Dean Health Plan, Inc.

www.deancare.com

Customer Care Center (800) 279-1301

2016

A Health Maintenance Organization (High and Standard option)

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See pages 23-69 for details.

IMPORTANT
- Rates: Back Cover
- Changes for 2016: Page 15
- Summary of benefits: Page 93

Serving: South Central Wisconsin

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 14 for requirements.

Enrollment code for this Plan:

WD1 High Option – Self Only
WD3 High Option – Self Plus One
WD2 High Option – Self and Family

WD4 Standard Option – Self Only
WD6 Standard Option – Self Plus One
WD5 Standard Option – Self and Family

NCQA Excellent Accreditation

Federal Employees
Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

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

Important Notice from Dean Health Plan About

Our Prescription Drug Coverage and Medicare

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

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and 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 Medicare Part D 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 will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

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

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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. Customer Care Center may be reached at 800-279-1301 or through our website: www.deancare.com. The address for Dean Health Plan's administrative office is:

Physical Address	**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 verbal statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. If you enroll in Self Plus One coverage, you and one eligible family member that you designate when you enroll are entitled to these benefits. You do not have a right to benefits that were available before January 1, 2016, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2016, and changes are summarized on page 15. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Services (IRS) website at http://www.irs.gov//uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

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.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

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

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

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

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

CALL THE HEALTH CARE FRAUD HOTLINE

877-499-7295

OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

You can also write to:

United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise) or
  - Your child age 26 or over (unless 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.
- If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

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 and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your 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 or nutritional supplements 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

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. These conditions and errors are called "Never Events". When a Never Event occurs, neither your FEHB plan nor you will incur costs to correct the medical error.

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.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

- **Minimum essential coverage (MEC)**

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

- **Minimum value standard**

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

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

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

  Information on the FEHB Program and plans available to you

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

  Also, your employing or retirement office can answer your questions, and give you 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 Plus One coverage is an enrollment that covers you and one eligible family member. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

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

The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you 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.

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

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below. A Self Plus One enrollment covers you and one eligible family member as described in the chart below.

Children	Coverage
Natural children, 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/healthcare-insurance.

- **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 Plus One or Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

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

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the 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 Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, 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. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2016 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 2015 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 additional information about your coverage choices. You can also visit OPM's website at http://www.opm.gov/healthcare-insurance/healthcare/plan-information.

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

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

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

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

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

- **Converting to individual coverage**

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

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

  If you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must 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.

- **Health Insurance Marketplace**

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

Section 1. How this plan works

This Plan is a health maintenance organization (HMO). 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 current and complete listing of physicians, clinics, pharmacies and more at www.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.

General Features - High Option Plan

- No Deductible
- 10% Coinsurance up to coinsurance limit ($500 Self Only enrollment, $500 per person for Self Plus One enrollment, $1,000 for Self and Family enrollment)
- Diagnostic services associated with an office visit and/or urgent care visit covered at 100% (no member cost share)
  - X-Rays and Readings
  - Laboratory Services and Readings
  - Hearing Services
  - Vision Care Services
  - Readings - MRI/MRA, CT Scans, PET Scans
- All other services subject to 10% coinsurance
- $20 Primary Care Provider Office Visit Copayment
- $40 Specialist and/or Urgent Care Office Visit Copayment
- $100 Emergency Room Copayment
- $6,600 Self Only enrollment or per person under Self Plus One enrollment / $13,200 Self Plus Family enrollment Catastrophic Protection Maximum Out-of-Pocket (Includes coinsurance and medical and pharmacy copays)
- Preventive care services are generally covered with no cost-sharing and are not subject to copayments, deductibles, or annual limits when received from a network plan provider.*

General Features - Standard Option Plan

- $500 Self Only / $500 per person under Self Plus One / $1,000 Self Plus Family Deductible
- 10% Coinsurance
- Diagnostic services associated with an office visit or urgent care visit covered at 100% (no member cost share)
  - X-Rays and Readings
  - Laboratory Services and Readings
  - Hearing Services
  - Vision Care Services
  - Readings - MRI/MRA, CT Scans, PET Scans

- All other services subject to 10% coinsurance
- $5,000 Self Only / $5,000 per person under Self Plus One / $10,000 Self Plus Family Deductible & Coinsurance Limit
- $5,000 Self Only / $5,000 per person under Self Plus One / $10,000 Self Plus Family Catastrophic Protection Maximum Out-of-Pocket (Includes deductible & coinsurance limit plus medical and pharmacy copayments)
- Preventive care services are generally covered with no cost-sharing and are not subject to copayments, deductibles, or annual limits when received from a network plan provider.*

*Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ and HHS at https://www.healthcare.gov/preventive-care-benefits/.

Open Access Benefits

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

Catastrophic Protection (Maximum Out-of-Pocket)

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles, coinsurance and medical and pharmacy copayments, cannot exceed $6,600 for Self Only enrollment, and $13,200 for a Self Plus One or Self and Family enrollment under the High Option plan; or $5,000 for Self Only enrollment or $10,000 for Self Plus One or Self and Family enrollment under the Standard Option plan.

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/healthcare-insurance) lists the specific types of information that we must make available to you. Some of the required information is listed below.

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

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 www.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.

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

Section 2. Changes for 2016

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

- Self Plus One enrollment type has been added effective January 1, 2016.
- We have removed the exclusion for services, drugs, or supplies related to sex transformations. See page 73.

Changes to both High and Standard Options

- **Acupuncture Benefit** - We have added coverage for acupuncture up to 10 visits per calendar year. Your share per visit is a $20 copayment. See page 41.
- **Out-of-Area Dependent Coverage** - Qualified dependent children who live outside the service area can see certain providers outside the service area and still have claims paid at an in-network rate. See page 14.

Changes to High Option Only

- Your cost share of the services below have increased to 10% of costs until you reach your $500/$1,000 annual coinsurance limit (see page 21). The 10% coinsurance would apply to services:
  - Inpatient/Outpatient Hospital Services
  - Skilled Nursing
  - Ambulance
  - Hearing Aids
  - Home Health
  - Inpatient Mental Health
  - Durable Medical Equipment

Changes to Standard Option Only

- Your cost share of the below diagnostic services when associated with and office visit and/or urgent care visit have been eliminated (see page 27):
  - X-Rays and Readings
  - Laboratory Services and Readings
  - Hearing Services
  - Vision Care Services
  - Readings - MRI/MRA
  - Readings - CAT Scans
  - Readings - PET Scans

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 www.deancare.com.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, 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 www.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 www.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. 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**

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

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

If you are in the third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **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 Out-of-Network Provider services (non-plan providers)
- Specific Radiology services
- Non-emergent ambulance transport and elective air ambulance transport
- Services provided in a home setting
- Durable medical equipment (DME) greater than $500; unless otherwise stated in our Medical Policies
- 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
- Select diagnostic testing (e.g. genetic testing)
- Skilled nursing facility/swing beds (SNF)
- Surgical procedures related to obesity
- Bariatric surgery
- Home infusion

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

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

Next, provide the following information:

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

- **Non-urgent care claims**

  For non-urgent care claims, we will 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 let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

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

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

- **Concurrent care claims**

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

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

- **Emergency inpatient admission**

  If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must 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. Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by 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 cost for covered services

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

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g. copayments) for the covered care you receive.

Coinsurance

Coinsurance is the percentage of covered expenses that a member is required to pay each time covered services are provided, subject to any maximums specified in this brochure. Coinsurance amounts are applied toward the catastrophic protection out-of-pocket maximum expense in most circumstances.

The calendar year coinsurance limit under the High Option is $500 for Self Only enrollment, or $500 per person for Self Plus One, or $1,000 for Self and Family enrollment.

The calendar year coinsurance limit under the Standard Option is $4,500 for Self Only enrollment, or $4,500 per person for Self Plus One, or $9,000 for Self and Family enrollment.

Example:

High Option Plan: For most services you pay 10% coinsurance of actual charges up to your coinsurance policy limit.

Standard Plan: For most services you pay 10% coinsurance of actual charges after your deductible has been met up to your Deductible & Coinsurance policy limits.

Copayments

A copayment is a specified dollar amount that you may be required to pay each time covered services are provided, subject to any maximums specified in this policy.

Copayment amounts are applied to our contracted fee or Maximum Allowable Fee, and apply at the benefit level.

Copayment amounts are applied toward the out-of-pocket expense maximum.

Example:

Primary Care Provider Copayment: When you see your primary care physician or chiropractor you pay a copayment of $20 per office visit.

Specialist Provider Copayment: When you see a specialty provider you pay a copayment of $40 per office visit.

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible.

The High Option plan does not have a deductible.

The Standard Option plan has a calendar year deductible of $500 per person. Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach $500 under the Standard Option. Under a Self Plus One enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the calendar year deductible for your enrollment reach $1,000 under the Standard Option. Under a Self and Family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $1,000 under the Standard Option.

Under a Self Plus One or Self and Family enrollment, no one member will ever be required to satisfy more than the Self Only deductible amount of $500.

Note: If you change plans during Open Season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

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 maximum

After your out-of-pocket expenses, including any applicable deductibles, copayments and coinsurance total $6,600 for Self Only, or $13,200 for a Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. ***The maximum annual limitation on cost sharing listed under Self Only of $6,600 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.***

Example Scenario: Your plan has a $6,600 Self Only maximum out-of-pocket limit and a $13,200 Self Plus One or Self and Family maximum out-of-pocket limit. If you or one of your eligible family members has out-of-pocket qualified medical expenses of $6,600 or more for the calendar year, any remaining qualified medical expenses for that individual will be covered fully by your health plan. With a Self and Family enrollment out-of-pocket maximum of $13,200, a second family member, or an aggregate of other eligible family members, will continue to accrue out-of-pocket qualified medical expenses up to a maximum of $6,600 for the calendar year before their qualified medical expenses will begin to be covered in full.

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

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

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

Carryover

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 and Standard Option Benefits

See page 15 for how our benefits changed this year. Pages 90 and 92 are a benefits summary. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Section 5. High and Standard Option Benefits Overview

This Plan offers both a High and Standard Option. Both benefit packages are described in Section 5. Make sure you review the benefits that are available under the option in which you are enrolled.

The High and Standard 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 and Standard Option benefits, contact us at 800-279-1301 or on our website at www.deancare.com/federalemployee.

Each option offers unique features.

High Option Plan Overview - $0 Deductible; 10% coinsurance up to the coinsurance limit*; $20 Primary Care Provider Office Visit Copayment or $40 Specialist Office Visit Copayment; $40 Urgent Care Copayment; $100 Emergency Room Copayment; $6,600 self only or $13,200 self and family maximum out-of-pocket.

*The calendar year coinsurance limit under the High Option is $500 for Self Only enrollment, $500 per person for Self Plus One enrollment and $1,000 for Self and Family enrollment.

Standard Option Plan Overview - The calendar year deductible under the Standard Option is $500 per person ($1,000 per Self Plus One enrollment, or $1,000 per Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section.

The calendar year coinsurance limit under the Standard Option is $4,500 for Self Only enrollment, or $4,500 per person for Self Plus One, or $9,000 for Self and Family enrollment.

Note: Under both the High Option and Standard Option, member cost share will be waived for the following diagnostic services associated with an office visit or urgent care visit:

- X-Rays and Readings of X-Rays
- Laboratory Services and Readings
- Hearing Services
- Vision Care Services
- Readings of MRI/MRA, CT Scans and/or PET Scans

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.
- The calendar year deductible under the Standard Option is $500 per person ($1,000 per Self Plus One enrollment, or $1,000 per Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. There is no calendar year deductible under the High Option.
- The calendar year coinsurance limit under the High Option is $500 for Self Only enrollment, or $500 per person for Self Plus One, or $1,000 for Self and Family enrollment.

  The calendar year coinsurance limit under the Standard Option is $4,500 for Self Only enrollment, or $4,500 per person for Self Plus One, or $9,000 for Self and Family enrollment.
- 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	**High Option**	**Standard Option**
Professional services of physicians • In physician's office	$20 copayment per visit - Primary Care Provider $40 copayment per visit - Specialist	$20 copayment per visit - Primary Care Provider $40 copayment per visit - Specialist
Professional services of physicians • In an urgent care center • Office medical consultation • Second surgical opinion	$40 copayment per visit	$40 copayment per visit
• During a hospital stay • In a skilled nursing facility	10% coinsurance	10% coinsurance after deductible
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**
Diagnostic services associated with an office visit or urgent care visit • X-Rays and Readings • Laboratory Services and Readings • Hearing Services • Vision Care Services • Readings - MRI/MRA, CAT Scans, PET Scans	Nothing	Nothing
• CAT Scan	$50 copayment per visit (3 copayment maximum of $150 per member per year) Outpatient services only	10% coinsurance after deductible Outpatient services only

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

Benefit Description	You pay	
Lab, X-ray and other diagnostic tests (cont.)	**High Option**	**Standard Option**
• MRI	$50 copayment per visit (3 copayment maximum of $150 per member per year) Outpatient services only	10% coinsurance after deductible Outpatient services only
• PET Scan	$50 copayment per visit (3 copayment maximum of $150 per member per year) Outpatient services only.	10% coinsurance after deductible Outpatient services only.
Preventive care, adult	**High Option**	**Standard Option**
Routine physical once annually which includes: Routine screenings, such as: • Total Blood Cholesterol • Colorectal Cancer Screening, including - Fecal occult blood test - Sigmoidoscopy screening - every five years starting at age 50 - Colonoscopy screening - every ten years starting at age 50 Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention.	Nothing	Nothing
Well woman care, including but not limited to: • Routine pap test • Human papillomavirus testing • Annual counseling for sexually transmitted infections • Annual counseling and screening for human immune-deficiency virus • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence • One annual well-woman preventive care visit per member to obtain the recommended services that are age and developmentally appropriate. Female members may choose a provider in Internal Medicine, Family Medicine or Ob/Gyn for this visit, but any additional visits to these providers in a calendar year will be subject to cost sharing.	Nothing	Nothing
Routine mammogram - covered for women age 40 and older.	Nothing	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
Note: Preventive services are defined as health care services that might include screenings, check-ups, and patient counseling to ***prevent*** *illnesses, disease, or other health problems. The Affordable Care Act (ACA) outlines preventive services which are offered at no cost sharing to the member.* *Additionally, in order to be covered under the plan, preventive services must:* • *Be performed by or ordered by a Primary Care Physician or Obstetrician/Gynecologist ; and* • *Be expenses for care to evaluate or assess health and wellbeing and screen for possible detection of unrevealed illness on a regular basis; and* • *Be provided by a Plan Provider; and* • *Not be performed for the primary reason of diagnosing or treating an illness or injury.* *Dean Health Plan follows the United States Preventive Service's Task Force (USPSTF) recommendations for preventive services. We allow services that receive an "A" or "B" rating. We do cover certain services under the ACA (preventive services) related to pregnancy at no member cost share.* *You may review the Health Resources and Services Administration (HRSA) guidelines available at http://www.hrsa.gov/womensguidelines/and related federal guidance for additional detail.* *Laboratory and diagnostic studies may be subject to other plan benefits (diagnostic or treatment benefits) if determined not to be part of a preventive visit. When a Member has symptoms or a history of an illness or injury, laboratory and diagnostic studies relating to that illness or injury are no longer considered part of a preventive visit.* *A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ and HHS at https://www.healthcare.gov/preventive-care-benefits/.*		
Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance.	*All charges*	*All charges*

Benefit Description	You pay	
Preventive care, children	**High Option**	**Standard Option**
• Physical health examinations and well baby/child checkups for preventive care (through age 18). • Immunizations recommended by the Advisory Committee on immunizations practices (ACIP) of the Centers of Disease Control. • Vision/hearing screenings for all children.* Note: This service (*) is only covered as preventive when done as part of a well-baby/child checkup.	Nothing	Nothing
• Pediatric Vision (eye glasses) – One pair of eyeglasses per contract year. Covered Expenses: • Single vision, Conventional (lined) Bifocal, and Conventional (lined) Trifocal lenses • Polycarbonate lenses are covered for children (monocular or patients with prescriptions ≥+/-6.00 diopters) • Frame • Scratch Resistant Coating • Ultraviolet Protective Coating Lenses include choice of glasses or plastic lenses, all lens powers (single vision, bifocal, trifocal). 1 pair of replacement glasses per year. Non-Covered Expenses: • Blended Segment Lenses • Intermediate Vision Lenses • Standard Progressives • Premium Progressives (Varilux®, etc.) • Photochromic Glass Lenses • Plastic Photosensitive Lenses (Transitions®) • Polarized Lenses • Standard Anti-Reflective (AR) Coating • Premium AR Coating • Contact lenses Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ and HHS at https://www.healthcare.gov/preventive-care-benefits/.	Nothing	Nothing

Benefit Description	You pay	
Travel immunizations	**High Option**	**Standard Option**
Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention.	Nothing	Nothing
Maternity care	**High Option**	**Standard Option**
Complete maternity (obstetrical) care, such as: • Delivery • Postnatal care	$20 copayment - Primary Care Provider or $40 copayment - Specialist per office visit* 10% coinsurance for inpatient professional delivery services	$20 copayment - Primary Care Provider or $40 copayment - Specialist per office visit* 10% coinsurance after deductible for inpatient professional delivery services.
• Prenatal care. • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk. • Breastfeeding support, supplies and counseling for each birth.	Nothing	Nothing
Note: Here are some things to keep in mind: • *Hospital services are covered under Section 5(c).* • *New members under this Certificate who are in their third trimester as of their effective date and are seeing an Out-of-Network Provider are allowed to continue receiving care with their Out-of-Network Provider for the duration of their pregnancy and until their first postpartum checkup. Services provided by an Out-of-Network Provider require Prior Authorization.* • *You do not need to precertify your normal delivery, see page 17 for other circumstances, such as extended stays for you or your baby.* • *You may remain in the hospital up to 48 hours after a 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 18 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 Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision.* • *We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.*		

Maternity care - continued on next page

Benefit Description	You pay	
Maternity care (cont.)	**High Option**	**Standard Option**
• *Dean Health Plan follows the United States Preventive Service's Task Force (USPSTF) recommendations for preventive services. We allow services that receive an "A" or "B" rating. We do cover certain services under the ACA (preventive services) related to pregnancy at no member cost share.* • You may review the Health Resources and Services Administration (HRSA) guidelines available at http://www.hrsa.gov/womensguidelines/ and related federal guidance for additional detail. Statement of Rights under the Newborns' and Mothers' Health Protection Act Under federal law, health insurers such as Us generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. Federal law does not prohibit the mother's or newborn's attending Health Care Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). If this occurs, We will only provide benefits for the shorter stay. We may not require you to obtain Prior Authorization for stays that are not in excess of 48 hours (or 96 hours). Although not required, you may obtain a Prior Authorization for services that might reduce your out-of-pocket costs. For information on Prior Authorization, please call Our Customer Care Center.		
Not covered: • *Amniocentesis, CVS (Chorionic Villi Sampling), or non-invasive pre-natal testing when performed exclusively for sex determination.* • *Birthing classes (e.g. Lamaze).* • *Elective abortions.* • *Home or intentional out of hospital deliveries (e.g. free standing birthing centers).* • *Maternity services received outside the service area during the last 30 days of the pregnancy except for emergency and urgent care services.* • *Treatment, services or supplies for a non-Member Traditional Surrogate or Gestational Carrier.*	*All charges*	*All charges*

Benefit Description	You pay	
Family planning	**High Option**	**Standard Option**
A range of voluntary family planning services, limited to: • Vasectomy (in an office setting) • Sterilization procedures for women • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo-Provera) • Diaphragms • Contraceptive counseling on an annual basis See Preventive care, adult Section 5 (a) for additional well women services. Note: We cover oral contraceptives under the prescription drug benefit.	$20 copayment per visit - Primary Care Provider $40 copayment per visit - Specialist Nothing	$20 copayment per visit - Primary Care Provider $40 copayment per visit - Specialist Nothing
Not covered: • *Reversal of voluntary surgical sterilization*	*All charges*	*All charges*
Infertility services	**High Option**	**Standard Option**
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	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*	*All charges*

Benefit Description	You pay	
Allergy care	**High Option**	**Standard Option**
Testing and treatment	$20 copayment per visit - Primary Care Provider $40 copayment per visit - Specialist	10% coinsurance after deductible
Allergy Injections Allergy Serum	Nothing	Nothing
Not covered: • *Provocative food testing and sublingual allergy desensitization*	*All charges*	*All charges*
Treatment therapies	**High Option**	**Standard Option**
• 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 47. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy	Nothing	10% coinsurance after deductible
• Applied Behavior Analysis (ABA) Therapy for Autism Spectrum Disorder Note: Growth hormone therapy (GHT) is covered under the prescription drug benefit. We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See other services on page 18.	$20 copayment per day per therapy type	$20 copayment per day per therapy type
Therapies & rehabilitation services	**High Option**	**Standard Option**
Autism ***Please contact our Customer Care Center for coordination of care assistance.*** Covered Expenses:	$20 office visit copay will apply where applicable (i.e. Autism Intensive/Non-Intensive Physician and Facility Charges)	$20 office visit copay will apply where applicable (i.e. Autism Intensive/Non-Intensive Physician and Facility Charges) 10% coinsurance after deductible for all other related services

Therapies & rehabilitation services - continued on next page

Benefit Description	You pay	
Therapies & rehabilitation services (cont.)	**High Option**	**Standard Option**
• 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 • 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.	$20 office visit copay will apply where applicable (i.e. Autism Intensive/Non-Intensive Physician and Facility Charges)	$20 office visit copay will apply where applicable (i.e. Autism Intensive/Non-Intensive Physician and Facility Charges) 10% coinsurance after deductible for all other related services

Therapies & rehabilitation services - continued on next page

Benefit Description	You pay	
Therapies & rehabilitation services (cont.)	**High Option**	**Standard Option**
• 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 but for whom non-intensive level services will improve the member's condition. Non-intensive Level Services must be consistent with the following: • The services are based upon a treatment plan and includes specific therapy goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that the Member be present and engaged in the intervention. • Implemented by qualified providers, qualified supervising providers, qualified professionals, qualified therapists or qualified paraprofessionals as defined by state law. • Provides treatment and services in an environment most conducive to achieving the goals of the Member's treatment plan. • Provides training and consultation, participation in team meetings and active involvement of the Member's family in order to implement therapeutic goals developed by the team • Provides supervision for qualified professionals and paraprofessionals in the treatment team. • Services must be assessed for progress and documented throughout the course of treatment.	$20 office visit copay will apply where applicable (i.e. Autism Intensive/Non-Intensive Physician and Facility Charges)	$20 office visit copay will apply where applicable (i.e. Autism Intensive/Non-Intensive Physician and Facility Charges) 10% coinsurance after deductible for all other related services
Not covered Autism Expenses:* • *Animal-based therapy including hippotherapy* • *Auditory integration training*	*All charges*	*All charges*

Therapies & rehabilitation services - continued on next page

Benefit Description	You pay	
Therapies & rehabilitation services (cont.)	**High Option**	**Standard Option**
• *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 Exclusions* ***These items may be covered under the normal terms and conditions of the policy and are not covered under the Autism benefit. Please see Section 5(f). Prescription drug benefits, if applicable, and/or Section 5(a). Medical services and supplies provided by physician and other health care professionals (Durable Medical Equipment) for more information.*	*All charges*	*All charges*
Physical and occupational therapies	**High Option**	**Standard Option**
Outpatient visits if significant improvement can be expected within two months for the services of each of the following: • Qualified Physical Therapists • Occupational Therapists Note: We only cover therapy when a provider orders the care. 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.	$40 copayment per day per therapy type	$40 copayment 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	10% coinsurance after deductible
Habilitative Services • Physical Therapy, Occupational Therapy and Speech Therapy.	$40 copayment per visit	$40 copayment per visit

Physical and occupational therapies - continued on next page

Benefit Description	You pay	
Physical and occupational therapies (cont.)	**High Option**	**Standard Option**
• Counseling. • Behavioral health services. • Developmental delay. • Cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings. • Certain services require Prior Authorization from our Medical Affairs Division. - Please contact the Customer Care Center for a current list of services that require Prior Authorization.	$40 copayment per visit	$40 copayment per visit
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* *Not Covered - Habilitative Services:* • *Custodial care.* • *Daycare.* • *Recreational care.* • *Respite care.* • *Vocational training.*	*All charges*	*All charges*
Speech therapy	**High Option**	**Standard Option**
Outpatient visits when medically necessary	$40 copayment per day per therapy type	$40 copayment per day per therapy type
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• Hearing services to determine if correction is needed • Treatment related to illness or injury, including diagnostic hearing tests performed by an M.D., D. O., or audiologist	Nothing	Nothing

Hearing services (testing, treatment, and supplies) - continued on next page

Benefit Description	You pay	
Hearing services (testing, treatment, and supplies) (cont.)	**High Option**	**Standard Option**
• One hearing aid per ear every 36 months • One adult hearing aid per ear, including repairs, ear molds and hearing aid dispensing fees. The hearing aid must be repaired by/purchased from Dean Clinic, S.C., or other authorized providers. Please contact the Customer Care Center with questions regarding authorized providers, or reference our website at www.deancare.com. • Infants and children through age 18 who are certified as deaf or hearing impaired by a physician or audiologist are eligible for bilateral hearing aids. Benefits are available per benefit period. The benefit period is 36 consecutive months from the date the benefit is first used. • Cochlear implants for children and adults, including procedures for implantation and post-cochlear implant aural therapy, with prior authorization by our Medical Affairs Division for therapy benefits please refer to Section 5(a) Orthopedic and prosthetic devices for benefits for devices). Note: • For routine hearing screening performed during a child's preventive care visit, see Section 5(a) Preventive care, children.	10% coinsurance	10% coinsurance after deductible
Not covered: • *Batteries for hearing aids* • *Hearing aids that can be purchased without a prescription and the following:* - *A fully implantable middle ear hearing aid and,* - *Non-implantable, intraoral bone conduction hearing aid*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• Routine Vision Exam • Non-Routine Vision Exam • Vision Care Services • Diagnostic Vision Services	$40 copayment per visit $40 copayment per visit Nothing Nothing	$40 copayment per visit $40 copayment per visit Nothing Nothing
Not covered: • *Eyeglasses or fitting of contact lenses* • *Eye exercises and orthoptics*	*All charges*	*All charges*

Vision services (testing, treatment, and supplies) - continued on next page

Benefit Description	You pay	
Vision services (testing, treatment, and supplies) (cont.)	**High Option**	**Standard Option**
• *Radial keratotomy and other refractive surgery*	*All charges*	*All charges*
Foot care	**High Option**	**Standard Option**
• Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. • Treatment of bunions and spurs *Note: See orthopedic and prosthetic devices for information on podiatric shoe inserts.*	$40 copayment per visit	$40 copayment per visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery).*	*All charges*	*All charges*
Orthopedic and prosthetic devices	**High Option**	**Standard Option**
• Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Lenses following cataract removal; or therapeutic contact lenses/bandages as well as the fitting as determined by Dean Health Plan. • 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.	10% coinsurance	10% coinsurance after deductible

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay	
Orthopedic and prosthetic devices (cont.)	**High Option**	**Standard Option**
Purchases exceeding $500 per month must be authorized by the plan's Medical Affairs Division. Your plan doctor will obtain the prior authorization.	10% coinsurance	10% coinsurance after deductible
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *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*	*All charges*
Durable medical equipment (DME)	**High Option**	**Standard Option**
Rental of a ventilator or other mechanical equipment or purchase of such equipment at the option of Dean Health Plan. Purchases exceeding $500 per month or rentals exceeding $500 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 • Oxygen therapy and other inhalation therapy and related items for home use must be prior authorized by the Utilization Management Department 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.	10% coinsurance	10% coinsurance after deductible
Not covered:	*All charges*	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay	
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**
• *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.* • *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*	*All charges*
Home health services	**High Option**	**Standard Option**
• 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.	10% coinsurance	10% coinsurance after deductible
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*	*All charges*

Benefit Description	You pay	
Chiropractic	**High Option**	**Standard Option**
• Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	$20 copayment per visit	$20 copayment per visit
Not covered: • *Maintenance and long term therapies.*	*All charges*	*All charges*
Alternative treatments	**High Option**	**Standard Option**
Acupuncture Note: Limited to 10 visits per member per contract period. Please visit our website at www.deancare.com for a list of participating acupuncturists.	$20 copayment per visit	$20 copayment per visit
Not Covered: • *Holistic medicine and other form of alternative medicine.*	*All charges*	*All charges*
Educational classes and programs	**High Option**	**Standard Option**
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.	Nothing	Nothing

Educational classes and programs - continued on next page

Benefit Description	You pay	
Educational classes and programs (cont.)	**High Option**	**Standard Option**
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. 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 at www.deancare.com/quitforlife.	Nothing	Nothing

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.
- The calendar year deductible under the Standard Option is $500 per person ($500 per Self Plus One enrollment, or $1,000 per Self and Family enrollment). The calendar year deductible applies to most all benefits in this Section.
- The calendar year coinsurance limit under the High Option is $500 for Self Only enrollment, or $500 per person for Self Plus One, or $1,000 for Self and Family enrollment.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See 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	**High Option**	**Standard Option**
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. • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information. • Cochlear implant procedures (requires prior authorization) • Voluntary sterilization (e.g., vasectomy) • Treatment of burns	10% coinsurance	10% coinsurance after deductible

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	**High Option**	**Standard Option**
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. 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.	10% coinsurance	10% coinsurance after deductible
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care* • *Sexual dysfunction treatment.*	*All charges*	*All charges*
Reconstructive surgery	**High Option**	**Standard Option**
• 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*)	10% coinsurance	10% coinsurance after deductible

Reconstructive surgery - continued on next page

Benefit Description	You pay	
Reconstructive surgery (cont.)	**High Option**	**Standard Option**
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.	10% coinsurance	10% coinsurance after deductible
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* • *Sexual dysfunction treatment*	*All charges*	*All charges*
Oral and maxillofacial surgery	**High Option**	**Standard Option**
• Surgery consult and/or evaluation. • Surgical procedures as follows: - Removal of impacted teeth - Removal of tumors and cysts that are not related to non-bony impacted teeth. - Treatment for accidental injuries of the jaw, cheeks, lips, tongue, roof, and floor of mouth. - Apicoectomy. - Removal of exostoses of the jaw and hard palate when not performed to facilitate denture placement. - Treatment of fractured facial bones. - External/ internal incision and drainage of facial abscess of soft tissues. - Cutting of accessory sinuses, salivary glands or ducts. - Reducing dislocations; alveoloplasty. - Lingual frenectomy. - Vestibuloplasty. - Residual root removal. Medically Necessary Hospitalization for Dental Procedures Prior Authorization is required and coverage is limited to hospitalization recommended by a physician and received during a dental procedure provided to a member who is a child under age seven or is severely disabled or has a medical condition that requires hospitalization or general anesthesia for dental care treatment. Hospitalization or use of general anesthesia necessary due to anxiety is not a covered benefit. Covered Expenses:	$40 copayment per visit (surgery consult and/or evaluation) 10% coinsurance (all other services)	$40 copayment per visit (surgery consult and/or evaluation) 10% coinsurance after deductible (all other services)

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay	
Oral and maxillofacial surgery (cont.)	**High Option**	**Standard Option**
• 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. Temporomandibular Disorders (TMD) Covered Expenses: Coverage is limited to diagnostic procedures and Medically Necessary surgical or non-surgical treatment for the correction of temporomandibular disorders (TMD), if the following apply: • Under the accepted standards of the profession of the Health Care Provider rendering the service, the procedure or device is reasonable and appropriate for the diagnosis or treatment of this condition. • The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.	$40 copayment per visit (surgery consult and/or evaluation) 10% coinsurance (all other services)	$40 copayment per visit (surgery consult and/or evaluation) 10% coinsurance after deductible (all other services)
Not Covered Expenses for Oral Surgery: • *All charges or costs exceeding a benefit maximum.* • *All dental services, except those listed as covered in Section 5(g). Dental Benefits subsection.* • *Surgery performed to correct functional deformities of the mandible or maxilla.* • *Correction of malocclusion.* • *Orthognathic surgery.* • *Orthodontic care, periodontic care, or general dental care.* • *Restoration. Examples include but are not limited to crowns and root canals.* • *Tooth damage due to eating, chewing or biting.* *Not Covered Expenses Hospitalization for Dental Procedures:*	*All Charges*	*All Charges*

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay	
Oral and maxillofacial surgery (cont.)	**High Option**	**Standard Option**
• *Hospitalization costs for services not listed in this Section, except those listed in the "Hospital & Surgical Services" subsection, for which Prior Authorization is required.* *Not Covered Expenses for Temporomandibular Disorders (TMD):* • *All dental services, except those listed as covered in this TMD subsection.*	*All Charges*	*All Charges*
Organ/tissue transplants	**High Option**	**Standard Option**
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 18. Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung: single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	Nothing	10% coinsurance after deductible

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
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 recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - 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) - 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 recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Epithelial ovarian cancer - Multiple myeloma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	Nothing	10% coinsurance after deductible

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
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 recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - 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 recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (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.	Nothing	10% coinsurance after deductible

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Multiple myeloma - Multiple sclerosis - Sickle Cell anemia Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Chronic lymphocytic leukemia • Chronic myelogenous leukemia • Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) • Multiple myeloma • Multiple sclerosis • Myelodysplasia/Myelodysplastic Syndromes • Myeloproliferative disorders (MSDs) • Autologous Transplants for - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin lymphomas - Childhood rhabdomyosarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Epithelial Ovarian Cancer	Nothing	10% coinsurance after deductible

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Systemic lupus erythematosus - Systemic sclerosis • National Transplant Program (NTP) Note: Coverage for organ-procurement costs is limited to costs directly related to the procurement of an organ from a cadaver or compatible living donor. Organ-procurement costs include the following: organ transportation, compatibility testing, hospitalization, and surgery (when a live donor is involved).	Nothing	10% coinsurance after deductible
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*	*All charges*
Anesthesia	**High Option**	**Standard Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Provider Office	Nothing	10% coinsurance after deductible

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.
- The calendar year deductible under the Standard Option is $500 per person ($500 per Self Plus One enrollment, or $1,000 per Self and Family enrollment). The calendar year deductible applies to most all benefits in this Section.
- The calendar year coinsurance limit under the High Option is $500 for Self Only enrollment, or $500 per person for Self Plus One, or $1,000 for Self and Family enrollment.
- 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	**High Option**	**Standard Option**
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.	10% coinsurance	10% coinsurance after deductible
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	10% coinsurance	10% coinsurance after deductible

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	**High Option**	**Standard Option**
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.	10% coinsurance	10% coinsurance after deductible
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*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard Option**
• 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.	10% coinsurance	10% coinsurance after deductible

Benefit Description	You pay	
Extended care benefits/Skilled nursing care facility benefits	**High Option**	**Standard Option**
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	10% coinsurance	10% coinsurance after deductible
Not covered: Custodial care	*All charges*	*All charges*
Hospice care	**High Option**	**Standard Option**
Hospice Care • Inpatient hospice • Hospice services while at a skilled nursing facility • Home-based hospice	Nothing	10% coinsurance after deductible
Not covered: Independent nursing, homemaker services	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**
Local professional ambulance service when medically appropriate (ground or air). Non-emergent ambulance service requires prior authorization.	10% coinsurance	10% coinsurance after deductible

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.
- The calendar year deductible under the Standard Option is $500 per person ($500 per Self Plus One enrollment, or $1,000 per Self and Family enrollment). The calendar year deductible applies to most all benefits in this Section.
- The calendar year coinsurance limit under the High Option is $500 for Self Only enrollment, or $500 per person for Self Plus One, or $1,000 for Self and Family enrollment.

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 $100 copayment per hospital emergency room visit. The $100 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 $100 copayment per hospital emergency room visit. The $100 copayment will be waived if admitted as inpatient through the emergency room.

Benefit Description	You pay	
Emergency within our service area	**High Option**	**Standard Option**
Emergency care at a doctor's office • With Primary Care Provider • With Specialist • Physician charges and related services Note: See *Section 5(a) Lab, X-Ray and Other Diagnostic Tests* for services covered without member cost share when associated with an office visit or urgent care visit.	 $20 copayment $40 copayment 10% coinsurance*	 $20 copayment $40 copayment 10% coinsurance after deductible*
Emergency care at an urgent care center • With Primary Care Provider or Specialist • Physician charges and related services Note: See *Section 5(a) Lab, X-Ray and Other Diagnostic Tests* for services covered without member cost share when associated with an office visit or urgent care visit.	 $40 copayment 10% coinsurance*	 $40 copayment 10% coinsurance after deductible*
Emergency care as an outpatient at a hospital; including doctors' services Note: We waive the ER copayment if you are admitted to the hospital (High Option). **Other charges will result from services rendered by other providers who treated you during your urgent care or emergency room visit. These charges include, but are not limited to; diagnostic services, procedures/ treatments and various medical supplies.*	$100 copayment per hospital emergency room visit and 10% coinsurance for related services*	10% coinsurance after deductible per hospital emergency room visit*
Not covered: Elective care or non-emergency care	*All charges*	*All charges*
Emergency outside our service area	**High Option**	**Standard Option**
Emergency care at a doctor's office • With Primary Care Provider • With Specialist • Physician charges and related services	 $20 copayment $40 copayment 10% coinsurance*	 $20 copayment $40 copayment 10% coinsurance after deductible*
Emergency care at an urgent care center • With Primary Care Provider or Specialist • Physician charges and related services	 $40 copayment 10% coinsurance*	 $40 copayment 10% coinsurance after deductible*

Emergency outside our service area - continued on next page

Benefit Description	You pay	
Emergency outside our service area (cont.)	**High Option**	**Standard Option**
Emergency care as an outpatient at a hospital; including doctors' services Note: We waive the ER copayment if you are admitted to the hospital (High Option). **Other charges will result from services rendered by other providers who treated you during your urgent care or emergency room visit. These charges include, but are not limited to; diagnostic services, procedures/ treatments and various medical supplies.*	$100 copayment per hopsital emergency room visit and 10% coinsurance for related services*	10% coinsurance after deductible per hospital emergency room visit*
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*	*All charges*
Ambulance	**High Option**	**Standard Option**
Professional ambulance service when medically appropriate (ground or air). Note: See 5(c) for non-emergency service.	10% coinsurance	10% coinsurnace after deductible

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

Certain services require prior authorization from our Medical Affairs Division. Please contact the Customer Care Center for a current list of services that require prior authorization. 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:

- The calendar year deductible under the Standard Option is $500 per person ($500 per Self Plus One enrollment, or $1,000 per Self and Family enrollment). The calendar year deductible applies to most all benefits in this Section.
- The calendar year coinsurance limit under the High Option is $500 for Self Only enrollment, or $500 per person for Self Plus One, or $1,000 for Self and Family enrollment.
- Court-ordered services may not be covered if those services are NOT performed by a Plan Provider, unless the services are a result of an Emergency Detention or received on an emergency basis and you or your provider notifies Dean within 72 hours after the initial services.
- 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 CERTAIN 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. Please contact the Customer Care Center prior to obtaining services.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary and with a plan provider unless otherwise authorized.

Benefit Description	You pay	
Professional services	**High Option**	**Standard Option**
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)	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.

Professional services - continued on next page

Benefit Description	You pay	
Professional services (cont.)	**High Option**	**Standard Option**
• 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.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnostics	**High Option**	**Standard Option**
• 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	$20 copayment per visit (Outpatient) 10% coinsurance (Inpatient)	$20 copayment per visit (Outpatient) 10% coinsurance after deductible (Inpatient)
Inpatient hospital or other covered facility	**High Option**	**Standard Option**
Inpatient mental health services means medically oriented treatment, psychotherapy and other mental health services provided by a licensed professional in a state licensed or certified hospital or mental health residential facility on a 24 hour per day basis to enable a person with a mental disorder or a mental disorder in combination with other impairments to function successfully. • Medically Necessary services provided at an in-network inpatient, mental health inpatient/ residential facility. • Medically Necessary services at an AODA residential/inpatient treatment programs for alcohol and/or drug dependent persons services provided by a licensed professional in a state licensed or certified facility. • Medically Necessary inpatient detoxification services are considered medical and, therefore, are NOT applied to this benefit. Please see the "Detoxification Services" provision under the "Hospital & Surgical Services" subsection for more information on this coverage.	10% coinsurance	10% coinsurance after deductible
Outpatient hospital or other covered facility	**High Option**	**Standard Option**
Partial hospitalization or day treatment programs are more intensive than outpatient services and less intensive than inpatient services. The services must be in a licensed mental health or AODA partial hospitalization or day treatment facility with services by a licensed mental health or AODA provider.	$20 copayment per visit	$20 copayment per visit

Outpatient hospital or other covered facility - continued on next page

Benefit Description	You pay	
Outpatient hospital or other covered facility (cont.)	**High Option**	**Standard Option**
• Medically Necessary outpatient services, including group, family and individual therapy in an office or clinic setting with a mental or AODA in Network Provider. For Full-Time Students attending school in Wisconsin, but outside the service area: • A clinical assessment by an Out-of-Network Provider and 5 visits for outpatient mental health or AODA treatment with an approved Prior Authorization. We retain the right to choose the provider. Further treatment may be approved upon review of Our Medical Affairs division. Medically Necessary and prior authorized services for the following treatments and programs: • Mental health or AODA services for adults, adolescents, and children in a partial hospitalization or day treatment program. • Services for persons with chronic mental illness provided through a community program. These programs provide services to people with chronic mental illnesses that, due to history or prognosis, require repeated acute treatment or prolonged periods of inpatient care. Benefits are payable only for charges directly related to treatment of mental illness. • Intensive outpatient programs for the treatment of drug and alcohol use disorders. Treatment must be provided by specialists in addiction medicine. • Intensive outpatient programs for the treatment of mental health disorders. • Coordinated emergency mental health services for persons who are experiencing a mental health crisis or who are in a situation likely to turn into a mental health crisis if support is not provided. Services are provided by a program certified for the period of time the person is experiencing a mental health crisis until the person is stabilized or referred to other providers for stabilization. Certified emergency mental health service plans shall provide timely notice to Us to facilitate coordination of services for persons who are experiencing, or are in a situation likely to turn into, a mental health crisis. Note: To qualify for coverage under mental health and AODA care, the care must be Medically Necessary and prior authorized by Our Medical Affairs division:	$20 copayment per visit	$20 copayment per visit

Outpatient hospital or other covered facility - continued on next page

Benefit Description	You pay	
Outpatient hospital or other covered facility (cont.)	**High Option**	**Standard Option**
• Medical Necessity will be reviewed by Our Medical Affairs division. To qualify, the treatment program must be staffed by a multi-disciplinary team, which should include registered nurses, occupational therapists, social workers, psychologists, physicians or other health care professionals. The treatment must be provided by AODA or mental health credentialed professionals and the treatment program must include a quality assurance program to review quality of care. • Prior Authorization will be approved if Our Medical Affairs division determines that the Member requires more intensive treatment than is available through outpatient services and that the care is the most appropriate level of care for the Member. Prior Authorization does not guarantee payment if the services would not otherwise be covered according to the provisions of this Certificate.		
Not covered mental health and AODA expenses: • *Biofeedback.* • *Family counseling for non-medical reasons.* • *Gambling addiction.* • *Wilderness and camp programs, boarding school, academy-vocational programs and group homes.* • *Halfway houses.* • *Hypnotherapy.* • *Long-Term or Maintenance Therapy.* • *Marriage counseling.* • *Phototherapy.* • *In-home mental health therapy services.*	*All charges*	*All charges*

Preauthorization	All services must be arranged and/or provided by a Plan Provider.
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.
- Federal law prevents the pharmacy from accepting unused medications.
- Members must make sure their physicians obtain prior approval/authorization for certain prescription drugs and supplies before coverage applies. Prior approval/authorization must be renewed periodically.
- Certain prescription drugs included in our formulary require prior authorization. The drug prior authorization process can be initiated by your plan physician or your plan pharmacy by filling out a Drug Prior Authorization Request form. A copy of this request including the determination will then be mailed to you, your plan pharmacy, and plan physician. 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 www.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 licensed physician or dentist, and in states allowing it, licensed or certified Physician Assistant, Nurse Practitioner and Psychologist must prescribe your medication.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy, national plan pharmacy or by mail for a maintenance medication.
- **We use a formulary.** Prescription drugs are included in our formulary by our plan Pharmacy and Therapeutics Committee to ensure that our members receive safe, effective treatment at a reasonable cost. The committee is staffed by providers from many different specialties. Drugs recently approved by the Food and Drug Administration are not automatically included in the formulary but may be added after the committee determines therapeutic advantages of the drug and it's medically appropriate application. In addition, certain drug products are excluded when therapeutic alternatives are available. If your physician prescribes a drug that is not on our formulary, the physician must obtain prior authorization from the Plan in order for the prescription to be covered under Plan benefits. In some cases, the physician will need to prescribe an alternative formulary drug if an alternative is available that is equally effective for the patient for treatment of the specific condition. To order a listing of the drugs that require prior authorization or are excluded, call our Customer Care Center at 800-279-1301 or visit our website at www.deancare.com.
- **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	**High Option**	**Standard Option**
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) • Growth Hormones (prior authorization required) • Tobacco cessation • Intravenous fluids and medication for home use are covered under Medical and Surgical Benefits	Tier 1 (Generics) $10 copayment* Tier 2 (Preferred brands and select generics) 30% co-insurance (maximum $75 copayment per prescription, up to a $1,500 out-of-pocket maximum per contract year, $10 copayment applies thereafter.)* Tier 3 (Non-preferred brands and select generics) 50% co-insurance (minimum $50 copayment and a maximum $150 copayment per prescription)* Tier 4 (Specialty drugs) $100 copayment* *Regardless of the tier your oral chemotherapy falls into you will never pay more than $100 for a 30 day supply, in compliance with the Wisconsin law governing coverage of oral chemotherapy drugs. Note: If there is no Tier 1 generic equivalent available, you will be required to pay the higher Tier 2 or Tier 3 copay.	Tier 1 (Generics) $10 copayment* Tier 2 (Preferred brands and select generics) 30% co-insurance (maximum $75 copayment per prescription, up to a $1,500 out-of-pocket maximum per contract year, $10 copayment applies thereafter.)* Tier 3 (Non-preferred brands and select generics) 50% co-insurance (minimum $50 copayment and a maximum $150 copayment per prescription)* Tier 4 (Specialty drugs) $100 copayment* *Regardless of the tier your oral chemotherapy falls into you will never pay more than $100 for a 30 day supply, in compliance with the Wisconsin law governing coverage of oral chemotherapy drugs. Note: If there is no Tier 1 generic equivalent available, you will be required to pay the higher Tier 2 or Tier 3 copay.
Women's contraceptive drugs and devices • Oral and injectable contraceptive drugs up to a 30 day supply; contraceptive diaphragms	Nothing	Nothing
Note: Zyban is covered through the Tobacco Cessation benefit (see page 39) Note: Drugs to treat sexual dysfunction are limited. Contact the plan for dose limits.	Nothing You pay 50% copay up to the doses' limit and all charges above that.	Nothing You pay 50% copay up to the doses' limit and all charges above that.
Mail Order Prescription Drug Benefit • 90 day supply for the cost of a 60-day supply	Tier 1 (Generics) - $20 copayment	Tier 1 (Generics) - $20 copayment

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
	Tier 2 (Preferred brands and select generics) - 30% coinsurance (maximum $150 copayment per prescription, up to a $1,500 out-of-pocket maximum per contract year; $20 copayment applies thereafter	Tier 2 (Preferred brands and select generics) - 30% coinsurance (maximum $150 copayment per prescription, up to a $1,500 out-of-pocket maximum per contract year; $20 copayment applies thereafter
• Fertility drugs	50% of the cost of the prescription unit or refill	50% of the cost of the prescription unit or refill
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Fertility drugs that are not approved by the plan* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them; except as required by ACA (except for Vitamin D for adults age 65 and older)* • *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 39.)	*All charges*	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- These benefits are intended for dental treatment needed to remove, repair, replace, restore and/or reposition sound, natural teeth damaged, lost, or removed due to an injury occurring while the person is covered under the medical plan.
- The calendar year deductible under the Standard Option is $500 per person ($500 per Self Plus One enrollment, or $1,000 per Self and Family enrollment). The calendar year deductible applies to most all benefits in this Section.
- The calendar year coinsurance limit under the High Option is $500 for Self Only enrollment, or $500 per person for Self Plus One, or $1,000 for Self and Family enrollment.
- A "sound, natural tooth" is a tooth that is fully erupted, has no restoration or minor restoration that does not compromise the strength and integrity of the tooth structure, and has no evidence of periodontal disease that would predispose the tooth injury.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- If you are enrolled in a Federal Employees Dental Vision Insurance program (FEDVIP) Dental Plan, your FEHB Plan will be First Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Desription	You Pay	
Accidental injury benefit	**High Option**	**Standard Option**
• Tooth extractions, initial repair, and/or replacement with artificial teeth, because of an accidental injury. Dental, Extraction of Natural Teeth, and Replacement with Artificial Teeth due to an accidental injury. Note: To be eligible for coverage, the accident and subsequent repair must occur while you are enrolled under this Policy. In addition: • The tooth must meet the definition of "sound, natural tooth". • The evaluation of the injured tooth must occur within 72 hours of the accident. • The repair of the injured tooth must be initiated within 120 days of the injury. • The treatment must be completed within 24 months of the injury. The term "injured" does not include conditions resulting from eating, chewing or biting. Medically Necessary Hospitalization for Dental Procedures:		

Accidental injury benefit - continued on next page

Benefit Desription	You Pay	
Accidental injury benefit (cont.)	**High Option**	**Standard Option**
Prior authorization is required and coverage is limited to hospitalization recommended by a physician and received during a dental procedure provided to a member who is a child under age seven or is severely disabled or has a medical condition that requires hospitalization or general anesthesia for dental care treatment. Hospitalization or use of general anesthesia necessary due to anxiety is not a covered benefit. Covered Expenses: • 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 9; 2. The Member has a chronic disability, or 3. The Member has a medical condition that requires hospitalization or general anesthesia for dental care.		
Routine Dental	**High Option**	**Standard Option**
Dean Health Plan does not provide any other dental benefits.	*All charges*	*All charges*

Section 5(h). Special features

Feature	Description
Feature	
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).
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
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. **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 www.mychart.deancare.com for a list of participating providers.*

Feature - continued on next page

Feature	Description
Feature (cont.)	
Living Healthy Rewards	The Living Healthy rewards program will reward you for participating in numerous health-related activities such as physical activity, weight management programs, healthy eating and more. Just track your healthy habits in your personalized wellness portal and reap the benefits. Go to www.deancare.com/livinghealthy for complete details.
Online Well-Being Assessment	The online Well-Being Assessment (WBA) is a confidential questionnaire that assesses your lifestyle and overall health. Upon completion of the WBA, you will receive a personalized summary of your current lifestyle and health status, as well as specific, actions—unique to you—to help improve your well-being. This questionnaire also helps to customize your wellness portal experience to ensure you are receiving the most appropriate health and wellness tips and updates.
Member Wellness Portal	The comprehensive member wellness portal includes interactive tools, trackers, recipes and meal planners, health tips and more that are all tailored to your specifics needs and interests. You can also download the wellbeingGO™ Mobile App for iPhone and stay connected to your customized resources wherever you are.
Quit For Life® Tobacco Cessation Program	The Quit For Life® Tobacco Cessation Program is completely free to Dean Health Plan 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.
Healthy Partners	Check out a list of fitness clubs that partner with Dean Health Plan to offer our members discounts.
Care Management	We understand that some of our members have complex health needs and we want to be there to help. If you require some extra help navigating your health care or managing your condition, we are here for you. There is no charge for this service. Our goal is to make your continuum of care seamless and effective. Your provider can help you get set up with these services, or you can opt in by contacting the Customer Care Center at 800-279-1301.

Non-FEHB benefits available to Plan members

Section 6. General exclusions – services, drugs, and supplies we do not cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **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 Emergency services/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 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.
- Services or supplies furnished by yourself, immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption.

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 website at www.deancare.com.

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

- Covered member's name, date of birth, address, phone number and ID number
- Name and address of the 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 emergency 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".

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.

Notice Requirements

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

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

Section 8. The disputed claims process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information 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. To make your request, please contact our Customer Care Center by writing Dean Health Plan, P.O. Box 56099, Madison, WI 53705 or calling 800-279-1301.

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

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

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

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

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

c) Ask you or your provider for more information

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

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

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

You must write to OPM within:

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

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, 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 file a lawsuit.. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

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

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

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

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

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays 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' (NAIC) guidelines. For more information on NAIC rules regarding the coordination of benefits, visit the NAIC website at www.NAIC.org.

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.

- **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

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

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

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

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

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

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

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

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com or by phone at 1-877-888-3337, (TTY 1-877-889-5680), you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical trials

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

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

- Routine care costs (as mandated by State) – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs – This plan does not cover these costs.
- Research costs - This plan does not cover these costs.

When you have Medicare

- **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. 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.

- **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 website at www.deancare.com.

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

Please review the following table it illustrates your cost share if you are enrolled in Medicare Part B. Medicare will be primary for all Medicare eligible services. Members must use providers who accept Medicare's assignment.

High Option

Benefit Description (High Option)	Member Cost without Medicare	Member Cost with Medicare Part B
Deductible	$0	$0
Coinsurance	10%	10%
Coinsurance Limit	$500 (Self Only)	$500 (Self Only)
Out-of-Pocket Maximum	$6,600 (Self Only)	$6,600 (Self Only)
Primary Care Physician	$20 copay	$20 copay
Specialist	$40 copay	$40 copay
Inpatient Hospital	10% coinsurance	10% coinsurance
Outpatient Hospital	10% coinsurance	10% coinsurance
Rx	Tier 1 – $10 copay Tier 2 – 30% coinsurance Tier 3 – 50% coinsurance Tier 4 - $100 copay	Tier 1 – $10 copay Tier 2 – 30% coinsurance Tier 3 – 50% coinsurance Tier 4 - $100 copay
Rx – Mail Order (90 day supply)	2 x retail copay (applies to Tier 1 and Tier 2 only)	2 x retail copay (applies to Tier 1 and Tier 2 only)

Standard Option

Benefit Description: (Standard Option)	Member Cost without Medicare	Member Cost with Medicare Part B
Deductible	$500 (Self Only)	$500 (Self Only)
Coinsurance	10%	10%
Deductible/Coinsurance Limit	$5,000 (Self Only)	$5,000 (Self Only)
Out-of-Pocket Maximum	$5,000 (Self Only)	$5,000 (Self Only)
Primary Care Physician	$20 copay	$20 copay
Specialist	$40 copay	$40 copay
Inpatient Hospital	10% coinsurance after deductible	10% coinsurance after deductible
Outpatient Hospital	10% coinsurance after deductible	10% coinsurance after deductible
Rx	Tier 1 – $10 copay Tier 2 – 30% coinsurance Tier 3 – 50% coinsurance Tier 4 - $100 copay	Tier 1 – $10 copay Tier 2 – 30% coinsurance Tier 3 – 50% coinsurance Tier 4 - $100 copay
Rx – Mail Order (90 day supply)	2 x retail copay (applies to Tier 1 and Tier 2 only)	2 x retail copay (applies to Tier 1 and Tier 2 only)

You can 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**

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).

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

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement 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.

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

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

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

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 21.

Coinsurance Limit

Includes Coinsurance amounts for certain medical expenses that a Member is required to pay when a covered service is provided. Pharmacy expenses and certain medical expenses are not included in the Coinsurance Limit. The Coinsurance amounts also apply toward the Out-of-Pocket Expense Maximum. No other out-of-pocket expenses apply toward the Coinsurance Limit.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 21.

Covered services

Care we provide benefits for, as described in this brochure.

Custodial care

The type of care given when the basic goal is to help a person in the activities of daily life. This includes help in walking, getting in and out of bed, bathing, dressing, eating, using the toilet, preparing special diets, taking medications properly and 24 hour supervision for potentially unsafe behavior. Such care is custodial when it does not require continued attention by trained medical personnel. Such care is custodial even if provided by registered nurses, licensed practical nurses, or other trained medical personnel. Custodial care that lasts 90 days or more is sometimes known as Long Term Care.

Deductible

The amount of Covered Expenses that the Member or family must pay each Contract Period before we will pay for Covered Expenses. The Deductible is applied to our contracted fee or to the Maximum Allowable Fee.

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.

Group Health Coverage The agreement between Us and the employer group to provide health insurance coverage to Members.

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

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

This amount may be based on:

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

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

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

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

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

We determine our Plan allowance as follows: Covered charges will be paid based on the contract agreement between the plan and the plan provider (subject to any 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.

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

When you enroll as a Member you will choose a physician or clinic from our network of providers to be responsible for managing your health care. This is your primary care provider (PCP) and is the provider you contact first whenever you need health care services. Your PCP evaluates your total health needs and provides personal medical care in one or more medical fields. If you choose a clinic rather than a physician, you may see any PCP in that clinic. When medically needed, your PCP preserves the continuity of care. Your PCP is also in charge of coordinating other provider health services.

Pre-service claims

Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Primary Care Provider (PCP)

A Network Plan Provider who evaluates the Member's total health needs and provides personal medical care in one or more medical fields. Typically a Primary Care Provider is a pediatrician, family practitioner, OB/GYN or an internist.

Reimbursement

A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

Subrogation

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

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. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no Government contribution.

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. Participating employees save an average of about 30% on products and services they 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 $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,550 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, prescriptions, **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).

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

- **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 children 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 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. **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 12-month waiting period. **Most FEDVIP dental plans cover adult orthodontia. Review your FEDVIP dental plan's brochure for information on this benefit.**

Vision Insurance

All vision plans provide comprehensive eye examinations and coverage for your choice of either lenses and frames or for 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/dental and www.opm.gov/vision. 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 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.

Notes

Do not rely on this page, it is for your convenience and may not show all pages where the terms appear.

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Summary of benefits for the High Option Benefit of Dean Health Plan - 2016

- **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
Maximum Out-of-Pocket Expenses		21
• **Coinsurance**	10% Coinsurance ($500 for Self Only or $500 per person for Self Plus One, or $1,000 for Self and Family enrollment)	21
• **Maximum Out-of-Pocket (coinsurance, medical and pharmacy drug copays)**	$6,600 for Self Only or $6,600 per person for Self Plus One, or $13,200 Self and Family enrollment	
Medical services provided by physicians:		27
• **Treatment services provided in the office**	$20 office visit copayment (Primary Care Provider) $40 office visit copayment (Specialist)	27
Services provided by a hospital and emergency services		55
• **Inpatient/Outpatient Hospital Services**	10% coinsurance	56
• **Emergency In-area**	$100 copayment per emergency room visit (waived if direct admit to inpatient) $40 copayment per urgent care visit 10% coinsurance for related services	
• **Emergency Out-of-Area**	$100 copayment per emergency room visit (waived if direct admit to inpatient) $40 copayment per urgent care visit 10% coinsurance for related services	56
Mental health and substance abuse treatment:	$20 copayment per visit (outpatient) 10% coinsurance (inpatient)	57
Prescription drugs:		59
• **Retail pharmacy**	Tier 1 (generics) $10 copayment Tier 2 (preferred brands and select generics) 30% co-insurance, maximum $75 copayment per prescription ($1,500 out-of-pocket maximum per contract year; $10 copayment applies thereafter)	60

	Tier 3 (expanded brands and select generics) 50% co-insurance with a minimum $50 copayment and a maximum $150 copayment per prescription. Tier 4 (specialty drugs) $100 copayment	
• **Mail order**	90 day supply (maintenance medications) • Tier 1 - $20 copayment (90 day supply) • Tier 2 - 30% co-insurance of the cost for a 2-month supply (90 day supply)	60

Summary of benefits for the Standard Option Benefit of Dean Health Plan - 2016

- **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.

Standard Option Benefits	You pay	Page
Maximum Out-of-Pocket Expenses		21
• **Deductible**	$500 for Self Only, or $500 per person for Self Plus One, or $1,000 for Self and Family enrollment	21
• **Coinsurance**	10% coinsurance after deductible ($4,500 for Self Only, or $4,500 per person for Self Plus One, or $9,000 for Self and Family enrollment)	
• **Maximum Out-of-Pocket (deductible, coinsurance, medical and pharmacy drug copays)**	$5,000 for Self Only, or $5,000 per person for Self Plus One, or $10,000 for Self and Family enrollment	
Medical services provided by physicians:		27
• **Treatment services provided in the office**	$20 office visit copayment (Primary Care Provider) $40 office visit copayment (Specialist) 10% coinsurance after deductible for related services	27
• **Diagnostic services provided in the office**	Nothing	27
Services provided by a hospital and emergency services:		52
• **Inpatient/Outpatient Hospital Services**	10% coinsurance after deductible	52
• **Emergency In-area**	10% coinsurance after deductible $40 copayment per urgent care visit	56
• **Emergency Out-of-area**	10% coinsurance after deductible $40 copayment per urgent care visit	56
Mental health and substance abuse treatment:	Outpatient Services: $20 copayment per visit Inpatient Services: 10% coinsurance after deductible up to the maximum out-of-pocket limit ($5,000 Individual / $10,000 Family)	57
Prescription drugs:		59
• **Retail pharmacy**	Tier 1 (generics) $10 copayment	60

	Tier 2 (preferred brands and select generics) 30% co-insurance, maximum $75 copayment per prescription ($1,500 out-of-pocket maximum per contract year; $10 copayment applies thereafter) Tier 3 (expanded brands and select generics) 50% co-insurance with a minimum $50 copayment and a maximum $150 copayment per prescription. Tier 4 (specialty drugs) $100 copayment	
• **Mail order**	90 day supply (maintenance medications) • Tier 1 - $20 copayment (90 day supply) • Tier 2 - 30% co-insurance of the cost for a 2-month supply (90 day supply)	60

2016 Rate Information for Dean Health Plan

Non-Postal rates apply to most non-postal employees. If you are in a special enrollment category, contact the agency that maintains your health benefits enrollment.

Postal rates apply to United States Postal Service employees.

Postal Category 1 rates apply to career bargaining unit employees.

Postal Category 2 rates apply to career non-bargaining unit employees.

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.

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

Type of Enrollment	Enrollment Code	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
South Central Wisconsin							
High Option Self Only	WD1	$213.37	$175.45	$462.30	$380.14	$163.59	$175.45
High Option Self Plus One	WD3	$461.02	$355.53	$998.88	$770.31	$329.92	$355.53
High Option Self and Family	WD2	$488.50	$405.81	$1,058.42	$879.25	$378.67	$405.81
Standard Option Self Only	WD4	$202.73	$67.57	$439.24	$146.41	$56.09	$67.57
Standard Option Self Plus One	WD6	$445.99	$148.66	$966.31	$322.10	$123.39	$148.66
Standard Option Self and Family	WD5	$486.53	$162.18	$1,054.16	$351.38	$134.61	$162.18