 240 milligrams of liquid (8oz); 60 grams of ointment, creams or topical preparation; or one commercially prepared unit (i. e., one inhaler, one vial opthamolic medication or insulin). You pay a copayment per prescription unit or refill for generic drugs or for name brand drugs when generic substitution is not permissible. When generic substitution is available, a generic equivalent will be dispensed, unless your physician specifically requires a name brand. If you received a name brand drug when a Federally approved generic drug is available, and your physician has not specified Dispensed as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic. The Dispensed as Written penalty charges are not applied to your out-of-pocket maximum. If you are called to active duty and require medication during a national emergency call us at 800-279-1301 for assistance.

Benefit Description	You pay
Covered medications and supplies	**Basic**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program • Drugs and medications that by Federal law of the United States require a physician's prescription for their purchase, except those listed as Not covered • Insulin, with a copayment applied to each vial • Diabetes care. We cover the following drugs and supplies related to diabetes care: - Insulin, disposable supplies and any prescription medication used to treat diabetes. Disposable supplies include: blood or urine glucose strips, control solutions for blood glucose monitors, finger stick devices, lancets and syringes. Single-packaged items such as blood glucose testing strips are limited to two items per cost-sharing amount. - Infusion pumps and related equipment and supplies are covered under the medical benefit as required by Wis. Stat. § 632.895(6) from a network durable medical equipment provider. - Continuous glucose monitoring equipment and related supplies. • Growth hormones (prior authorization required) • Drugs to treat gender dysphoria. Drug therapy for patients with gender dysphoria is established by the treating provider. Members should review their drug formulary for coverage information. Note: See Section 5(a) and 5(b) for intravenous fluids and medication for home use. Zyban is covered through the Tobacco Cessation benefit with no member cost share (see Tobacco cessation found in Section 5(a) - Educational classes and programs).	Tier 1 (Generics) $20 copayment* Tier 2 (Preferred brands and select generics) $45 copayment* Tier 3 (Non-preferred brands and select generics) $70 copayment* Tier 4 (Specialty drugs) $150 copayment* *Regardless of the tier your oral chemotherapy falls into you will never pay more than $100 for a 30-day supply, in compliance with the Wisconsin law governing coverage of oral chemotherapy drugs. Note: If there is no Tier 1 generic equivalent available, you will be required to pay the higher Tier 2 or Tier 3 copayment.

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**Basic**
6 for $6 Select unique generic medications for conditions such as diabetes, high blood pressure, mood disorders and bone health available to members for $6 for a 6-month supply at all participating in-network SSM Health retail pharmacies and Costco retail pharmacy. Refer to your drug formulary for the most current listing of eligible medications.	$6 for a 6 month supply
Mail Order Prescription Drug Benefit • 90-day supply for the cost of a 60-day supply (Tiers 1 and 2 only) • 90-day supply at mail order for 3 copayments (Tier 3)	Tier 1 (Generics) - $40 copayment Tier 2 (Preferred brands and select generics) - $90 copayment
• Specialty drugs not available at mail order (Tier 4)	Tier 1 (Generics) - $40 copayment Tier 2 (Preferred brands and select generics) - $90 copayment Tier 3 (Non-preferred brands and select generics) - $210 copayment Tier 4 (Specialty drugs) - 90-day supply not available
Contraceptive drugs and devices as listed in the ACA/HRSA site. Contraceptive coverage is available at no cost to FEHB members. The contraceptive benefit includes at least one option in all methods of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. • Over-the-counter contraceptives are a covered benefit with a prescription. • To obtain a non-formulary contraceptive for a member, the provider should fill out an Exception to Coverage form and send to the PBM. The PBM will approve the request if the provider notes that the non-formulary contraceptive product is medically necessary.	Nothing
Drugs to treat sexual dysfunction are limited to Viagra and Cialis. Contact the plan for dose limits.	50% copayment per unit or refill
• Outpatient Infertility drugs Self-Injectable and Oral medications for the diagnosis and treatment of infertility, except as described below under not covered. Dean Health Plan's drug formulary covers all related drug categories of fertility drugs, including IVF medications with an approved prior authorization when Prescribed by a Reproductive Specialist AND Member has a primary diagnosis of infertility AND this medication is NOT prescribed for assisted reproductive technology. The outpatient infertility pharmacy benefit allows for up to three IVF cycles annually (5 months of medications).	50% copayment of the allowed amount per unit or refill regardless of the tier the covered formulary drug is on.

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**Basic**
Note: See formulary for covered drugs at https://www.deancare.com/getmedia/95ae4b9f-4408-4462-a504-f82063259610/Traditional-4-Tier-Formulary.pdf See formulary management procedures at https://www.deancare.com/members/pharmacy-benefits/formulary-management-procedures	50% copayment of the allowed amount per unit or refill regardless of the tier the covered formulary drug is on.
Not covered: • *Drugs to enhance athletic performance* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Nonprescription medications unless specifically indicated elsewhere* • *Infertility drugs, including, but not limited to, those administered by a medical provider for the purpose of Assisted Reproductive Technology (ART).* • *Drugs prescribed by a provider who is not acting within their scope of licensure.* • *New to market Drugs. Products recently approved by the FDA and introduced into the market will not be covered until they are reviewed and considered for placement on Our Drug List.* • *New to market biologics, biosimilars and professionally administered drugs. Biologics, biosimilars and professionally administered drugs recently approved by the FDA (including approval for a new indication) will not be covered until they are reviewed and approved for coverage by Us.* • *If you fail to provide your prescription coverage information to the pharmacy, you will be responsible for any amount above what We would have paid for your prescription under this policy.* • *Products that are duplicative to, or are in the same class and category as, products on Our Drug list.* • *Drugs, supplies, biologics and biosimilars that have not been approved by the U.S. Food and Drug Administration (FDA).* • *Professionally administered drugs that do not meet both of the following requirements: (a) administered in conjunction with a covered benefit and (b) administered by a physician acting within the scope of the provider's license.* • *Any form, mixture or preparation of cannabis for medical or therapeutic use and any device or supplies related to its administration.* • *Services or drugs used to treat conditions that are cosmetic in nature, unless otherwise determined to be reconstructive.* *Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco and nicotine dependence are covered under the Tobacco cessation benefit. (See Section 5(a), Educational classes and programs, page 46.*	*All charges*

Benefit Description	You pay
Preventive Care Medications	**Basic**
Medications to promote better health as recommended by ACA The following drugs and supplements are covered without cost-share, even if over-the-counter, are prescribed by a healthcare professional and filled at a network pharmacy. • Select preventive medications from the drug formulary within the following categories: Antihypertensives, Antihyperlipidemics, Antidiabetics, Anticoagulants, Antiplatelets, Osteoporosis, Antiasthmatics/Bronchodilators and mental health medications • Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age • Folic acid supplements for women of childbearing age (400 & 800 mcg) • Liquid iron supplements for children age 0-1 year • Prescription strength vitamin D supplements for members age 65 or older (400 • Pre-natal vitamins for pregnant individuals • Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6 years Note: To receive this benefit a prescription from a doctor must be presented to pharmacy. Note: Preventive Medications with a USPSTF recommendation of A or B are covered without cost-share when prescribed by a health care professional and filled by a network pharmacy. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations.	Nothing
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Fertility drugs that are not approved by the plan* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them; except as required by ACA (except for Vitamin D for adults age 65 and older)* • *Nonprescription medications unless specifically indicated elsewhere* *Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco and nicotine dependence are covered under the Tobacco cessation benefit.* *(See Section 5(a), Educational classes and programs. page 46.)*	*All charges*

Benefit Description	You pay
Maintenance Medications - Tier 1 (Generics)	**Basic**
Mandatory 90-Day Generic Maintenance Drug Fill For Tier 1 generic maintenance Drugs as defined by Us, a retail provider must dispense a 90-day supply. This requirement will apply after you have received three consecutive 30-day supplies. • Tier 1 (Generics) maintenance drugs will be required to be filled at a 90-day supply. • For newly written prescriptions for a Tier 1 generic maintenance drug and new to taking this drug you will be allowed three 30-day fills of the drug before being required to fill at a 90-day supply. • Brand maintenance drugs are NOT mandatory to fill with a 90-day supply, but is optional if you wish to do so. • You will experience a lower out-of-pocket cost using our Costco mail order pharmacy (90-day supply for 2 copayments) vs. retail pharmacy (90-day supply for 3 copayments). Note: You may request an exception to this requirement to continue filling your Tier 1 (Generic) maintenance drug with a 30-day supply by either: 1) asking the retail pharmacy provider to contact Our pharmacy benefit manager (Navitus Health Solutions), or 2) contacting Our Customer Care Center at 800-279-1301.	Retail Tier 1 (Generics) - $60 copayment Mail Order Tier 1 (Generics) - $40 copayment

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- These benefits are intended for dental treatment needed to remove, repair, and/or replace sound, natural teeth damaged, lost, or removed due to an injury. The term "injured" does not include conditions resulting from eating, chewing or biting.
- A "sound, natural tooth" is a tooth that is fully erupted, has no restoration or minor restoration that does not compromise the strength and integrity of the tooth structure, and has no evidence of periodontal disease that would predispose the tooth injury.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental Vision Insurance program (FEDVIP) Dental Plan, your FEHB Plan will be First Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Desription	You Pay
Accidental injury benefit	**Basic**
• Tooth extractions, initial repair, and/or replacement with artificial teeth, because of an accidental injury. Dental, Extraction of Natural Teeth, and Replacement with Artificial Teeth due to an accidental injury. To be eligible for coverage: • The services must be Medically Necessary while you are enrolled under this Policy. • The tooth must meet the definition of “sound, natural tooth”. • A “sound, natural tooth” is a tooth (including supporting structures) that is free from disease that would prevent continual function of the tooth for at least one year. In the case of primary (baby) teeth, the tooth must have a life expectancy of one year. The term "injured" does not include conditions resulting from eating, chewing or biting. • Medically Necessary hospital or ambulatory surgery center charges incurred, and anesthetics provided in connection with dental care that is provided to a Member in a hospital or ambulatory surgery center may require prior authorization. Please contact our Customer Care Center for a current list of services that require Prior Authorization.	$80 copayment per visit

Section 5(h) Wellness and Other Special Features

Feature	
Feature	**Basic**
24/7 Access to your Health Care Information	**Member Portal** Visit www.deancare.com/account-login-page and use your member number located on your ID card to activate your account • View insurance plan details • Request member ID cards or download a digital copy • Change your primary care clinic • Review past claim details and more **MyChart** Visit www.mychart.ssmhc.com/mychart/Authentication/Login? to activate your account. • Send and receive secure messages with your primary care provider • Schedule appointments • Get lab results • View and pay your medical bill • Request prescription refills and more
Behavioral Health Case Management	Behavioral Health Resources are available at www.deancare.com/wellness/behavioral-health. If you are a Dean Health Plan member and have a mental health and/or substance use condition, you may benefit from free case management. Through case management, you'll be connected with a behavioral health registered nurse or social worker who serves as your resource. Your case manager works with you, your health care provider and other members of your health care team to establish the best plan of care for you. You can request behavioral health case management services by calling the Dean Health Plan Customer Care Center at 800-279-1301 or online at www.deancare.com/wellness/care-management/behavioral-health-and-substance-use.
Care Management Programs	Our care management team combines registered nurses, licensed social workers and program outreach specialist – all available to help you manage your health care needs. Through in-person and phone outreach, our team works closely with you to navigate health care and community resources to help you be the healthiest you can be. Care management services are a free benefit from Dean Health Plan. Our services include: • Behavioral health and substance use • Complex case management, care coordination • Maternal and child health • Social work • Transplant case management Visit www.deancare.com/wellness/care-management
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services.

Feature - continued on next page

Feature	
Feature (cont.)	**Basic**
	• We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Health Care Support	Nurse Advice Line is there whenever you have a health question. You can connect with an experienced registered nurse by calling 800-576-8773. For additional information, visit DeanCare.com/DeanOnCall. The Nurse Advice Line is available after-clinic hours from 5 pm - 8 pm and 24/7 on weekends and holidays to serve patient triage needs. NOTE: Due to licensing restrictions Nurse Advice Line's triage services are only available to residents of Wisconsin.
Maternal and Child Health	Dean Health Plan's Care Management department offers outreach and education to pregnant women enrolled in our Strong Beginnings program, obstetric (OB) case management for high-risk pregnant women and pediatric case management for our youngest members with complex medical conditions. Our team of nurses, social workers, and program outreach specialists can help you navigate the health care system, locate community resources and services, and coordinate care to ensure your, and your child's, individual needs are met to achieve an optimal health outcome. Our certified lactation counselors can provide you with the support you need to be successful with breastfeeding and pumping. Case management begins with an assessment of your, or your child's, needs to develop an individual care plan with personalized goals. **Your OB case manager or program outreach specialist can help you:** • Choose a doctor for yourself and your child • Receive support with any health concerns or chronic conditions you may have • Make healthy changes – like quitting tobacco • Care for yourself and your baby before and after birth • Connect with local resources and find pregnancy education classes • Get support with breastfeeding and find information about breast pumps

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Feature	
Feature (cont.)	**Basic**
	• Transition into the Well Child Program **Your pediatric case manager can help you:** • Understand your child's medical condition, treatment, medications, and home health care needs • Advocate for your child during the discharge planning process • Coordinate outpatient care, specialty services, and community resources to manage chronic medical conditions and provide support for families • Identify community resources that provide emotional support • Understand your individual health care plan including how to maximize your benefits • Get support with breastfeeding Enrollment is voluntary. Sign up and one of our team members will contact you
Nicotine Cessation	We offer two nicotine cessation programs: • Freedom From Smoking • Quit for Life **Freedom From Smoking** Dean Health Plan offers both an on-site and virtual no-cost tobacco program, Freedom from Smoking. This small group program includes eight one-hour sessions led by a certified Freedom from Smoking facilitator. The program features a step-by-step plan for quitting tobacco. Each session is designed to help tobacco users understand their triggers and urges, and develop coping strategies to stay committed to quitting. This engaging program uses a variety of evidence-based techniques to personalize and address individual needs along with the benefits of support from the group. For the schedule of upcoming dates and locations visit www.deancare.com/quitnow. **Quit for Life®** Dean Health Plan offers the Quit For Life® Program, at no cost to members 18 years and older. The program can help you quit tobacco use and overcome physical, psychological and behavioral addictions using a seamlessly integrated mix of medication, one-on-one coaching, group video sessions and digital tools for support. A highly trained Quit Coach® can help you gain the knowledge, skills and behavioral strategies to quit for life. All complimentary, you'll receive three coaching interactions (call, text or chat), two group video sessions, plus 24/7 support through unlimited access to a Quit Coach® for the duration of the program. Call 866-QUIT4LIFE (866-784-8454) or enroll online at www.deancare.com/quitnow.
Notables	Notables is a bi-annual magazine for members featuring articles about living a healthy and active life, specialty wellness offerings from Dean Health Plan, benefit updates and more.
Nutritional Resources	• Eating healthy made simple. Get personalized nutrition guidance and make building healthy habits easy. • Nutritional resources are available through the WebMD Living Healthy Portal, and an array of helpful offerings, all free on deancare.com/Nutrition.

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Feature	
Feature (cont.)	**Basic**
Partner Perks	Dean Health Plan has partnered with businesses in the area to offer you membership, service, and product discounts that support your overall well-being. To take advantage of these perks, just show your Dean Health Plan member ID card at participating locations. Visit www.deancare.com/wellness for more information.
Pharmacy Concierge Services	Dean Health Plan Pharmacy team offers direct consultation. • Benefits navigation • Formulary • Prior authorization • Step therapy • Enhanced onboarding support for new members (especially those with complex needs). • Navigate to the "Contact Us" section at the bottom of deancare.com. - Click on "contact information". - Click email Customer Care button. - Complete form and when Pharmacy Services is selected for "question regarding" inquiry will route to a Dean Health Plan pharmacist for review and response.
Wellness Events Calendar	Access live monthly webinars, book club discussions and more that cover the eight dimensions of wellness, held virtually for you to attend from anywhere. Learn more at www.deancare.com/events.
Wellness Programs and Features	**Health Assessment** Based on your individual questionnaire results, WebMD provides recommendations for each lifestyle category. A variety of interactive self-management tools are customized to your needs. **Health Coach** • Get expert support if you have diabetes, COPD, asthma, heart failure or coronary artery disease.* **Case Management** • Provides support through complex health situations. **Partner Perks** • Discounts for gyms, spas, golfing, devices, equipment, nutrition and more. **Tobacco Cessation** • Tobacco cessation and vape free programs for families. Free medications may be available. **R.E.A.L. Goals (Realistic, Easy, Attainable, Life Goals)** • Preset goals covering all eight dimensions along with tips and trackers to help you achieve success. **Wellness Webinars** • Covering all eight dimensions, available 24/7. *Dean Health Plan shares secure claims information with WebMD. This data is only shared for the purpose of identifying health coaching opportunities through WebMD Condition Management program. Visit www.deancare.com/Wellness/health-and-wellness/Living-Healthy-Plus.

Non-FEHB Benefits Available to Plan Members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at, 800-279-1301 or visit their website at www.deancare.com.

Term	Definition
Individual and Family Health Insurance Plans	If you or a family member are not eligible under the FEHB Program benefits, Dean Health Plan offers a variety of individual and family health insurance plans. For more information, visit our website at www.deancare.com/Shop-Plans/Individual-Family-Plans.
New to Medicare?	Whether you are eligible for Medicare coverage now, or will be soon, Dean Health Plan is here to help you understand more about Medicare. For more information, visit our website at www.deancare.com/medicare/shop-medicare-advantage-plans. If you are turning 65 and need current year plan information, call one of our Dean Medicare Representatives directly at 877-234-0126 (TTY: 711).
Learn about Medicare Advantage from Dean	Dean Medicare Advantage offers several free events where you can learn more about eligibility, enrollment periods and coverage options. See if you live in a participating county by visiting www.deancare.com/medicare/shop-medicare-advantage-plans/service-area.

Section 6. General Exclusions – Services, Drugs and Supplies We Do not Cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. A**lthough we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition**. For information on obtaining prior approval for specific services, such as transplants, see Section 3 When you need prior Plan approval for certain services.

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency services/accidents).
- Drugs provided or administered by a physician or other provider, except those drugs that meet the definition of Professionally Administered Drugs.
- Exercise programs.
- Items that can be purchased over-the-counter.
- Long-term or maintenance therapy.
- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices; (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when: 1) an individual suffers from a physical disorder, physical injury, or physical illness that would place the individual in danger of death unless an abortion is performed; 2) the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.
- Services required for administrative examinations such as employment, licensing, insurance, adoption, or participation in athletics.
- Services or supplies for, or in connection with, a non-covered procedure or service, including complications; a denied referral or prior authorization; or a denied admission.
- Services or supplies furnished by yourself, immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption.
- Services or supplies we are prohibited from covering under the Federal law.

Section 7. Filing a Claim for Covered Services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan providers, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment and/or coinsurance.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider.

If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Providers must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, call us at 800-279-1301, or at our website at www.deancare.com.

When you must file a claim – such as for services you receive outside the Plan's service area – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name, date of birth, address, phone number and ID number
- Name and address of the provider or facility that provided the service or supply
- Dates you received the services or supplies
- Diagnosis
- Type of each service or supply
- The charge for each service or supply
- A copy of the explanation of benefits, payments, or denial from any primary payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to: Dean Health Plan, P.O. Box 56099, Madison WI 53705

Prescription drugs

If you receive prescription drugs from a non-network pharmacy in an emergency or urgent situation, please submit your receipts along with a Prescription Drug Claim Form found on our website at www.deancare.com/members/pharmacy-benefits under "Forms" and then selecting Reimbursement Form.

Deadline for filing your claim

If you receive services from a Health Care Provider that require you to submit the claim to us for reimbursement, you must obtain an itemized bill and submit it to:

Dean Health Plan
Attention: Claims Department
P.O. Box 56099
Madison, WI 53705

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a healthcare professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

If you live in a country where at least 10% of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as phone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the healthcare provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information or to make an inquiry about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 If you disagree with our pre-service claim decision, we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Care Center by writing Dean Health Plan, P.O. Box 56099, Madison, WI 53705 or calling 800-279-1301.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/ investigational), we will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or their subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: P.O. Box 56099, Madison, WI 53705 ; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or.

c) Ask you or your provider for more information You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3

If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, FEHB 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM’s decision via email. Please note that by providing your email address, you may receive OPM’s decision more quickly.
- Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a healthcare professional with knowledge of your medical condition may act as your authorized representative without your express consent.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

4

OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision or notify you of the status of OMP's review within 60 days. There are no other administrative appeals.

If you do not agree with OPM’s decision, your only recourse is to file a lawsuit. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: If you have a serious or life threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 800-279-1301. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's FEHB 3 at 202-606-0737 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a family member is covered under the plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9 Coordinating Benefits With Medicare and Other Coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays healthcare expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website at www.deancare.com/federalemployee.

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan processes the benefit, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

- **TRICARE and CHAMPVA**

TRICARE is the healthcare program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

- **Workers' Compensation**

Every job-related injury or illness should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices. If you are a federal or postal employee, ask your supervisor to authorize medical treatment by use of form CA-16 before you obtain treatment. If your medical treatment is accepted by the Dept. of Labor Office of Workers' Compensation (OWCP), the provider will be compensated by OWCP. If your treatment is determined not job-related, we will process your benefit according to the terms of this plan, including use of in-network providers. Take form CA-16 and form OWCP-1500/HCFA-1500 to your provider, or send it to your provider as soon as possible after treatment, to avoid complications about whether your treatment is covered by this plan or by OWCP.

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar federal or state agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

- **Medicaid**

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar state-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these state programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the state program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, state, or federal government agency directly or indirectly pays for them.

When others are responsible for injuries

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage.

If you have received benefits or benefit payments as a result of an injury or illness and you or your representatives, heirs, administrators, successors, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgment, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on www.benefeds.com/ or by phone at 877-888-3337, (TTY 877-889-5680), you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical Trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs (as mandated by state) – costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy.

- Extra care costs – This plan does not cover these costs.
- Research costs – This plan does not cover these costs.

When you have Medicare

For more detailed information on "What is Medicare?" and "Should I Enroll in Medicare?" please contact Medicare at 800-MEDICARE (800-633-4227), (TTY 877-486-2048) or at www.medicare.gov.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 800-279-1301 or see our website at www.deancare.com.

We waive some costs if the Original Medicare Plan is your primary payor. We will waive some out-of-pocket costs as follows:

- **Medical services and supplies provided by physicians and other healthcare professionals.**
- **Standard member cost-share will apply for services not covered by Medicare (i.e. oral surgery).**

Please review the following examples which illustrates your cost share if you are enrolled in Medicare Part B. If you purchase Medicare Part B, your provider is in our network and participates in Medicare, Medicare will be the primary payor.

Basic Option

Benefit Description: Deductible
Basic Option You pay without Medicare: N/A
Basic Option You pay with Medicare Part B: N/A

Benefit Description: Coinsurance
Basic Option You pay without Medicare: N/A
Basic Option You pay with Medicare Part B: N/A

Benefit Description: Coinsurance Limit
Basic Option You pay without Medicare: N/A
Basic Option You pay with Medicare Part B: N/A

Benefit Description: Out-of-Pocket Maximum
Basic Option You pay without Medicare: $6,000 (Self Only), $12,000 (Self + 1), $12,000 (Self + Family)
Basic Option You pay with Medicare Part B: $6,000 (Self Only), $12,000 (Self + 1), $12,000 (Self + Family)

Benefit Description: Primary Care Provider
Basic Option You pay without Medicare: $40 copayment per visit
Basic Option You pay with Medicare Part B: Nothing

Benefit Description: Specialist
Basic Option You pay without Medicare: $80 copayment per visit
Basic Option You pay with Medicare Part B: Nothing

Benefit Description: Inpatient Hospital
Basic Option You pay without Medicare: $1,000 copayment per day up to a maximum of $3,000 per contract year
Basic Option You pay with Medicare Part B: Nothing

Benefit Description: Outpatient Hospital
Basic Option You pay without Medicare: $1,000 copayment per occurrence up to a maximum of $3,000 per contract year
Basic Option You pay with Medicare Part B: Nothing

You can find more information on how our plan coordinates benefits with Medicare by calling our Customer Care Center at 800-279-1301.

www.deancare.com/employers/resources/medicare

www.deancare.com/employers/resources/claims

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private healthcare choices (like HMOs and regional PPOs) in some areas of the country.

To learn more about Medicare Advantage plans, contact Medicare at 800-MEDICARE (800-633-4227), (TTY 877-486-2048) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers).

However, we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation		✓*
9) Are a Federal employee receiving disability benefits for six months or more	✓	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

Section 10. Definitions of Terms We Use in This Brochure

Assignment

An authorization by you (the enrollee or covered family member) that is approved by us (the Carrier), for us to issue payment of benefits directly to the provider.

- We reserve the right to pay you directly for all covered services. Benefits payable under the contract are not assignable by you to any person without express written approval from us, and in the absence of such approval, any assignment shall be void.
- Your specific written consent for a designated authorized representative to act on your behalf to request reconsideration of a claim decision (or, for an urgent care claim, for a representative to act on your behalf without designation) does not constitute an Assignment.
- OPM's contract with us, based on federal statute and regulation, gives you a right to seek judicial review of OPM's final action on the denial of a health benefits claim but it does not provide you with authority to assign your right to file such a lawsuit to any other person or entity. Any agreement you enter into with another person or entity (such as a provider, or other individual or entity) authorizing that person or entity to bring a lawsuit against OPM, whether or not acting on your behalf, does not constitute an Assignment, is not a valid authorization under this contract, and is void.

Assisted Reproductive Technology (ART)

All treatments or procedures that include the handling of human eggs, sperm, and/or embryos to help an individual become pregnant. ART includes, but is not limited to, gamete intrafallopian transfer (GIFT), uterine embryo lavage, embryo transfer, in vitrofertilization (IVF), pronuclear state transfer (PROST), tubal embryo transfer (TET), zygote intrafallopian transfer (ZIFT), low tubal ovum transfer, intracytoplasmic sperm injection, cryopreservation (e.g., egg, embryo, sperm), and other third party-assisted ART methods (e.g., sperm donation, egg donation, Traditional Surrogates and Gestational Carriers, embryo donation).

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Clinical trials cost categories

An approved clinical trail includes a phase I, phase II, phase III, or phase IV clinical trail that is considered in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either Federally-funded, conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trail, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs - costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trail or is receiving standard therapy.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.
- Research costs - costs related to conducting the clinical trail such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trails. This plan does not cover these costs.

Coinsurance

See Section 4, Your Costs for Covered Services, page 24.

Coinsurance Limit	Includes Coinsurance amounts for certain medical expenses that a Member is required to pay when a covered service is provided. Pharmacy expenses and certain medical expenses are not included in the Coinsurance Limit. The Coinsurance amounts also apply toward the Out-of-Pocket Expense Maximum. No other out-of-pocket expenses apply toward the Coinsurance Limit.
Confinement/Confined	a) The period of time between admission to and discharge from an inpatient or outpatient hospital, AODA residential center, skilled nursing facility, or licensed ambulatory surgical center on the advice of your physician, and discharge there from; or b) the time spent in a hospital receiving emergency care for illness or injury. Hospital swing bed Confinement is considered the same as Confinement in a skilled nursing facility. If the Member is transferred to another facility for continued treatment of the same or related condition, it is one Confinement. Specific to a skilled nursing facility (SNF), an inpatient stay begins on the day of admission into a skilled nursing facility. The 120 day SNF benefit renews when you haven't received any inpatient hospital care or skilled care in a skilled nursing facility for the same or a similar diagnosis for 60 days in a row. If you go into a hospital or a skilled nursing facility after one SNF benefit period has ended, a new benefit period begins. There is no limit to the number of SNF Inpatient benefit periods. However, an additional 120 days is not available until skilled care has not been required for at least 60 consecutive days.
Copayment	See Section 4, Your Costs for Covered Services, page 24.
Cosmetic Surgery, Services or Procedures	Services and procedures that improve physical appearance but do not correct or improve a physiological function and that are not Medically Necessary unless the service or procedure meets the definition of Reconstructive Surgery.
Cost-Sharing	See Section 4, Your Costs for Covered Services, page 24.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial Care	The type of care given when the basic goal is to help a person in the activities of daily life. This includes help in walking, getting in and out of bed, bathing, dressing, eating, using the toilet, preparing special diets, taking medications properly and 24 hour supervision for potentially unsafe behavior. Such care is custodial when it does not require continued attention by trained medical personnel. Such care is custodial even if provided by registered nurses, licensed practical nurses, or other trained medical personnel. Custodial care that lasts 90 days or more is sometimes known as Long Term Care.
Deductible	See Section 4, Your Costs for Covered Services, page 24.
Experimental or Investigational Service	We regularly evaluate new medical devices, new techniques, and new uses for older existing procedures. This process is both proactive and reactive. Health care experts in the Dean organization, including physician, and specialty providers, review and evaluate all pertinent information. If new technology is approved, procedures and policies are revised or established to implement this decision.
Fertility Treatment	Treatment or procedure intended to assist conception, undergone as the result of infertility or for any other reason.
Group Health Coverage	The agreement between Us and the employer group to provide health insurance coverage to Members.
Healthcare Professional	A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law.

Infertility

Infertility is a disease of the reproductive system defined by the failure to achieve a pregnancy by any means including artificial insemination after 12 months or more of attempts to conceive for individuals under age 35; and 6 months for individuals age 35 and older. Infertility may also be established through evidence of medical history and diagnostic testing.

Maximum Allowable Fee

Maximum Allowable Fee is the maximum amount We allow for a given service/procedure with an Out-of-Network Provider.

This amount may be based on:

- Geographic location;
- Provider specialty;
- Training and experience of provider;
- Date of service;
- Complexity of treatment; or
- Degree of skill required of provider.

If there is a difference between the Maximum Allowable Fee and the amount billed by an Out-of-Network Provider, the Member will be responsible for the difference.

When you are seeking care with an Out-of-Network Provider, you can obtain information about Maximum Allowable Fees prior to receiving care. You need to contact your Out-of-Network Provider for the procedure code(s) and the amount(s) the provider intends to charge. Then provide this information to Our Customer Care Center in order for Us to determine the Maximum Allowable Fee for the service(s) in question. Within 5 business days of receiving your request for Maximum Allowable Fee details, We will notify you as to whether the service is covered and if it is subject to the Maximum Allowable Fee or any other Policy provisions (e.g. Deductibles or Copayments).

Medical necessity

The services or supplies provided by a hospital, or plan provider (or a non-plan provider if there is an authorized referral requested or in an emergency or urgent care situation) that are required to identify or treat a member's illness or injury as which, as determined by the Utilization Management Department, are: (a) consistent with the illness or injury; (b) in accordance with generally accepted standards of acceptable medical practice; (c) not solely for the convenience of a member, hospital, plan provider, or other provider; and (d) the most appropriate supply or level of services that can be safely provided to the member.

Plan allowance

Plan allowance is the amount we use to determine our payment and your co-insurance for covered services.

We determine our Plan allowance as follows: Covered charges will be paid based on the contract agreement between the plan and the plan provider (subject to any coinsurance and copayment provisions outlined in this Certificate). If there is a difference between our contracted amount and the amount that the provider bills us, you will not be responsible for that amount.

You should also see Important Notice About Surprise Billing – Know Your Rights in Section 4 that describes your protections against surprise billing under the No Surprises Act.

Post-Service Claims

Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Plan Provider (Network Provider)

We use providers in a specific geographic area. Being a Member of Dean Health Plan means you agree to use providers who are part of our provider network (Network Providers). Any care you need should be provided by Network Providers, including doctors and hospitals.

	When you enroll as a Member you will choose a physician or clinic from our network of providers to be responsible for managing your health care. This is your primary care provider (PCP) and is the provider you contact first whenever you need health care services. Your PCP evaluates your total health needs and provides personal medical care in one or more medical fields. If you choose a clinic rather than a physician, you may see any PCP in that clinic. When medically needed, your PCP preserves the continuity of care. Your PCP is also in charge of coordinating other provider health services.
Pre-Service claims	Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.
Primary Care Provider (PCP)	A Network Plan Provider who evaluates the Member's total health needs and provides personal medical care in one or more medical fields. Typically a Primary Care Provider is a pediatrician, family practitioner, OB/GYN or an internist.
Professionally Administered Drugs	Professionally Administered Drugs must be, as determined by Us, typically administered or directly supervised by a qualified provider or a licensed/certified health professional. We generally consider Drugs that require intravenous infusion or injection, intrathecal infusion or injection, intramuscular injection or intraocular injection, as well as Drugs that, according to the manufacturer's recommendations, must typically be administered by a Health Care Provider, to be Professionally Administered Drugs.
Quantity Limits (QL)	Certain covered Drugs have limits on the maximum quantity allowed per prescription over a specific time period. The medications subject to Quantity Limits are shown on Our Drug List with the abbreviation "QL." Some Quantity Limits are based on the manufacturer's packaging, FDA labeling or clinical guidelines.
Reconstructive Surgery	Surgery to rebuild or correct a: 1. Body part when such surgery is incidental to or following surgery resulting from injury, sickness, or disease of the involved body part; or 2. Congenital disease or anomaly which has resulted in a functional defect as determined by your Health Care Provider. In the case of mastectomy, surgery to reconstruct the breast on which the mastectomy was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance shall be considered reconstructive. Surgery that is cosmetic is not reconstructive.
Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.
Step Therapy	Process that involves trying an alternative covered Drug first before moving to another covered Drug for treatment of the same medical condition. The medications subject to Step Therapy are shown on the Drug list with the abbreviation "ST." You must meet applicable Step Therapy requirements before We will cover these preferred brand or nonpreferred brand drugs.
Restorative Surgery	Surgery to rebuild or correct a physical defect that has a direct adverse effect on the physical health of a body part, and for which the restoration or correction is Medically Necessary.

Subrogation

A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

Surprise Bill

An unexpected bill you receive for

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating providers of air ambulance services.

Us/We

Us and We refer to Dean Health Plan.

You

You refers to the enrollee and each covered family member.

Urgent Care Claims

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve pre-service claims and not Post-service claims. We will determine whether or not a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Care Center at 800-279-1301. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

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Summary of Benefits for The Basic Option of Dean Health Plan - 2024

- Do not rely on this chart alone. This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.deancare.com/federalemployee.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Basic Option Benefits	You Pay	Page
• **Deductible**	Nothing (this plan does not have a deductible)	24
• **Coinsurance**	Nothing (this plan does not have coinsurance)	24
• **Maximum Out-of-Pocket (coinsurance, medical and pharmacy drug copayments)**	$6,000 Self Only enrollment or $12,000 Self Plus One and Self and Family enrollment	24
Medical services provided by physicians: Treatment Services provided in the office	$40 office visit copayment (Primary Care Provider) $80 office visit copayment (Specialist)	30
Medical services provided by physicians: Diagnostic services provided in the office	Nothing	30
Services provided by a hospital and emergency services: Inpatient/Outpatient Hospital Services	$1,000 copayment per day up to a maximum of $3,000 per contract year (Inpatient) $1,000 copayment per occurrence up to a maximum of $3,000 per contract year (Outpatient)	58
Services provided by a hospital and emergency services: Emergency In-area	$300 copayment per emergency room visit (waived if direct admit to inpatient) $40 copayment per urgent care visit	63
Services provided by a hospital and emergency services: Emergency Out-of-Area	$300 copayment per emergency room visit (waived if direct admit to inpatient) $40 copayment per urgent care visit	63
Behavioral health and substance use disorder treatment:	$40 copayment per visit (outpatient) $1,000 copayment per day up to a maximum of $3,000 per contract year (inpatient)	66
Prescription drugs: Retail pharmacy	Tier 1 (Generics) $20 copayment Tier 1 (Select Generics) $6/6 month supply Tier 2 (Preferred Brands and select Generics) $45 copayment Tier 3 (Non-Preferred Brands and select Generics) $70 copayment Tier 4 (Specialty Drugs) $150 copayment	69
Prescription drugs: Mail order	90-day supply (maintenance medications) • Tier 1 - $40 copayment (90-day supply)	69

	• Tier 2 - $90 copayment (90-day supply) • Tier 3 - $210 copayment (90-day supply) • Tier 4 - Not available	

Notes

Notes

2024 Rate Information for Dean Health Plan

To compare your FEHB health plan options please go to www.opm.gov/fehbcompare.

To review premium rates for all FEHB health plan options please go to www.opm.gov/FEHBpremiums **or** www.opm.gov/Tribalpremium.

Premiums for Tribal employees are shown under the Monthly Premium Rate column. The amount shown under employee pay is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
Wisconsin					
Basic Option Self Only	AG1	$167.76	$55.92	$363.48	$121.16
Basic Option Self Plus One	AG3	$352.31	$117.43	$763.33	$254.44
Basic Option Self and Family	AG2	$377.47	$125.82	$817.85	$272.61