Dean Health Plan, Inc.

http:\\www.deancare.com

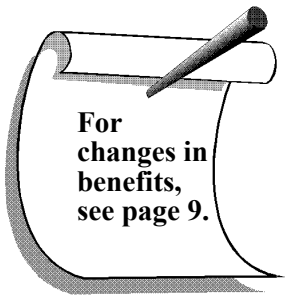
Dean HEALTH PLAN

2012

A Health Maintenance Organization (high option)

Serving: South Central Wisconsin

Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See page 8 for requirements.



Enrollment code for this Plan:
WD1 High Option – Self Only
WD2 High 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

RI 73-189

Important Notice from Dean Health Plan About

Our Prescription Drug Coverage and Medicare

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. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit 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 Dean Health 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's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% 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'll 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 15th through December 7th) 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 1-800-772-1213 (TTY 1-800-325-0778).

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 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048).

Table of Contents

Introduction

This brochure describes the benefits of Dean Health Plan, Inc. under our contract (CS 1966) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for Dean Health Plan's administrative office is:

Physical Address	**Mailing Address**
Dean Health Plan, Inc. 1277 Deming Way Madison, WI 53717	Dean Health Plan, Inc. P.O. Box 56099 Madison, WI 53705

This brochure is the official statement of benefits. No oral 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 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, 2012, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2012, and changes are summarized on page 9. 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 or 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 first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management Healthcare and Insurance, Federal Employee Insurance Operations, Program Analysis and Systems Support, 1900 E Street, NW, Washington, DC 20415-3650.

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 telephone 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.

- Please review your claims history periodically for accuracy to ensure services are not being billed to your accounts that were never rendered.
- 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

202-418-3300

OR 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 he/she was disabled and incapable of self-support prior to age 26)
- 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.
- 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.
- 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.

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. 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. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. 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 ask questions and understand answers.

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- 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 medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

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

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

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 you are taking.

Patient Safety Links

- www.ahrq.gov/consumer. 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 health care providers and improve the quality of care you receive.

- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

- www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communications about the safe, appropriate use of medicines.

- 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 health care professionals working to improve patient safety.

Never Events

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct never events, if you use Dean Health Plan network providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

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 reduce medical errors that should never happen called "Never Events". When a Never Event occurs, neither your FEHB plan nor you will incur costs to correct the medical error.

Section 1. Facts about this HMO Plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Dean Health Plan offers a curent and complete listing of physicians, clinics, pharmacies and more at deancare.com. Important contact information such as phone numbers and locations are listed on our website. You may also contact the Plan for a copy of their most recent provider directory.

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 co-insurance 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.

This plan is a "grandfathered health plan" under the Affordable Care Act. A grandfathered plan must preserve basic health coverage that was already in effect when the law passed. Specifically, this plan cannot eliminate all or substantially all benefits to diagnose or treat a particular condition; it cannot increase your coinsurance (the percentage of a bill you pay); and any increases in deductibles, out-of-pocket limits, and other copayments (the fixed-dollar amount you pay) must be minimal.

As a grandfathered health plan, this plan, has also decided to follow immediate reforms that apply to non-grandfathered plans.

Questions regarding what protections apply may be directed to us at 800-279-1301. You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

General features of our High Option

We have Open Access benefits

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

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 copayments or co-insurance.

Your Rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. 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 is business since 1983
- Dean Health Plan, Inc. is a for-profit HMO

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 contact us by fax at 608-827-4212 or visit our website at deancare.com.

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. Our service area is: Adams, Columbia, Crawford, Dane, Dodge, Fond du Lac, Grant, Green, Green Lake, Iowa, Jefferson, Juneau, Lafayette, Marquette, Richland, Rock, Sauk, Vernon, Waukesha, and Walworth counties in Wisconsin.

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. We will not pay for any other health care 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.

Section 2. How we change for 2012

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

- Sections 3, 7 and 8 have changed to reflect claims processing and disputed claims requirements of the Patient Protection and Affordable Care Act, Public Law 111-148.

Changes to this Plan

- Your share of the non-Postal premium will increase for Self Only and/or Self and Family. See back cover.
- Physical, Occupational, Speech Therapy office visit - The Plan will eliminate member responsibility of a 20% co-insurance and add a $10 copay for each therapy visit.
- Durable Medical Equipment (DME) - The Plan will decrease the DME co-insurance from 25% to 20% co-insurance up to a $2,000 annual out-of-pocket maximum.

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 website at deancare.com.

Where you get covered care

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

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to NCQA and Dean Health Plan standards.

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

- **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 periodically. The list is also on our website at deancare.com.

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 physician. This decision is important since your primary care physician provides or arranges for most of your health care. When you enroll, you (and your family members) must choose a primary care physician. Each member of your family may select a different primary care physician. Your primary care physician must be a doctor who practices a general scope of medicine. A physician who specializes in only one area of medicine would not be able to treat all of your basic health care needs.

- **Primary care**

The following types of physicians can be a primary care physician for you: Family Practice doctors treat people of all ages. They focus on family health problems. General Practice doctors treat people of all ages. Pediatric doctors treat children and adolescents, and generally manage their health. Internal Medicine doctors treat adult men and women. Obstetrics and Gynecology doctors manage a woman's care during pregnancy and childbirth. They also treat conditions unique to females. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation. The primary care physician must submit the written referral request for services with the specialist being referred to. Written referrals are not required when seeing a Dean Health Plan provider.

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

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals.

Your primary care physician 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 physician. If he or she decides 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 physician, 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;

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.

- **Hospital care**

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

- **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 primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

  Prior Authorization must be obtained for certain procedures/services in this Certificate. Examples of procedures/services requiring Prior Authorization are listed below. This is NOT an all-inclusive list. Members should contact the Customer Care Center at 800-279-1301 to verify whether a procedure/service requires a Prior Authorization.

  Examples of Procedures/Services Requiring Prior Authorization

  - All Non-Plan Provider services
  - Radiology services (in-network and out-of-network)
    - CT scan
    - Nuclear exercise tolerance test (ETT)
    - MRI/MRA
    - PET scan
  - Cardiac rehabilitation - Phase II greater than 18 visits
  - Pulmonary rehabilitation greater than16 visits
  - Non-emergent ambulance transport and elective air ambulance transport
  - Home health care
  - Durable medical equipment (DME) greater than $250
  - Therapies (physical therapy, occupational therapy, speech therapy)
  - Potentially cosmetic procedures (e.g., varicose vein treatments, breast reduction/ augmentation, blepharoplasties)
  - New technologies not commonly accepted as standard of care
  - Hospice
  - Transplants (except cornea)
  - Elective inpatient surgical procedures
  - All hospital admissions, includes observation and inpatient stays
  - Select diagnostic testing (e.g. capsule endoscopy)
  - Skilled nursing facility/swing beds (SNF)
  - Behavioral/mental health services (out-of-network only)
  - Surgical procedures related to obesity
  - Bariatric surgery
  - Home infusion
  - Genetic testing
  - Follow-up care to urgent/emergent services
    - In some situations, Members might require follow-up care after the initial urgent/ emergent care visit outside of the service area. In these cases, follow-up care requires written, approved Prior Authorization by Dean's Medical Affairs Division prior to services being rendered by a Non-Plan Provider, including a non-plan facility.

- **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 planned days of confinement.

- **Non-urgent care claims**

  For non-urgent care claims, we will then 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 it is an urgent care claim by applying the judgment of a prudent layperson who 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 provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary 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.

- **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 telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity care**

  Your Plan primary care physician will make the necessary arrangements.

- **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, then 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, including facility confinements and/or surgery.

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 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 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.

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 health care 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.

Subject to a request for additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will hasten the review process, which allows oral or written requests for appeals and the exchange of information by telephone, 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

Copayments	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services. Example: When you see your primary care physician you pay a copayment of $10 per office visit and when you go in the hospital, you pay nothing per admission.
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.
Deductible	This Plan does not have a deductible.
Co-insurance	This is a specified percentage of Covered Expenses that a Member or family is required to pay each time covered services are provided, subject to any maximums specified in this Certificate. This amount is applied to the Dean Health Plan contracted fee or Maximum Allowable Fee. Co-insurance amounts are applied toward the maximum out-of-pocket expense in most circumstances. Please refer to your Schedule of Benefits for exceptions. Please refer to your Schedule of Benefits for applicable Coinsurance amounts. Example: In this Plan, you pay 50% of actual charges for diagnosis and treatment of infertility services and 20% for durable medical equipment up to an annual out-of-pocket maximum of $2,000.
Differences between our Plan allowance and the bill	The maximum amount payable based upon the average charge for the same service provided.
Your catastrophic protection out-of-pocket	Catastrophic protection out-of-pocket maximum is not applicable to this Plan.
Carryover	Carryover is not applicable to this Plan.
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.

Section 5. High Option Benefits

See page 9 for how our benefits changed this year. Page 7 is a benefits summary. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5. High Option Benefits Overview

This Plan offers a High Option. Our benefit package is described in Section 5. Make sure that you review the benefits that are available.

The High Option 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 High Option benefits, contact us at 800- 279-1301 or at our Web site at deancare.com.

High Level Plan Summary - High Option Plan Offering - $0 Deductible; $10 Office Visit Copayment; $0 Copayment for inpatient/outpatient services; no written referrals required when seeing a Dean Health Plan provider.

Quality Committment

As your partner in health care, Dean Health Plan is committed to providing you with a superior level of care and service. We continually monitor and evaluate our performance against rigorous national and regional standards.

We encourage you to learn more about what Dean Health Plan has to offer by visiting our website and reading about the following:

- **National Committee for Quality Assurance (NCQA) Accreditation**. How accreditation ensures that Dean Health Plan (DHP) delivers superior care and service. DHP is proud to announce for eleven consecutive years we have earned **Excellent Accreditation** - the highest level attainable - for our Commercial product line from the NCQA.
- **Consumer Assessment of Healthcare Providers and Systems (CAHPS).** Dean Health Plan annually measures member satisfaction scores using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) study methodology. In 2010, the study findings of DHP compared to national averages was quite positive.

  DHP - Customer Service 88% (Nat'l Average 83%)
  DHP - Claims Processing 88% (Nat'l Average 88%)
  DHP - Getting Needed Care 87% (Nat'l Average 86%)
  DHP - Overall Rating of Health Care 72% (Nat'l Average 60%)

- **J.D. Power Award.** Dean Health Plan earned the "Highest Member Satisfaction among Commercial Health Plans in the Minnesota/Wisconsin Region, three years in a row," from the prestigious J.D. Power and Associates 2011 U.S. Member Health Insurance Plan Study℠. For more information about the study, go to deancare.com/about-dean/news.
- **HEDIS Performance**. How Dean Health Plan compares to national standards regarding the care we provide our members.
- **Member Satisfaction Survey Results**. How Dean Health Plan compares to national standards regarding member satisfaction.
- **Quality Commitment**. How Dean Health Plan continues to provide you with exceptional quality of care and service.

For greater detail on the above, please visit our website at:

http://www.deancare.com/about-dean/quality

Superior Customer Care

It is important that, as a DHP member, you stay informed and educated about your health care benefit information. Our customer care specialists are ready to answer your questions and address any concerns you may have about your plan benefits, such as:

- How to select a primary care practitioner (PCP)
- The details of your health care coverage
- Your financial responsibilities as a DHP member

- Prior authorizations and referrals
- Coordination of benefits
- Cost transparency

Customer care specialists can be reached by calling 800-279-1301 between 7:30 a.m. and 5 p.m. Monday through Thursday or on Fridays between 8 a.m. and 4:30 p.m. You can also submit a question online at deancare.com/contact-us. Our goal is to eliminate confusion and help you remain a happy, healthy and satisfied member.

Customer Service Focus

In addition to our excellent telephonic Customer Care Center and comprehensive website, we now have an on-site Customer Care Specialist at two Dean Clinic sites in Madison (one at Dean Clinic - East and one at Dean Clinic - West) to answer questions about your health care benefits. A Customer Care Specialist is available at the clinics Monday through Thursday from 7:30 a.m. to 5 p.m. and Friday from 8 a.m. to 4:30 p.m. We are excited about the new in-clinic customer care sites and plan to expand into more clinics throughout 2012. And, as always, a Customer Care Specialist is available during the same hours by phone at (800) 279-1301. You can also send a secure message to the Customer Care Center any time of day via deancare.com/contact-us.

New, Expanded Health Care in Janesville

SSM Health Care of Wisconsin, the parent company of St. Mary's Hospital in Madison, and Dean Clinic are excited about the new community hospital and clinic in Janesville, scheduled to open January 9, 2012. St. Mary's Janesville Hospital, a 50-bed hospital totaling approximately 163,000 square feet, and Dean Clinic - Janesville will allow easy access for patients coming from Janesville and the surrounding communities. The site incorporates space for future growth of both the hospital and the clinic. Please note that if you are currently using Dean Clinic - Riverview or Dean Clinic - Northview in Janesville, your physician and care will move over to the new Dean Clinic - Janesville after it opens in January. You will receive additional communications with the specific details of the transition later this fall from the clinic and insurance offices.

Section 5(a). Medical services and supplies provided by physicians and other health care 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.
- 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 Description	You pay
Diagnostic and treatment services	
• Professional services of physicians • In physician's office	$10 per office visit
Professional services of physicians • In an urgent care center • Office medical consultation • Second surgical opinion	$10 per office visit
• During a hospital stay • In a skilled nursing facility	Nothing
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG	Nothing
• CAT Scan (outpatient services only)	$50 copay per visit (3 copayment maximum of $150 per member per year)
• MRI (outpatient services only)	$50 copay per visit (3 copayment maximum of $150 per member per year)

Benefit Description	You pay
Preventive care, adult	
Routine screenings, such as annual physical: • Total Blood Cholesterol • Colorectal Cancer Screening, including - Fecal occult blood test - Sigmoidoscopy, screening – every five years starting at age 50 - Colonoscopy screening	Nothing
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing
Routine Pap test	Nothing
Routine mammogram - covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	Nothing
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC). This includes travel immunizations.	Nothing
Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance.	*All charges*
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics (including travel immunizations).	Nothing
• Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: - Eye exams through age 17 to determine the need for vision correction - Hearing exams through age 17 to determine the need for hearing correction - Examinations done on the day of immunizations (up to age 22)	Nothing

Benefit Description	You pay
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care	Nothing for prenatal care or the first postpartum care visit. $10 per office visit for all postpartum care visits thereafter. Nothing for inpatient professional delivery services.
Note: Here are some things to keep in mind: • *You do not need to precertify your normal delivery, see page 13 for other circumstances, such as extended stays for you or your baby.* • *You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery, (you do not need to precertify the normal length of stay). We will extend your inpatient stay for you or your baby if medically necessary . See page 13 for other circumstances.* • *We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a 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.*	
Family planning	
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Diaphragms • Vasectomy (in an office setting) Note: We cover oral contraceptives under the prescription drug benefit.	$10 per office visit
Not covered: *Reversal of voluntary surgical sterilization*	*All charges*

Benefit Description	You pay
Infertility services	
Diagnosis and treatment of infertility such as: • Artificial insemination: Intravaginal insemination (IVI) Intracervical insemination (ICI) Intrauterine insemination (IUI) • Fertility drugs (injectables) Note: We cover injectible fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.	50% of actual charges
Not covered: Assisted reproductive technology (ART) procedures, such as: • In vitro fertilization • Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT) Services and supplies related to ART procedures Cost of donor sperm Cost of donor eggs Storage of donor sperm Storage of donor eggs	*All charges*
Allergy care	
• Testing and treatment • Allergy injections	$10 per office visit
Allergy serum	Nothing
Not covered: • *Provocative food testing and sublingual allergy desensitization*	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 36. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis	$10 per office visit

Treatment therapies - continued on next page

Benefit Description	You pay
Treatment therapies (cont.)	
• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: 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. See Other services on page 12.	$10 per office visit
Physical and occupational therapies	
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 to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. 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.	$10 per office visit per day per therapy type
Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction. Phase II treatment must begin within 90 days of surgery.	Nothing
Not covered: • Long-term rehabilitative therapy • Exercise programs	All charges
Speech therapy	
Outpatient visits when medically necessary.	$10 per office visit per day per therapy type

Benefit Description	You pay
Hearing services (testing, treatment, and supplies)	
Hearing Services Covered Expenses: • Hearing exams to determine if correction is needed. • One adult hearing aid per ear, including repairs, ear molds and hearing aid dispensing fees. The hearing aid must be repaired by/purchased from Dean Clinic, S.C., or other authorized providers. Please contact the Customer Care Center with questions regarding authorized providers, or reference our website at deancare.com. • Infants and children under 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, including procedures for implantation. Note: • $1,000 benefit maximum per 36 month period. • One hearing aid per ear every 36 months. • For routine hearing screening performed during a child's preventive care visit, see Section 5(a) Preventive care, children. **Non-Covered hearing expenses:** • Batteries for hearing aids	All costs over $1,000 per 36 month period (limit does not apply to children ages 0-18).
Vision services (testing, treatment, and supplies)	
In addition to the medical and surgical benefits provided for the diagnosis and treatment of diseases of the eye, annual eye refractions (which include the written lens prescription for eyeglasses) Note: See *Preventive care, children* for eye exams for children. • Eye exam to determine the need for vision correction	$10 for office visit
Not covered: • Eyeglasses or fitting of contact lenses • Eye exercises and orthoptics • Radial keratotomy and other refractive surgery	All charges

Benefit Description	You pay
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Treatment of bunions and spurs See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$10 per office 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; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery).*	*All charges*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Lenses following cataract removal • 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. 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. Purchases exceeding $200 per month must be authorized by the plan's Medical Affairs Division. Your plan doctor will obtain the prior authorization.	25% of charges per purchase or rental
Not covered: • Orthopedic and corrective shoes • Arch supports	All charges

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay
Orthopedic and prosthetic devices (cont.)	
• Foot orthotics (that are not custome made) • Heel pads and heel cups • Lumbosacral supports • Corsets, trusses, elastic stockings, support hose, and other supportive devices • Prosthetic replacements provided less than 3 years after the last one we covered	All charges
Durable medical equipment (DME)	
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. Purchases exceeding $200 per month or rentals exceeding $200 per month must be authorized by the plan's Medical Director. Your plan doctor will obtain the prior authorization. • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs (requires prior authorization by our Medical Affairs department) • Crutches, splints, trusses, orthopedic braces and appliances • Walkers • Blood glucose monitors • Insulin pumps • TENS unit • Intrauterine devices (IUDs) • Oxygen therapy and other inhalation therapy and related items for home use must be prior authorized by the Utilization Management Department Rental of a ventilator or other mechanical equipment or purchase of such equipment at the option of Dean Health Plan.	20% co-insurance of charge per purchase or rental up to an annual $2,000 out-of-pocket maximum per member
Not covered: • Repairs and replacement of durable medical equipment/supplies unless they are prior authorized by the Utilization Management Department. • Elastic support stockings (e.g., TEDS, JOBST, etc.) • Shoes or orthotics that are not custom made and can be purchased over the counter.	All charges

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	
• 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 such as, but not limited to: air conditioners, air cleaners, humidifiers, physical fitness equipment, physician's equipment, 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 Dean Health Plan. • Any durable medical equipment or supplies used for work, athletic or job enhancement.	All charges
Home health services	
• home health care 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.	Nothing
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. • Non-licensed private duty nursing or nursing aide.	All charges

Benefit Description	You pay
Chiropractic	
• Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	$10 per office visit
Not covered: • Maintenance and long term therapies.	All charges
Alternative treatments	
No benefits	All charges
Educational classes and programs	
Tobacco cessation As part of your health benefits, Dean Health Plan provides coverage of smoking cessation medications. You can receive any of the smoking 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 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 tobacco. 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 eight 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: 2. **Quit At Your Own Pace:** Quit on your own terms, but get the help you need, when you need it. 3. **Conquer Your Urges to Smoke:** Gain the skills you need to control cravings, urges and situations involving alcohol.	Nothing

Educational classes and programs - continued on next page

Benefit Description	You pay
Educational classes and programs (cont.)	
4. **Use Medications So They Really Work:** Learn how to supercharge your quit attempt with the proper use of nicotine substitutes or medications. 5. **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 atwww.deancare.com/quitforlife**.**	Nothing
Therapies & rehabilitation services	
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 reserves the right to require a second opinion with a provider mutually agreeable to the Member and Dean. - **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	Your office visit copay will apply where applicable

Therapies & rehabilitation services - continued on next page

Benefit Description	You pay
Therapies & rehabilitation services (cont.)	
• 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 goal's of the Members treatment plan • 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 nonintensive-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 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.	Your office visit copay will apply where applicable

Therapies & rehabilitation services - continued on next page

Benefit Description	You pay
Therapies & rehabilitation services (cont.)	
• 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.	Your office visit copay will apply where applicable
Non-covered Autism Expenses*: • Acupuncture • 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 • 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 Limitations and Exclusion***	All charges

Therapies & rehabilitation services - continued on next page

Benefit Description	You pay
Therapies & rehabilitation services (cont.)	
*****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

Section 5(b). Surgical and anesthesia services provided by physicians and other health care 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.
- 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 a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the 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	
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*) • Surgical treatment of morbid obesity (bariatric surgery) (prior authorization is required) • Bariatric surgery for the treatment of morbid obesity for a person over the age of 18, and has persisted for at least 5 years. - Laboratory assessment has been performed. - There is a confirmed failure of a multifaceted weight loss program including consultation with a dietician. - A behavioral health consultation. - Prior authorization is required. • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information. • Cochlear implants (requires prior authorization) • Voluntary sterilization (e.g., tubal ligation, vasectomy)	Nothing

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	
• 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
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care*	*All charges*
Reconstructive surgery	
• 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*) 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
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* • *Surgeries related to sex transformation*	*All charges*

Benefit Description	You pay
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Surgical removal of impacted teeth, tumors, and cysts; • Excision of cysts and incision of abscesses when done as independent procedures; • Other surgical procedures that do not involve the teeth or their supporting structures; • Diagnostic procedures and medically necessary surgical or non-surgical treatment for the correction of temporomandibular disorders (TMD) if all of the following apply: - The condition is caused by congenital, developmental or acquired deformity, disease or injury. - 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. This includes coverage for prescribed intra oral splint therapy devices. All services must be prior authorized by the Utilization Management Department, and provided by a plan provider designated by us to treat TMD. - Benefit Maximum is $1,250 per member per year.	$10 per office visit
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*

Benefit Description	You pay
Organ/tissue transplants	
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 *You need prior approval for certain services* on page 12. Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Intestinal transplants - Small intestine - Small intestine with the liver • Small intestine with multiple organs, such as the liver, stomach, and pancreas - Kidney - Liver - Lung: single/bilateral 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) **Blood or marrow stem cell transplants** limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
- Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - 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 • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Epithelial ovarian cancer - Multiple myeloma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors **Mini-transplants performed in a clinical trial setting** (non-myeloablative, 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 - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Acute myeloid leukemia	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
- Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, 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 reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Neuroblastoma 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 and 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 - Multiple myeloma - Multiple sclerosis - Sickle Cell anemia	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
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) • Multiple myeloma • Multiple sclerosis • Myeloproliferative disorders (MSDs) • Autologous Transplants for - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Systemic lupus erythematosus - Systemic sclerosis • National Transplant Program (NTP) Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	Nothing
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	
Professional services provided in – • Hospital (inpatient)	Nothing
Professional services provided in – • 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.
- 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
Inpatient hospital	
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.	Nothing
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • 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	Nothing

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	
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.	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • 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.	Nothing
Not covered: Blood and blood derivatives not replaced by the member	*All charges*

Benefit Description	You pay
Extended care benefits/Skilled nursing care facility benefits	
Extended care benefit: The plan provides a comprehensive range of benefits for up to 120 days per contract year 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	Nothing
Not covered: Custodial care	All charges
Hospice care	
Hospice Care • Inpatient hospice • Hospice services while at a skilled nursing facility • Home-based hospice	Nothing
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	
Local professional ambulance service when medically appropriate (ground or air). Non-emergent ambulance service requires prior authorization.	Nothing

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.

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 telephone 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. It is your responsibility to ensure that the Plan has been notified.

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. Maximum Allowable Fee: The maximum 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. You pay a $75 copayment per hospital emergency room visit. The $75 copayment will be waived if admitted inpatient through the emergency room.

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.

Follow up care and non-emergency care for all members is covered at 50% up to the maximum allowable fee if medically necessary and prior authorized. This benefit is available if you are temporarily out of the service area.

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. Maximum Allowable Fee: The maximum 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.

You pay a $75 copayment per hospital emergency room visit. The $75 copayment will be waived if admitted as inpatient through the emergency room.

Benefit Description	You pay
Emergency within our service area	
Emergency care at a doctor's office	$10 per office visit
Emergency care at an urgent care center	$10 per office visit
Emergency care as an outpatient at a hospital , including doctors' services	$75 per hospital emergency room visit; Note: We waive the ER copay if you are admitted to the hospital.
Not covered: Elective care or non-emergency care	*All charges*
Emergency outside our service area	
Emergency care at a doctor's office	$10 per office visit
Emergency care at an urgent care center	$10 per office visit
Emergency care as an outpatient at a hospital, including doctors' services	$75 per hospital emergency room visit; Note: We waive the ER copay if you are admitted to the hospital.
Not covered: *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	
Professional ambulance service when medically appropriate (ground or air). Note: See 5(c) for non-emergency service.	Nothing

Section 5(e). Mental health and substance abuse benefits

You need to get Plan approval (preauthorization) for services and follow a treatment plan we approve in order to get benefits. When you receive services as part of an approved treatment plan, cost-sharing and limitations for Plan mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions.

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.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan. See the instructions after the benefits description below.

Benefit Description	You pay
Professional services	
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance abuse 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, mental illness, or mental 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 alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.

Benefit Description	You pay
Diagnostics	
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse 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	$10 per visit (Outpatient) $0 per visit (Inpatient)
Inpatient hospital or other covered facility	
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	Nothing
Outpatient hospital or other covered facility	
Outpatient services provided and billed by a hospital or other covered facility Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	$10 per office visit
Not covered	
Services that are not part of a preauthorized approved treatment plan.	All charges

Preauthorization	To be eligible to receive these benefits you must obtain a treatment plan and follow all of the network authorization processes.
Limitation	We may limit your benefits if you do not obtain a treatment plan.

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.
- 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. Updates to our drug formulary are provided in Notables, our quarterly news magazine sent to the subscriber's home. Members may also obtain a listing by calling our Customer Care Center at 800-279-1301 or at our website at deancare.com.
- 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 plan physician or referral doctor must write the prescription.
- **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 deancare.com.
- **These are the dispensing limitations.** 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 $10 copay per prescription unit or refill for generic drugs and 30% co-insurance 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. If you are called to active duty and require medication during a national emergency call us at 800-279-1301 for assistance.
- **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 do 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.

Benefit Description	You pay
Covered medications and supplies	
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 medicines 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 copay applied to each vial • Diabetic supplies, including disposable needles and syringes needed for injecting the covered prescribed medication, glucose test tablets and test tape, Benedict's solution or equivalent and acetone test tablets; a copay will apply for each item purchased • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (see note below) • Oral and injectable contraceptive drugs up to a 30 day supply; contraceptive diaphragms • Growth Hormones and Ceredase (prior authorization required) • Zyban is covered through the Tobacco Cessation program (see page 28) • Intravenous fluids and medication for home use are covered under Medical and Surgical Benefits	Tier 1 generics $10 copay Tier 2 preferred brands and select generic 30% co-insurance (maximum $75 copay per prescription, up to a $1,500 out-of- pocket maximum per contract year, $10 copay applies thereafter.) Tier 3-Expanded brands and select generics 50% co-insurance (minimum $50 copay and a maximum $150 copay per prescription) Note: If there is no Tier 1 generic equivalent available, you will be required to pay the higher Tier 2 or Tier 3 copay.
Note: (Limited Benefits): Drugs to treat sexual dysfunction are limited. Contact the plan for dose limits.	You pay 50% copay up to the doses limit and all charges above that.
Mail Order Prescription Drug Benefit	The member receives a 3-month supply of generic prescription for $20. The member receives a 3-month supply of brand prescription at 30% of the cost for a 2-month supply. (The 30% brand copay limit is $1,500 for the out-of-pocket costs per member, per contract year. A $20 copay applies thereafter)
• Infertility drugs	50% of the cost of the prescription unit or refill
Here are some things to keep in mind about our prescription drug program. • A generic equivalent will be dispensed if it is available, unless your physician specifically required a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispensed as Written for the brand drug, you have to pay the difference in cost between the name brand drug and the generic.	

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	
• We administer a formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. 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 deancare.com.	
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Fertility drugs (not approved by the plan)* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Nonprescription medicines* Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit. (See page 29.)	All charges

Section 5(g). Dental benefits

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
- 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.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- 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	
Dental, Extraction of Natural Teeth, and Replacement with Artificial Teeth due to an accidental injury. Covered Services: • Tooth extractions and replacement with artificial teeth, because of an accidental injury. • Services for tooth extractions must begin within 18 months after the accident unless treatment could not begin within 18 months for documented medical reasons and/or under the recommendation of a provider • All 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, if prior authorized by our Medical Affairs Division, and if any of the following applies: 1. The Member is a child under age 7; 2. The Member has a chronic disability, or 3. The Member has a medical condition that requires hospitalization or general anesthesia for dental care. To be eligible for coverage, the accident must occur while you are enrolled under this Plan, or repair of teeth after accidental injury was delayed according to a Provider evaluation and recommendation, and could not be completed prior to enrollment under this Plan.	Nothing

Accidental injury benefit - continued on next page

Benefit Desription	You Pay
Accidental injury benefit (cont.)	
A "sound, natural tooth" is a tooth that is fully erupted, lacks clinical evidence of periodontal disease, lacks dental restoration (filling), or minor restoration that does not compromise the strength and integrity of the tooth structure. The tooth must have an excellent long term prognosis. The term "injured" does not include conditions resulting from eating, chewing or biting. Evaluation of treatment Plan must occur within 90 days of the date of the accident.	Nothing

Dental benefits

Dean Health Plan does not provide any other dental benefits.

Dental Benefits	You Pay

Section 5(h). Special features

Feature	Description
Feature	
24 hour nurse line	Dean on Call is a free telephone service that's available to Wisconsin residents 24 hours a day, 365 days a year. If you're not sure you need to see a doctor; or you're wondering if you have a problem, give us a call. You may call 800-576-8773 and talk with a registered nurse who will discuss treatment options and answer your health questions
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • 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).

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 out-of-pocket maximums.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.

24/7 Access to your Health Care Information – **Dean*Connect***, your complete member portal, allows you to view your health insurance information, such as benefit and claim information online and access your health records. Also review instructions and details from recent clinic visits, view lab results, review health history, view appointment information, ask for medical advice and much more.Together, **Dean*Connect*** and **MyChart*** provides you with many conveniences to manage your health care.

Health and Wellness Incentives – The Wellness Incentives Now (WIN) program is available to reimburse members for selected health and wellness improvement activities. Program details are available on our website at deancare.com and will be subject to change annually.

24 hour nurse line – Dean on Call is a free telephone service that's available to Wisconsin residents 24 hours a day, 365 days a year. If you're not sure you need to see a doctor; or you're wondering if you have a problem, give us a call. You may call 800-576-8773 and talk with a registered nurse who will discuss treatment options and answer your health questions.

**MyChart is currently available to those patients who have a Dean Clinic family medicine, internal medicine or pediatrics primary care provider. Please see our website at mychart.deancare.com for a list of participating providers.*

Section 6. General exclusions – things we don't cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although 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 Emergencyservices/accidents).
- 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 the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies related to sex transformations.
- 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.
- Treatment, services, and supplies provided in connection with any illness or injury caused by: (a) a member's engaging in an illegal occupation or (b) a member's commission of, or an attempt to commit, a felony.
- 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.

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 physicians, 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. Physicians 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 web site 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 HCFA-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 physician 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 emergent or urgent situation, please submit your receipts along with a prescription manual claim reimbursement form found on our website at www.deancare.com under "Dean Health Plan/Insurance Services/More Member Resources/Pharmacy Forms/Expense Reimbursement".

Other supplies or services

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

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

Claims must be submitted within 60 days after the services are received, or as soon as possible. If we do not receive the claim within 12 months after the date it was otherwise required, we may deny coverage of the claim. If you do not notify a provider that you have coverage with Dean, and this failure results in a claim not being filed in a timely manner, we may deny coverage of the claim. If Dean is the secondary payor, the time limit for timely submission begins with the date of notice of payment or rejection by the primary payor.

Urgent care claims procedures

If you have an urgent care claim, please contact our Customer Care Center at 800-279-1301. Urgent care claims must meet the definition found in Section 10 of this brochure, and most urgent care claims will be claims for access to care rather than claims for care already received. We will notify you of our decision not later than 24 hours after we receive the claim as long as you provide us with sufficient information to decide the claim. If you or your authorized representative fails to provide sufficient information, we will inform you or your authorized representative of the specific information necessary to complete the claim not later than 24 hours after we receive the claim and a time frame for our receipt of this information. We will decide the claim within 48 hours of (i) receiving the information or (ii) 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 a written or electronic notification within three days of oral notification.

Concurrent care claims procedures

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 as an appealable decision. 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, then we will make a decision within 24 hours after we receive the claim.

Pre-service claims procedures

As indicated in Section 3, certain care requires Plan approval in advance. We will notify you of our decision within 15 days after the 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 before the expiration 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.

If you fail to follow these pre-service claim procedures, then we will notify you of your failure to follow these procedures as long as (1) your request is made to our Customer Care Center and (2) your request names you, your medical condition or symptom, and the specific treatment, service, procedure, or product requested. We will provide this notice within five days following the failure or 24 hours if your pre-service claim is for urgent care. Notification may be oral, unless you request written correspondence.

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.
When we need more information	Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.
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 health care 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.

Section 8. The disputed claims process

You may be able to appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information 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 visit www.deancare.com.

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.

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, Health Insurance x, 1900 E Street, NW, Washington, DC 20415.

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 health care 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 within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. 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 sue 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 hasten 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 Health Insurance Group at (202) 606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with 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 health care 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' guidelines.

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 pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age or older
- Some people with disabilities under 65 years of age
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)
- Medicare has four parts:
- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213, (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213, (TTY 1-800-325-0778) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10% increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **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 Web site at deancare.com.

We do not waive any costs if the Original Medicare Plan is your primary payor.

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

- **Tell us about your Medicare coverage**

To reflect the new Medicare secondary payor requirement to collect health care ID numbers or SSNs for dependents who have Medicare, 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 health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

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

  This Plan and our Medicare Advantage plan:

  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), but we will not waive any of our copayments, co-insurance, 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 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 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.

TRICARE and CHAMPVA

TRICARE is the health care 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 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

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 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

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person or any party, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement. Unless we agree in writing, you may not deduct attorneys' fees and expenses, which you incur in the recovery of monies from any party, from our reimbursement or subrogated recovery.

If you do not seek damages you must agree to let us try. This is called subrogation. You agree to honor our subrogation rights, and to take no action which would prejudice our interest. If you need more information, contact us for our subrogation procedures.

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 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 BENEFEDS.com, 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

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. These costs are covered by this Plan.
- Extra care costs - excluded from coverage
- Research costs - excluded from coverage

Section 10. Definitions of terms we use in this brochure

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	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.
Co-insurance	Co-insurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 15.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 15.
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.
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.
Health care professional	A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.
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 DHP and the plan provider (subject to any co-insurance and copay 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.
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.
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.

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 judge whether 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.

Section 11. 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.

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

See www.opm.gov/insure/health 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 who 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, and give you a *Guide to Federal Plans,* brochures for other plans, 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 don't 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.

- **Types of coverage available for you and your family**

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children your employing or retirement office authorizes coverage for. 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 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 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 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 marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status including your marriage, divorce, annulment, or when your child reaches age 26.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse and children in the chart below.

Children	Coverage
Natural, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster Children	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	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	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	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/insure.

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for 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 for 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 and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- 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 and Family 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 and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

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 doesn't 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 doesn't serve the area in which your children live as long as the court/administrative order is in effect. 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 paid according to the 2012 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2011 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 divorced from a Federal employee or annuitant, you may not continue to get benefits 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 RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

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

If you leave Federal service, 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 job, if you are a covered dependent child and you turn 26.

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

- **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 service, your employing office will notify you of your right to convert. You must apply in writing to us 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 apply in writing to us 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, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

- **Getting a Certificate of Group Health Plan Coverage**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site at www.opm.gov/insure/health; refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

Section 12. Other Federal Programs

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $250 and a maximum annual election of $5,000.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin, products, physician prescribed over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA**) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337). Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

The Federal Empolyees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program, and was established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

All dental plans provide a comprehensive range of services, including:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.

Class D (Orthodontic) services with up to a 24-month waiting period for dependent children up to age 19.

Vision Insurance

All vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/vision and www.opm.gov/insure/dental. These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337, (TTY 1-877-889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives, are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1 800-LTC-FEDS (800-582-3337) (TTY 800-843-3557) or visit www.ltcfeds.com.

Pre-Existing Condition Insurance Program (PCIP)

Do you know someone who needs health insurance but can't get it? The Pre-Existing Condition Insurance Plan (PCIP) may help.

An individual is eligible to buy coverage in PCIP if:

- He or she has a pre-existing medical condition or has been denied coverage because of the health condition;
- He or she has been without health coverage for at least the last six months. (If the individual currently has insurance coverage that does not cover the pre-existing condition or is enrolled in a state high risk pool then that person is not eligible for PCIP.);
- He or she is a citizen or national of the United States or resides in the U.S. legally.

The Federal government administers PCIP in the following states: Alabama, Arizona, District of Columbia, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, North Dakota, Nebraska, Nevada, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wyoming. To find out about eligibility, visit www.pcip.gov and/or www.healthcare.gov or call 1-866-717-5826 (TTY: 1-866-561-1604).

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Summary of benefits for the High Option Benefits of Dean Health Plan - 2012

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions , limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- 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.

High Option Benefits	You pay	Page
Medical services provided by physicians:		20
• **Diagnostic and treatment services provided in the office**	Office visit copay: $10 primary care; $10 specialist	20
• **Preventive care services, such as routine screenings and annual physicals**	Nothing	21
Services provided by a hospital:		42
• **Inpatient**	Nothing	42
• **Outpatient**	Nothing	43
Emergency benefits:		45
• **In-area**	$75 per emergency room visit	46
• **Out-of-area**	$75 per emergency room visit	46
Mental health and substance abuse treatment:	$10 copay per visit	47
Prescription drugs:		49
• **Retail pharmacy**	Tier 1 generics $10 copay Tier 2 preferred brands 30% co-insurance, maximum $75 copay per prescription $1,500 brand drug out of pocket maximum per contract year. $10 copay applies thereafter Tier 3-Expanded brands and select generics 50% co-insurance with a minimum $50 copay and a maximum $150 copay per prescription.	49
• **Mail order**	90 day supply for two copays • Tier 1- $20 (90 day supply) • Tier 2 - 30% of the cost for a 2-month supply (90 day supply) • Tier 3 - Not eligible for mail order savings	50
Dental care:	Accidental injury benefit	52
Vision care:	One refraction annually; $10 per office visit	25

2012 Rate Information for Dean Health Plan

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the *Guide to Federal Benefits* for that category or contact the agency that maintains your health benefits enrollment.

Postal Category 1 rates apply to career employees covered by the National Postal Mail Handlers Union (NPMHU), National Association of Letter Carriers (NALC) and Postal Police bargaining units.

Postal Category 2 rates apply to other non-APWU, non-PCES, non-law enforcement Postal Service career employees, including management employees, and employees covered by the National Rural Letter Carriers' Association bargaining unit.

Special Guides to Benefits are published for American Postal Workers Union (APWU) employees (see RI 70-2A) including Material Distribution Center, Operating Services and Information Technology/Accounting Services employees and Nurses; Postal Service Inspectors and Office of Inspector General (OIG) law enforcement employees (see RI 70-2IN), Postal Career Executive Service (PCES) employees (see RI 70-2EX), and noncareer employees (see RI 70-8PS).

Career APWU employees hired before May 23, 2011, will have the same rates as the Category 2 rates shown below. In the Guide to Benefits for APWU Employees (RI 70-2A) this will be referred to as the "Current" rate; otherwise, "New" rates apply.

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center
1-877-477-3273, option 5
TTY: 1-866-260-7507

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable *Guide to Federal Benefits*.

Guide for that category or contact the agency that maintains your health benefits enrollment.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
Service Area: South Central Wisconsin							
High Option Self Only	WD1	$185.75	$69.36	$402.46	$150.28	$48.73	$46.15
High Option Self and Family	WD2	$414.35	$223.43	$897.76	$484.10	$177.39	$171.63