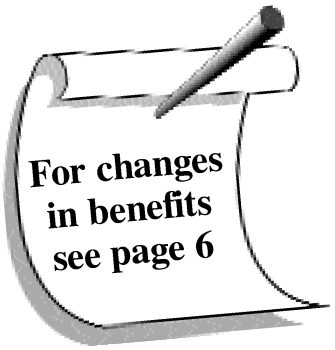
Dean Health Plan, Inc.

http:// www.deancare.com

2002

A Health Maintenance Organization



Serving: South Central Wisconsin

Enrollment in this plan is limited. You must live or work in our Geographical service area to enroll. Please see page 5 for requirements.

This Plan has Excellent Accreditation from the NCQA. See the *2002 Guide* for more information on NCQA.

Enrollment Codes for this Plan:

WD1 Self Only
WD2 Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management
Retirement and Insurance Service
http://www.opm.gov/insure

Federal Employees Health Benefits Program

RI 73-189

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Introduction

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

This brochure describes the benefits of Dean Health Plan under our contract CS1996 with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and changes are summarized on page 45. Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

- 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 Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

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

Inspector General Advisory

Stop health care fraud! Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital 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 or write:

THE HEALTH CARE FRAUD HOTLINE
202-418-3300
The United States Office of Personnel Management,
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415.

Penalties for Fraud Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

Section 1: Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services.

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 only pay the copayments, coinsurance, and deductibles 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.

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 coinsurance.

Your Rights

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

- Dean Health Plan Inc. is a for-profit HMO, and has been in business since 1983. If you want more information about us, call 800-279-1301, or write to Dean Health Plan, Attention Customer Service, 1277 Deming Way, Madison, WI 53717. You may also contact us by fax at 608-827-4152 or visit our website at www.deancare.com.

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: Columbia, Crawford, Dane, Dodge, Fond Du Lac, Grant Green Lake, Iowa, Jefferson, Juneau, Lafayette, Marquette, Richland, Rock, Sauk and Walworth Counties in Wisconsin.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

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

Section 2: How we change for 2002

Do not rely on these change descriptions; this page is not an official statement of benefits. For that, got 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

- We changed speech therapy benefits by removing the requirement that services must be required to restore functional speech. (Section 5(a))

Changes to this Plan

- Your share of the non-Postal premium will increase by 7.3% for Self Only or -5.8% for Self and Family

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- We no longer limit total blood cholesterol tests to certain age groups. (Section 5(a))
- We now cover certain intestinal transplants. (Section 5(b))
- You pay $10 for generic drugs and $15 for brand name drugs under the prescription drug benefit.
- Smoking cessation is now covered up to $100 for smoking cessation program per member per lifetime, including the drug Zyban with a 2 month supply.

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 (for annuitants), or your 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

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance, and you will not have to file claims.

• 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. Provider updates are also included in the quarterly mailing to all members in the *Notables* newsletter.

• 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.

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 chose a primary care physician. Each member of your family may select a different primary care physician. Your primary care physician must be a doctor who practices a general scope of medicine. A physician who specializes in only one area of medicine would not be able to treat all of your basic health care needs.

• Primary care

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

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

• Specialty care

Your primary care physician will arrange your referral to a specialist for needed care. You may also seek services from other Plan providers, including specialists, located at the same clinic as your primary care physician, without a referral. Written referrals are not required for the following types of services when provided by a Dean Health Plan Provider: MRI (Magnetic Resonance Imaging), Diagnostic tests & respiratory therapy, Home Health, Oral Surgery for covered procedures, Routine vision care, and Chiropractic care.

Here are 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 use our criteria when creating your treatment plan

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. 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 or disabling condition and lose access to your specialist because we:

  - terminate our contract with your specialist for other than cause; or

  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or

  - reduce our service area and you enroll in another FEHB Plan,

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

If you are in the second or 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 in the hospital when your enrollment in our Plan begins, call our Customer Service Department immediately at 800-279-1301. If you are new to the FEHB Program, we will arrange for you to receive care.

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; or
- 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.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may our 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.

Services requiring our prior approval

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

We call this review and approval process prior authorization. Your physician must obtain prior authorization before sending you to a hospital, referring you to a non-plan provider or facility, or recommending follow-up care.

We will provide benefits for covered services only when the services are medically necessary to prevent, diagnose, or treat your illness or condition.

Section 4: Your costs for covered services

You must share the cost of some services. You are responsible for:

Copayments	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, when you receive services. Example: When you see your primary care physician you pay a copayment of $10 per office visit and when you go in the hospital, you pay nothing per admission.
Coinsurance	Coinsurance is the percentage that you must pay for specific services. Example: In our Plan, you pay 50% of actual charges for diagnosis and treatment of infertility services, and 20% of charges for orthopedic services, prosthetic devices, lenses following cataract removal, and durable medical equipment.
Your out-of-pocket maximum	We do not have an out-of-pocket maximum.`

Section 5: Benefits – OVERVIEW

Please see page 6 for how our benefits changed this year and page 45 for a benefits summary

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 800-279-1301 or at our website at www. deancare.com.

Section 5 (a): Medical services and supplies provided by physicians and other health care professionals

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office	$10 per office visit
Professional services of physicians 1) In an urgent care center 2) Office medical consultations 3) Second surgical opinion	$10 per office visit
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing
Preventive care, adult	
Routine screenings, such as annual physical: • Total Blood Cholesterol • Colorectal Cancer Screening, including - Fecal occult blood test - Sigmoidoscopy, screening – every five years starting at age 50	$10 per office visit
Prostate Specific Antigen (PSA test) – one annually for men age 40 and older	$10 per office visit
Routine pap test Note: The office visit is covered if pap test is received on the same day; see *Diagnostic and Treatment Services*, above.	$10 per office visit
Routine mammogram – covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	$10 per office visit

Preventive care, adult *(continued)*	**You Pay**
Routine immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over	$10 per office visit
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	All charges.
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics	$10 per office visit
• Well-child care charges for routine examinations, immunizations and care (through age 17)	Nothing
• Examinations, such as: - Eye exams through age 17 to determine the need for vision correction. - Ear exams through age 17 to determine the need for hearing correction - Exams done on the day of immunizations (under age 22)	$10 per office visit
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 13 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	Nothing
Not covered: Routine sonograms to determine fetal age, size or sex	All charges.

Family planning	You Pay
Family planning care such as: • Voluntary sterilization • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms NOTE: We cover oral contraceptives under the prescription drug benefit.	$10 per office visit
Not covered: reversal of voluntary surgical sterilization and genetic counseling	All charges
Infertility services	

Diagnosis and treatment of infertility, such as:
• Artificial insemination:
  • intravaginal insemination (IVI)
  • intracervical insemination (ICI)
  • intrauterine insemination (IUI)
• Fertility drugs
 	
NOTE: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit. Coverage for infertility services is limited to one diagnostic treatment per member per lifetime.
	50% of actual charges

Not covered:
• *Assisted reproductive technology (ART) procedures, such as*:
  - in vitro fertilization
  - embryo transfer, gamete (GIFT) and zygote (ZIFT)
  - zygote transfer
• *Services and supplies related to excluded ART procedures*
• *Cost of donor sperm*
• *Cost of donor egg*
	All charges

Allergy care	
Testing and treatment Allergy injection	$10 per office visit
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	All charges

Treatment therapies	You Pay
• Chemotherapy and radiation therapy NOTE: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 21. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) NOTE: Growth hormone is covered under the prescription drug benefit. NOTE: We will only cover GHT when your primary care provider prior authorizes the treatment	$10 per office visit
Physical and occupational therapies	
• Inpatient or outpatient basis for up to two months per condition if significant improvement can be expected within two months for the services of each of the following: • qualified physical therapists; and • occupational therapists. NOTE: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living. • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarctio. Phase II treatment must begin within 90 days of surgery.	Nothing
Not covered: • *long-term rehabilitative therapy* • *exercise programs*	All charges
Speech therapy	
• Inpatient or outpatient basis for up to two months per condition when medically necessary.	Nothing
Hearing services (testing, treatment, and supplies)	
• Hearing exam • Hearing testing for children through age 17 (see Preventive Care, children) • Hearing Aid – limited to one in any 36 month period. This includes ear molds and hearing aid dispensing fees NOTE: Infants and children under the age of 18 with bilateral hearing loss are eligible for bilateral hearing aids.	$10 for associated office visit All costs over $500
Not covered: all other hearing aids, testing and examinations for them	All charges

Vision services (testing, treatment, and supplies)	You Pay
• In addition to the medical and surgical benefits provided for the diagnosis and treatment of diseases of the eye, annual eye refractions (which include the written lens prescription for eyeglasses)	$10 per office visit
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	$10 per office visit
• Eye exam to determine the need for vision correction	$10 per office visit
Not covered: • *Eyeglasses or contact lenses and, after age 17, examinations for them* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	All charges
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$10 per office visit
Not covered: Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above. *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	All charges
Orthopedic and prosthetic devices	
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. NOTE: We pay internal prosthetic devices as hospital benefits; see Section 5(c) for payment information. See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. NOTE: Purchases exceeding $200 per month must be authorized by the plan's Medical Director. Your plan doctor will obtain the prior authorization.	20% of the charges per purchase or rental

Orthopedic and prosthetic devices *(continued)*	**You Pay**
Not covered: • *arch supports* • *orthopedic and corrective shoes* • *foot orthotics, heel pads and heel cups* • *lumbosacral supports, corsets, trusses, elastic stockings, support hose, and other supportive devices* • *prosthetic replacements provided less than 3 years after the last one we covered*	All charges
Durable Medical Equipment (DME)	
NOTE: Medical supplies and equipment are covered when prescribed by your Plan physician for treatment of a diagnosed illness or injury. The supplies or equipment must be purchased from a plan durable medical equipment provider. NOTE: Purchases exceeding $200 per month or rentals exceeding $200 per month must be authorized by the plan's Medical Director. Your Plan doctor will obtain the prior authorization. Some examples of medical supplies, durable and disposable medical equipment are: • Wheelchairs (requires prior authorization by our Health Services Department) • Hospital beds • Splints, trusses, crutches, 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 Health Services Department • Rental of a ventilator or other mechanical equipment or purchase of such equipment at the option of Dean Health Plan NOTE: Call us at 800-279-1301 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	20% of the charges per purchase or rental
Not covered: • *Repairs and replacement of durable medical equipment/supplies unless they are prior authorized by the Health Services Department* • *Elastic support stockings (e.g., TEDS, JOBST, etc.)* • *Shoes or orthotics that are not custom made and can be purchased over the counter.*	All charges

Durable Medical Equipment *(continued)*	**You Pay**
Not Covered: • *Medical supplies and durable medical equipment for comfort, personal hygiene, and convenience such as, but not limited to: air conditioners, air cleaners, humidifiers, physical fitness equipment, physician's equipment, disposable supplies, alternative communication devices, and self-help devices not medical in nature.* • *Home testing and monitoring supplies and related equipment except those used in connection with the treatment of diabetes.* • *Equipment, models or devices that have features over and above that which is medically necessary. Coverage will be limited to the standard model as determined by Dean Health Plan.* • *Any durable medical equipment or supplies used for work, athletic, or job enhancement.*	All charges
Home Health Services	
Home health services of nurses and health aides, including intravenous fluids and medications, when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need.	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	All charges
Chiropractic	
• Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	$10 per office visit
Not covered: • *Long-term or maintenance therapy* • *Chiropractic services preformed by a non-plan provider*	All charges
Alternative treatments	
No benefits	All charges
Educational classes and programs	
• Smoking Cessation Limited coverage available in the following programs: • Group Counseling • Internet Program • Self-Direct Kit • Telephonic Program NOTE: Please call us at 800-279-1301 for details on each of the above options.	$100 per member per lifetime through program **Zyban** is covered for a 2-month supply under this program. You pay a $15 brand name copay. See prescription drug benefits.

Section 5 (b): Surgical and anesthesia services provided by physicians and other health care professionals

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).

IMPORTANT

Benefit Description	You pay
Surgical procedures	
A comprehensive range of services, such as Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity – a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over • Insertion of internal prosthetic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information. • Voluntary sterilization • Treatment of burns NOTE: Generally, we pay for internal prosthesis (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	Nothing
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot Care*	All charges

Reconstructive surgery	You Pay

• 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; webbed fingers; and webbed toes.
• All stages of breast reconstruction surgery following a mastectomy, such as: surgery to produce a symmetrical appearance on the other breast; treatment of any physical complications, such as lymphedemas; breast prostheses and surgical bras and replacements (see Prosthetic devices)
 	
NOTE: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.
	Nothing

Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	All charges
Oral and maxillofacial surgery	

Oral surgical procedures, limited to:
• Reduction of fractures of the jaws or facial bones;
• Surgical correction of cleft lip, cleft palate or severe functional malocclusion;
• Removal of stones from salivary ducts;
• Excision of leukoplakia or malignancies;
• Excision of cysts and incision of abscesses when done as independent procedures; and
• Other surgical procedures that do not involve the teeth or their supporting structures.
• Diagnostic procedures and medically necessary surgical or non-surgical treatment for the correction of temporomandibular disorders (TMD) if all of the following apply:
  • The condition is caused by congenital, developmental or acquired deformity, disease or injury
  • Under the accepted standards of the profession of the health care provider rendering the service, the procedure or device is reasonable and appropriate for the diagnosis or treatment of this condition.
  • The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction. This includes coverage for prescribed intra oral splint therapy devices.
  All services must be prior authorized by the Health Services Department, and provided by a plan provider designated by us to treat TMD.
	$10 per office visit

Oral and maxillofacial surgery *(continued)*	**You Pay**
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	All charges
Organ/tissue transplants	
Limited to: • Cornea • Heart/lung • Kidney/Pancreas • Pancreas • Heart • Kidney • Liver • Lung: Single –Double • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas • National Transplant Program (NTP) • Limited Benefits - Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols NOTE: We cover related medical and hospital expenses of the donor when we cover the recipient.	Nothing
Not covered: • *Donor screening tests and donor search expenses except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered* • Professional services provided in hospital (inpatient)	All charges
Anesthesia	
• Professional services provided in hospital (outpatient department) • Skilled nursing facility • Ambulatory surgical center • Office	Nothing

Section 5 (c): Services provided by a hospital or other facility, and ambulance services

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Sections 5(a) or (b).

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
• Room and board, such as ward, semiprivate, or intensive care accommodations; • general nursing care; and • 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. 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 • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home 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 heat disease; the need for anesthesia, by itself, is not such a condition. The Plan will not cover the cost of the professional dental services.	Nothing

Inpatient hospital *(continued)*	**You Pay**
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; and private nursing care	All charges
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service	Nothing
Not covered: blood and blood derivatives not replaced by the member	All charges
Extended care benefits/skilled nursing care facility benefits	

• Extended care benefit: The Plan provides a comprehensive range of benefits for up to 120 days per benefit period 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.
• Hospice Care
	Nothing

Hospice care	
See above – Extended care benefit	Nothing
Not covered: Independent nursing, homemaker services	All charges
Ambulance	
Local professional ambulance service when medically appropriate (Ground and/or air)	Nothing

Section 5 (d): Emergency services/accidents

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- 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.

IMPORTANT

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.

What to do in case of emergency:

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. Your or a family member should notify the Plan within 48 hours. It is your responsibility to ensure that the Plan has been timely 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 non-Plan facilities and Plan doctors believe care is 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.

You pay a $50 copayment per hospital emergency room visit

Emergencies outside our service area:

Benefits are available for any medically necessary health service 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 a Plan believes you can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

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

Plan pays reasonable charges for emergency care services to the extent the services would have been covered in received from Plan providers.

You pay a $50 copayment per hospital emergency room visit.

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$10 per office visit $10 per office visit $50 per hospital emergency room visit
Not covered: Elective care or non-emergency care	All charges
Emergency outside our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$10 per office visit $10 per office visit $50 per hospital emergency room visit
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	All charges
Ambulance	
Professional ambulance service when medically appropriate (ground or air). See 5(c) for non-emergency service	Nothing

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

IMPORTANT

When you get our approval for services and follow a treatment plan we approve cost-sharing and limitations for mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Here are some important things to keep in mind about these benefits:

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- 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 OF THESE SERVICES.** See the instructions after the benefits description below.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. NOTE: Plan 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.	Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$10 per office visit
Not covered: Services we have not approved. *NOTE: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	All charges

Pre-authorization

To be eligible to receive these benefits you must follow your treatment plan and all the following authorization processes:

If you are seeking care from a mental health or substance abuse provider at the same clinic as your primary care provider, no referral is needed. Your provider will need to file a treatment plan with us for prior approval for ongoing treatment.

If you are seeking care outside of your primary care provider or clinic, you must obtain a referral from your primary care provider before receiving services. On your behalf, your provider must submit referral request (and treatment plan if applicable) to us for prior approval. We will provide written confirmation to the provider if approval is given for the services. For information on available plan providers or status of a referral, please contact Customer Service at 800-279-1301.

Limitations

We may limit your benefits if you do not obtain a treatment plan.

Section 5 (f): Prescription drug benefits

IMPORTANT

Here are some important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Certain prescription drugs included in our formulary require prior authorization. The drug prior authorization process can be initiated by you r 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 back to you, your plan pharmacy, and plan physician. Updates to our drug formulary are provided in Notables, our quarterly news magazine sent to the member's home. Members may also obtain a listing by calling our Customer Service Department at 800-279-1301.
- 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.

IMPORTANT

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

- **Who can write your prescription.** A plan physician or referral doctor must write the prescription
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy or national plan pharmacy.
- **We use a formulary.** Prescription drugs are included in our formulary by our 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 its 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 Service Department at 800-279-1301.
- **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 a $10 copay per prescription unit or refill for generic drugs and a $15 copay 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 receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.
- **Why use generic drugs?** Generic drugs contain the same active ingredients and are equivalent in strength and dosage to the original brand name product. Generic drugs cost you and your plan less money than a name-brand drug.
- **When you have to file a claim.** If you receive a prescription outside of the area or a situation arises where the pharmacy cannot process a prescription under the plan, you may submit an itemized receipt to us for reimbursement for all covered prescription drugs. Send the receipt to: Dean Health Plan, 1277 Deming Way, Madison, WI 53717.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase. • Oral and injectable contraceptive drugs up to a 30 day supply; contraceptive diaphragms • Insulin, with a copay charge applied to each vial • Diabetic supplies, including disposable needles and syringes needed forthe injecting covered prescribed medication, glucose test tabletsand test tape, Benedict's solution or equivalent and acetone test tablets; a copay will apply for each item purchased	$10 per generic prescription $15 per name brand prescription NOTE: If there is no generic equivalent available, you will still have to pay the brand name copay.
• Infertility drugs and growth hormones; you pay 50% of the cost of the prescription unit or refill	50% of cost
• Intravenous fluids and medication for home use are covered under Medical and Surgical Benefits • Zyban is covered for a one time 2-month supply under the brand name prescription drug benefit through the Smoking Cessation program	
NOTE: (Limited Benefits): Drugs to treat sexual dysfunction are limited. Contact the Plan for dose limits	You pay a 50% copay up to the doses limit and all charges above that
Here are some things to keep in mind about our prescription drug program: • A generic equilivant will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic. • We administer a closed formulary. If your physician beleives a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a listing of the drugs that require prior authorization or are excluded, call our Customer Service Department at 800-279-1301.	
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Fertility drugs not approved by the Plan* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Vitamins, nutritional substances and food supplements that can be purchased without a prescription* • *Nonprescription medicines*	All charges

Section 5 (g): Special features

- **24 hour nurse line** Dean on Call. For any of your health concerns, 24 hours a day, 7 days a week, you may call 800-576-8773 and talk with a registered nurse who will discuss treatment options and answer your health questions.

Section 5 (h): Dental benefits

IMPORTANT

Here are some important things to 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 dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay
Accidental injury benefit	
• We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. Treatment must begin within 90 days from injury.	Nothing
Dental benefits	
We have no other dental benefits	

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

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition and we agree, as discussed under What Services Require Our Prior Approval on page 9.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are 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;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term;
- Services, drugs, or supplies related to sex transformations; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.

Section 7: Filing a claim for covered services

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 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 HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 800-279-1301

When you must file a claim – such as for out-of-area care – submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name 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 payer – such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.
- **Submit your claims to: 1277 Deming Way, Madison, WI 53717**

Prescription drugs

Send your prescription drug receipts to the address noted above

Deadline for filing your claim

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

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

Section 8: The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for pre-authorization:

Step	Description
1	Ask us in writing to reconsider our initial decision. Write to us at 1277 Deming Way, Madison, WI 53717. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: 1277 Deming Way, Madison, WI 53717; 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.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial – go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request – go to step 3.
3	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.
4	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: Office of Personnel Management, Office of Insurance Programs Contracts Division 3, 1900 E Street, NW, Washington, DC 20415-3630. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call.

Step	Description
4	NOTE: If you want OPM to review different claims, 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. NOTE: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.
5	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.
6	If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied pre-certification or prior approval. This is the only deadline that may not be extended. OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record. You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute. **NOTE: If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and (a) We haven't responded yet to your initial request for care or pre-authorization/prior approval, then call us at 800-279-1301 and we will expedite our review; or (b) We denied your initial request for care or pre-authorization/prior approval, then: • If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or • You can call OPM's Health Benefits Contracts Division IV at 202-606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9: Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you are covered or a family member is covered under another group health plan or have 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 payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

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

When we are the secondary payer, we will determine our reasonable charge. After the primary plan pays, we will pay either what is left of the reasonable charge or our regular benefit, whichever is less. We will not pay more than our reasonable charge. If we are the secondary payer, we may be entitled to receive payment from your primary plan.

•What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age and 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 two 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. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE 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

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare+Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

•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. Some things are not covered under Original Medicare, like prescription drugs.

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. Tell us if you or a family member is enrolled in Medicare Part A and B. Medicare will determine who is responsible for paying for medical services and we will coordinate the payments. On occasion you may need to file a Medicare claim form.

The following chart illustrates whether the Original Medicare Plan or this Plan should be the primary payer 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.

Primary Payer Chart		
A. When either you - or your covered spouse- are age 65 over and you...	**Then the primary payer is...**	
	Original Medicare	**This Plan**
1) Are you an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when… a) The position is excluded from FEHB, or b) The position is not excluded from FEHB (Ask your employing office which of these applies to you.)	✓	✓
4) 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),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' Compensation.)	
B. When you - or a covered family member - have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, and		
a) Are an annuitant, or	✓	
b) Are an active employee, or		✓
c) Are a former spouse of an annuitant, or	✓	
d) Are a former spouse of an active employee		✓

Claims process - when you have the Original Medicare Plan – You probably will never have to file a claim form when you have both our Plan and the Original Medicare Plan.

- When we coordinate benefits as the primary plan, we will process the claims without consideration of what Medicare may cover. All plan copayments, deductibles, policy maximums, limitations and exclusions will apply

- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 800-279-1301.

We do not waive any costs when you have Medicare.

Medicare managed care plan

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from another type of Medicare+Choice plan – a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

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

This Plan and our Medicare managed care plan: You may not enroll in our Medicare managed care plan and also remain enrolled in our FEHB plan.

This Plan and another plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, but we will not waive any of our copayments, coinsurance. If you enroll in a Medicare managed care plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare managed care plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare managed care plan:
If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care 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 managed care plan's service area.

If you do not enroll in Medicare Part A or Part B

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

TRICARE

TRICARE is the health care program for eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' Compensation

We do not cover services that:

- you 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. You must use our providers.

Medicaid

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

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal Government agency directly or indirectly pays for them.

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

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.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 38.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 12.

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.

Experimental or investigational services

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 physicians, 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.

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 and which, as determined by the Health Services 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 service that can be safely provided to the member.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services

Us/We

Us and we refer to Dean Health Plan

You

You refers to the enrollee and each covered family member.

Section 11: FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure. Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about:

- 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;
- When your enrollment ends; and
- 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.

Types of coverage available for you and your family

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will not notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

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.

When benefits and premiums start

The benefits in this brochure are effective on 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. 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.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

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.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage.

- **Spouse equity coverage**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices.

- **Temporary Contination Coverage (TCC)**

Enrolling in TCC. If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your job, if you are a covered dependent child and you turn 22 or marry, etc.

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

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

• Converting to individual coverage

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

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

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

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

Getting a Certificate of Group Health Plan Coverage

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

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

Long Term Care Insurance is coming later in 2002

- Many FEHB enrollees think that their health plan and/or Medicare will cover their long-term care needs. Unfortunately, they are WRONG!
- How are YOU planning to pay for the future custodial or chronic care you may need?
- You should consider buying long-term care insurance

The Office of Personnel Management (OPM) will sponsor a high-quality long-term care insurance program effective in October 2002. As a part of its educational effort, OPM asks you to consider these questions:

What is long-term care (LTC) insurance?

- It's insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer's.
- LTC insurance can provide broad, flexible benefits for nursing home care, care in an assisted living facility, care in your home, adult day care, hospice care, and more. LTC insurance supplement care provided by family members, reducing the burden you place on them.

I'm healthy. I won't need Long-term care. Or, will I?

- Welcome to the club!
- 76% of Americans believe they will never need long-term care, but the facts are that about half of them will. And it's just not the old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long-term care, but everyone should have a plan just incase. Many people now consider long-term care insurance to be vital to their financial and retirement planning.

Is long-term care expensive?

- Yes, it can be very expensive. A year in a nursing home can exceed $50,000.00. Home care for only three 8-hour shifts a week can exceed $20,000.00 a year. And that's before inflation!
- Long-term care can protect your savings. *Long-term care Insurance can protect your savings.*

But won't my FEHB plan, Medicare or Medicaid cover my long term care?

- Not FEHB. Look at the "Not covered" blocks in sections 5(a) and 5(c) of your FEHB brochure. Health plans don't cover custodial care or a stay in an assisted living facility or a continuing need for home health aide to help you get in and out of bed and with other activities of daily living. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care (the highest level of nursing care) after a hospitalization for those who are blind, age 65 or older or fully disabled. It also has a 100 day limit.
- Medicaid covers long term care for those who meet their state's poverty guidelines, but has restrictions on covered services and where they can be received. *Long-term care insurance can provide choices of care and preserve your independence.*

When will I get more information on how to apply for this new insurance coverage?

- Employees will get more information from their agencies during the LTC open enrollment period in the late summer/early fall of 2002.
- Retirees will receive information at home.

How can I find out more about the Program NOW?

- Our toll-free teleservice center will begin in mid-2002. In the meantime, you can learn more about the program on our web site at www.opm.gov/insure/ltc.

Index

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

Summary of benefits for Dean Health Plan, Inc. 2002

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.

Benefits	You Pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	Office visit copay: $10 copayment per office visit	12
Services provided by a hospital:		
• Inpatient	Nothing	22
• Outpatient	$10 for office visit or a house call by a doctor (except for well child care through age 17 and maternity visits)	23
Emergency benefits:		
• In-area	$50 per hospital emergency room visit	24
• Out-of-area	$50 per hospital emergency room visit	24
Mental health and substance abuse treatment	$10 copayment for each visit	26
Prescription drugs:		27
• Generic prescription drugs	$10 per prescription or refill	
• Brand name prescription drugs	$15 per prescription or refill	
Dental Care: Accidental injury	Nothing	29
Vision Care: One refraction annually	$10 per office visit	16

2002 Rate Information for
Dean Health Plan

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

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and special FEHB guides are published for Postal Service Nurses, RI 70-2B; and for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

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

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
South Central Wisconsin							
High Option Self Only	WD1	$88.76	$29.59	$192.32	$64.11	$105.04	$13.31
High Option Self & Family	WD2	$223.41	$96.15	$484.06	$208.32	$263.75	$48.04