DeanHealthPlan
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Dane County FAQs

POS Plan: Frequently Asked Questions

This information and additional resources are available at deancare.com/danecounty or by calling our Customer Care Center at 800-279-1301 (TTY 711)

What is a plan provider?

A plan provider is a doctor, hospital, pharmacy or other medical provider who has contracted with Dean Health Plan to provide services through our network and is listed in our provider directory. Out-of-network or non-plan providers do not participate in our network and are therefore not listed in the directory. Members who see plan providers will receive the highest benefit level available at the lowest out-of-pocket cost.

Do I need to choose a Primary Care Provider (PCP)?

Point of Service members are not required to select a Primary Care Provider. You simply choose the provider you wish to see at the time you seek services. However, you are encouraged to choose a provider that you feel comfortable seeing on a continuing basis.

If I had Dean Insurance in the past and had a previous relationship with a Dean primary Physician, am I able to see that same Physician again?

Yes. We will work with you to reestablish that connection even if that Physician is currently listed as not accepting new patients. Dean Medical Group has established a phone line to welcome Dane County employees and assist with scheduling appointments for family medicine, internal medicine and pediatric care. Please call **(608) 250-1444** for assistance.

I am currently seeing a provider who is not in the Dean Health Plan network. Will you pay for this service?

Yes. Any Point of Service member can see in-network providers for some services and out-of-network providers for others. Deductibles, coinsurance and copayment costs are calculated for each person, for each visit or treatment, depending on the provider chosen for that service. Payment for charges submitted by out-of-network providers is limited to the maximum allowable fee (after the deductible and coinsurance are applied).

How does my in-network copayment apply to the maximum out-of-pocket?

You will always pay a copayment each time you receive a service. The copayment amounts you pay accumulate to fulfill the maximum out-of-pocket amount stated in your policy. Deductible and coinsurance amounts also apply to maximum out-of-pocket expense.

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How are deductibles accumulated?

The deductible is the amount that you must pay before your insurance begins to cover expenses. For families, each member must meet the “single” amount to begin receiving benefits, but once the “family” amount has been met, no more deductibles will be collected for any family member.

Deductible amounts are combined between in-network and out-of-network providers. In-network copayments do not apply toward the deductible. However, they do apply to the maximum out-of-pocket.

What if there are charges from an out-of-network provider that are greater than the maximum allowable fee?

Payments for charges submitted by out-of-network providers will be limited to the maximum allowable fee. Any amount that exceeds this is your responsibility and does not apply to the maximum out-of-pocket.

What about referrals and approvals?

Point of Service members are not required to obtain referrals to see their provider of choice, even if that provider is an out-of-network provider. However, some services do require prior authorization. If you use an in-network provider, the prior authorization requirements are lessened.

Will I have access to eVisits?

Yes. eVisits are available thru My Chart for patients who have established care with a Dean primary care provider and who have an active My Chart account. Treatable conditions for an eVisit include back pain, cough and/or cold symptoms, fatigue, headache, heartburn, nausea, vomiting or diarrhea symptoms, red eye, sinus problems, urinary problems and vaginal discharge/ irritation. There is no copayment for eVisits.

What should I do for a hospital admission?

For a planned hospital admission, call our Customer Care Center at least 10 business days before admission to obtain certification approval. For an emergency admission, call our Customer Care Center by the next business day for certification approval.

What is prior authorization?

Prior authorization is approval for certain prescription drugs, medical equipment purchase or rental and certain services. Some services require prior authorization only if received from an out-of-network provider. It is the member’s responsibility to obtain prior authorization from Dean Health Plan before services are received and charges are incurred.

To request prior authorization, or inquire whether or not you need prior authorization, please call our Customer Care Center. A representative will make the necessary arrangements for your request to be filed.

Why are prior authorizations important?

When you call our Customer Care Center for prior authorization, we will verify coverage of the service or drug in question, notify you of coinsurance or deductibles that may apply, and provide information that may help you minimize your out-of-pocket costs. If you are receiving long-term treatment, we may assign a case manager who can help you understand your coverage for different provider and treatment options.

In some cases, prior authorization helps us ensure that the health care services that you receive are coordinated between providers and consistent with the guidelines for most effective care that have been written by our physicians.

What is a precertification?

Precertification is approval of an admission to a facility and/or the approval of a specified number of days for a facility confinement prior to the services being received. If possible, you must request precertification at least 10 days prior to the planned admission to allow time for us to review your needs and estimate the number of days of inpatient treatment required.

What if prior authorization or precertification is needed after hours?

You can call our Customer Care Center after hours and leave a message for prior authorization or admission certification. A representative will return your call the next business day.

How are my insured dependents living out of the service area covered?

If you have an out-of-area dependent, please complete the Out-of-Area Dependent form as part of your health plan enrollment. This will ensure your dependent receives the highest level of benefit for their care.

What benefit level would apply if an in-network provider advises me to see an out-of-network provider?

The deductible, coinsurance or copayment amount for an out-of-network provider would apply. Please note whether prior authorization is necessary before receiving services.

What if I need to see a specialist?

You may choose to see either an in-network or out-of-network specialist at any time without a referral. However, many services provided by specialists require approval prior to being received.

There are numerous area medical specialists affiliated with Dean Health Plan, including but not limited to Dean Medical Center, one of the largest multi-specialty clinics in the nation.

How does Dean cover hearing aids?

Infants and children through age 18 who are certified as deaf or hearing impaired by a physician or audiologist are eligible for bilateral (both ears) hearing aids once every 36 months. For adults, the plan will cover one hearing aid per ear every 36 months.

Can I go to any emergency room?

If you need emergency care, proceed immediately to the nearest medical facility. Emergency room benefits are the same whether you use an in-plan facility or non-plan facility. Payments for charges submitted by out-of-network providers will be limited to the maximum allowable fee. Any amount that exceeds this is your responsibility and does not apply to the maximum out-of-pocket

How do I get reimbursed for emergency care received while overseas?

To reimburse you, Dean Health Plan needs an itemized bill, in English, with the current U.S. exchange rate, along with the foreign claim form. You can download the foreign claim form at deancare.com.

Do I have coverage for acupuncture?

Acupuncture is covered subject to your office visit copayment and is limited to 10 visits per contract year.

Is vision covered?

Routine vision exams are covered and subject to a copayment. Vision correction materials, such as glasses and contacts are not covered.

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Is maintenance chiropractic care covered?

Maintenance chiropractic care is not covered.

In what way does Medicare eligibility affect my Dean Health Plan insurance coverage?

Many factors can determine the primary payer of your health claims, due to Medicare eligibility and coverage. For information, please contact a Medicare analyst through the Customer Care Center.

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How is Dean Health Plan helping to make my prescription transition?

Member satisfaction is our number one priority. Our pharmacists will be evaluating prescription data and working with members to ensure a smooth transition. You may be contacted directly by a pharmacist to help with this process.

How are prescription drugs covered?

If you fill your prescription at an in-network pharmacy, prescriptions are covered as outlined in your policy. If you go to an out-of-network pharmacy, you must pay for the full amount of the prescription, then submit a claim to Dean Health Plan to receive reimbursement at the reduced level.

Can I get my prescription filled out of state?

The pharmacy network is nationwide and includes all major chains and most retail pharmacies.

Are contraceptives available at $0 copay?

Specific contraceptives are covered at $0 copay. Please see our prescription drug formulary at **deancare.com/medications** for details. Select Drug Formulary, then Employer Based and Select 3 Tier Formulary. CTRL F on your keyboard will allow you to enter the name of your prescription to search the formulary.

How will I know what tier my prescription is with Dean Health Plan?

Dane County is utilizing the 3 Tier Select formulary. You may access the formulary and search for your prescription to find out what tier it is in.

What if my prescription is denied at the pharmacy and they say I do not have coverage?

Either you or the pharmacy should contact the Customer Care Center for assistance.

If I don't want to go through step therapy can I just get the prescription and pay the $40 copay?

Step therapy requirements for new prescriptions will always apply. All tier 3 drugs require a $40 copay, whether it's subject to step therapy or not.

I am currently using a mail order service to receive a 3 month supply. Will that change?

Yes. Dean uses WelldyneRx for mail order prescription fulfillment. Maintenance type medications may receive the 3 month supply for only 2 copayments. Information is available at deancare.com/medications.

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I am currently taking a specialty drug. Will that process change?

Dean Specialty Pharmacy fulfills most requests for specialty drugs and they will help coordinate personalized care for each person.

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