2023 Medicare **Enrollment Guide**

Your partner **in wellness**

Choose a **Dean Medicare Advantage Plan** with benefits made just for you

- Essential (HMO)
- Assurance (HMO-POS)
- Balance (HMO-POS)
- Complete (HMO)
- Harmony (HMO-POS) MA-Only
- SSM Presence (HMO-POS)

DeanHealthPlan®

Contents

Ready to Enroll?

You can enroll with Dean Medicare Advantage one of the following ways:

CALL

By Phone
Call **877-234-0126 (TTY: 711)** to enroll over the phone with a Medicare sales consultant

CLICK

Enroll online
Visit **deancare.com/medicare2023**

VISIT

In Person
We offer one-on-one discussions with those who are interested in learning more about our Medicare coverage options. Please call us at **877-234-0126 (TTY: 711)** to schedule an appointment. Visit **deancare.com/seminars** to see our upcoming seminars.

Discover the Dean Advantage

Thank you for your interest in Medicare Advantage from Dean Health Plan, a member of SSM Health. We offer a strong network of providers with a history of exceptional care.

Our Coordinated Care Network is a true collaboration between health care experts, hospital partners and Dean Health Plan, leading to a streamlined and simpler experience for members.

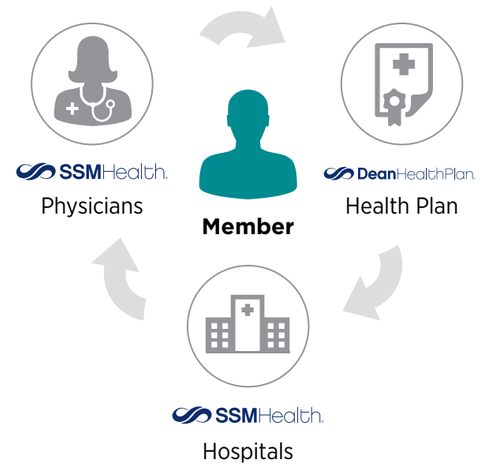
Local: Our roots are local. Our health plan employees are your friends and neighbors. You'll find your primary care provider just down the road.

Caring: Community is important to us. Our employees participate in a variety of volunteer efforts throughout the year to make local life a little better for everyone.

Premier Benefits: Our plans offer a suite of premier benefits to give you a Medicare plan that covers your health needs, including dental, over the counter allowance and more.

DeanHealthPlan

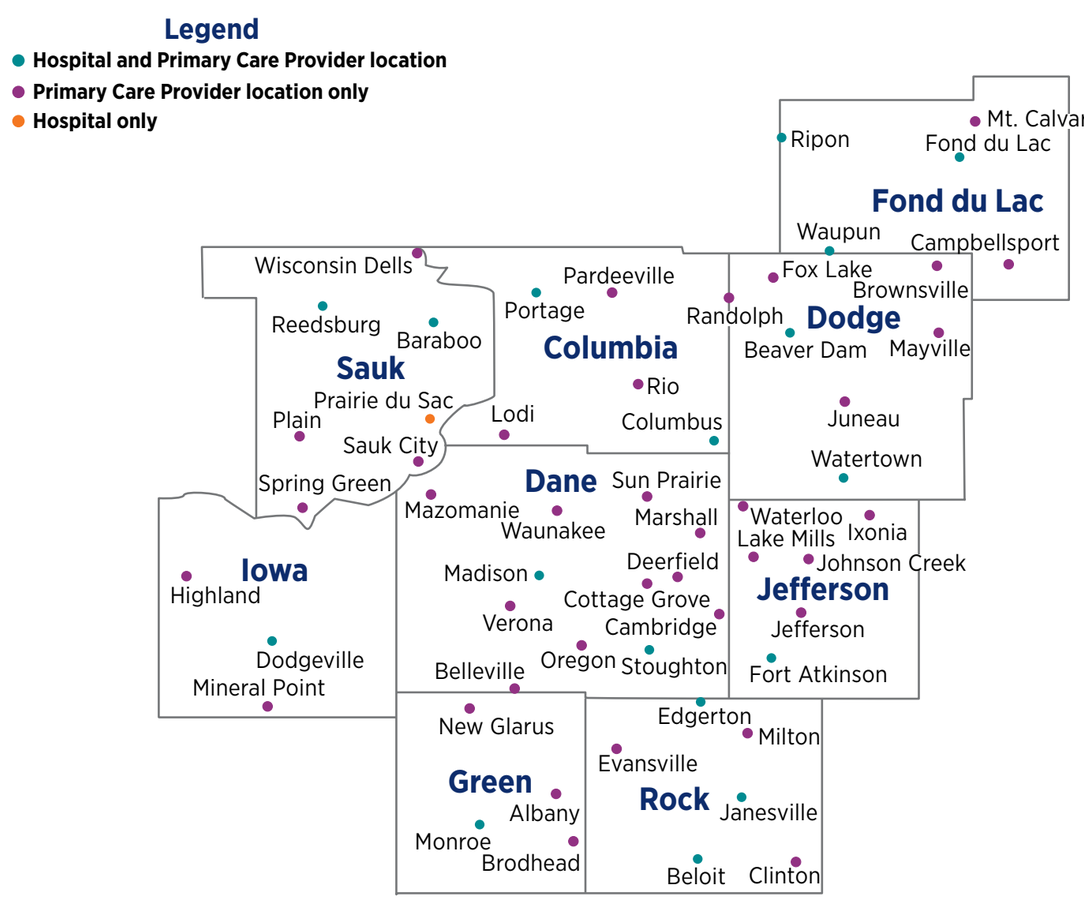
Coordinated Network



Dean Medicare Advantage Service Area

The service area for Dean Medicare Advantage is Columbia, Dane, Dodge, Fond du Lac, Green, Iowa, Jefferson, Rock and Sauk counties. You must live in one of these counties to join a Dean Medicare Advantage plan.

One plan. **One strong network.**



Medicare Eligibility and Enrollment Periods

Who's Eligible For Medicare?

You are eligible for Medicare, the federal health insurance program, if you are a legal U.S. resident and one of the following applies to you:

- You are 65 years old or older
- You are any age and have a qualifying permanent disability
- You are any age and have been diagnosed with end-stage renal disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS, also called Lou Gehrig's disease)

Medicare Advantage Enrollment Periods

IEP

Initial Enrollment Period (IEP)

This is the seven-month period during which you may enroll in Medicare for the first time. This includes the three months prior, the month of your birthday and the three months after. If you are enrolling for the first time due to disability, your IEP timing is based on your disability date.

Your Initial Enrollment Period
You can enroll before you turn 65, but your coverage may not be effective before your 65th birthday. For your Initial Enrollment Period the earliest effective date will be the first day of the month you turn 65. If you are born on the first of the month, coverage will begin the first of the month before.

If you enroll during the month of your 65th birthday or within the three months after you turn 65, your effective date will be the first day of the next month.

AEP

Annual Enrollment Period (AEP)

Oct. 15–Dec. 7 of every year is the period during which you may make changes to your Medicare Advantage coverage. Your coverage will become effective January 1.

OEP

Open Enrollment Period (OEP)

Jan. 1 – Mar. 31 of every year is the period during which you may switch from one Medicare Advantage plan to another Medicare Advantage plan, or cancel your Medicare Advantage plan and return to Original Medicare.

SEP

Special Enrollment Period (SEP)

This is a period during which Medicare recipients may change Medicare Advantage coverage outside of the AEP, if they **meet certain requirements and have a qualifying event**, such as moving to a new service area or leaving an employer-based plan.

Dean Medicare Advantage Plans At-a-Glance

Choose the Dean Advantage plan that suits you.

Preventive care is covered at 100%

Plan Name	Monthly Premium	Additional Savings	Hospital Copay	Primary Care Copay	Specialist Copay	Emergency Room Copay	Urgent Care Copay	Ground Ambulance	Therapy: Physical, Occupational, Speech	Outpatient Surgery	Maximum Out-of-Pocket (per year)
Essential (HMO) **In-Network Only**	**$0** per month	N/A	$350/day for days 1-5	$0	$50	$110	$50	$275	$40	$350	$5,500
Assurance (HMO-POS)	**$50** per month	N/A	**In-Network:** $350/day for days 1-5 **Out-of-Network:** $600/day for days 1-7	**In-Network:** $0 **Out-of-Network:** $60	**In-Network:** $40 **Out-of-Network:** $60	$110	$40	$275	**In-Network:** $40 **Out-of-Network:** $60	**In-Network:** $350 **Out-of-Network:** 40% Coinsurance	$4,500
Balance (HMO-POS)	**$97** per month	N/A	**In-Network:** $350/day for days 1-5 **Out-of-Network:** $600/day for days 1-7	**In-Network:** $0 **Out-of-Network:** $60	**In-Network:** $30 **Out-of-Network:** $60	$125	$30	$275	**In-Network:** $40 **Out-of-Network:** $60	**In-Network:** $350 **Out-of-Network:** 40% Coinsurance	$3,650
Complete (HMO) **In-Network Only**	**$251** per month	N/A	$350/day for days 1-5	$0	$10	$125	$10	$275	$40	$350	$2,000
Harmony (HMO-POS) MA-Only	**$0** per month	$20 Monthly Part B Premium Reduction	**In-Network:** $350/day for days 1-5 **Out-of-Network:** $600/day for days 1-7	**In-Network:** $0 **Out-of-Network:** $75	**In-Network:** $35 **Out-of-Network:** $75	$110	$35	$275	**In-Network:** $40 **Out-of-Network:** $75	**In-Network:** $350 **Out-of-Network:** 40% Coinsurance	$4,500
SSM Presence* (HMO-POS)	**$0** per month	FlexSpend: $650 yearly for Dental/ Vision/Hearing	**In-Network:** $350/day for days 1-5 **Out-of-Network:** $600/day for days 1-7	**In-Network:** $0 **Out-of-Network:** $60	**In-Network:** $40 **Out-of-Network:** $60	$90	$40	$275	**In-Network:** $40 **Out-of-Network:** $60	**In-Network:** $350 **Out-of-Network:** 40% Coinsurance	$4,900

** SSM Presence (HMO-POS) is only available to residents of Fond du Lac and Dodge Counties.*

Extra Benefits Not Covered by Original Medicare

Dean Health Plan is dedicated to our members' well-being. The benefits listed below are included in all of our Medicare plans.

Learn more at...

Find more information about our extra benefits at **deancare.com/extrabenefits23**

New for 2023:

Your over-the-counter and eyewear benefit are on your Dean Wallet Card.

Over-the-Counter

We cover $50 per quarter to spend on eligible over-the-counter products like bandages, pain relievers and much more.

You can shop:

- In-store at participating retailers including Walgreens, CVS, Walmart, Dollar General and Kroger stores
- Order online or by phone
- Mail-order catalog

Vision**

We cover one $0 routine vision exam at in-network providers, and a $150 eyewear allowance per year at any free standing vision centers.

Dental*

We cover both preventive and comprehensive dental benefits through our partner Delta Dental. Our plan has no waiting period, no deductibles or coinsurance.

- Preventive and diagnostic services: $0 copay
- Gum disease maintenance and bridge/implants/ dentures repairs: $45 copay
- Fillings, gum disease treatment and extractions: $95 copay
- Root canals, bridges, implants, dentures crowns and surgical gum disease treatment: $595 copay
- We cover $1,500 in dental services per year

See our network of dentists at **deancare.com/extrabenefits23**

DELTA DENTAL®

In-Home Support from Papa

We partnered with Papa, a company that connects you with screened and trained Papa Pals who provide assistance with organization, light housework, technology and transportation. Your Pal can visit with you in your home or virtually for up to 120 hours per year.

Hearing

We cover one $0 routine hearing exam and a $750 hearing aid allowance per year.

Chiropractic Care / Acupuncture

We cover additional chiropractic and acupuncture benefits to help you stay healthy and active.

Transportation

We cover 24 one-way personal rides each year to medical appointments and to the pharmacy.

Post-Discharge Meals

We cover 14 meals from Mom's Meals delivered to your door after you are discharged from the hospital or a skilled nursing facility.

Fitness

The One Pass™ program includes:

- Fitness center memberships
- Home fitness kit
- On-demand fitness videos

Nurse Line

Experienced registered nurses are always available to answer your questions and concerns. Nurses are available 24 hours a day, 365 days a year. Call if you're unsure if you need to see a doctor, or if you have other health related questions.

Living Healthy Rewards

You can earn up to $150 in rewards for completing healthy activities like receiving a flu shot, going to the dentist and getting an annual physical.

** See page 11 for SSM Presence plan dental, vision and hearing benefits.*

*** Benefits vary by plan. Please see the Summary of benefits for full plan details.*

$0 Benefits

All of our plans include many benefits at no cost to you.

Diabetic Benefits

Dean Health Plan understands the special needs of individuals with diabetes. Our Medicare Advantage plans offer specific benefits geared toward those needs.

Additional Savings

Make our additional savings work for you. Additional savings are available on our SSM Presence (HMO-POS) plan that is only available to residents of Fond du Lac and Dodge counties.

$0 Benefits

- All Primary Care Visits: In-person and Telehealth
- Routine Vision and Hearing Exams
- Meals Post-Discharge
- Transportation
- In-Home Support
- Dental Exams, Cleanings and X-Ray
- Vaccines
- Mammograms and Pelvic Exams
- Prostate Cancer Screening
- Preventive Colonoscopy Screenings
- Diabetes Screenings, Testing Supplies and Self-Management Training
- E-Visit For Eligible Conditions
- Three-month Fill at a Costco Mail Order Pharmacy for Tier 1 and Tier 2 Drugs

Diabetic Benefits

- $30 Insulin Fills at Preferred Pharmacy Locations
- $35 Insulin Fills at Standard Retail Pharmacies
- $0 Continuous Glucose Monitors (Freestyle Libre and Dexcom)
- $0 PCP
- $0 Diabetic Testing and Insulin Supplies
- 20% Coinsurance for Insulin Pumps
- Two Additional Dental Cleanings Per Year
- Over-the-Counter Benefit Includes Coverage for Products Like Diabetic Socks and Glucose Tablets

	SSM Presence* (HMO-POS)
FlexSpend Benefit Prepaid allowance on your Dean Wallet Card to be used towards additional dental services, vision services, eyewear, hearing services and hearing aids. Your FlexSpend benefit can be spent at any freestanding dental, vision or hearing facility. You are not restricted to in-network providers.	**$650** yearly
Dental We partnered with Delta Dental to provide you dental benefits with no waiting periods or deductibles	**$300 of dental** services per year • Preventive and diagnostic services: $0 copay • Comprehensive services: 50% coinsurance **+ FlexSpend Benefit**
Eyeglasses We cover eyeglasses, frames, lenses or contact lenses from an in-network eyewear location or freestanding vision center	**FlexSpend Benefit**
Hearing Aids We cover hearing aids when purchased from an in-network hearing aid provider	**$750** In-Network Only **+ FlexSpend Benefit**

** SSM Presence (HMO-POS) is only available to residents of Fond du Lac and Dodge Counties.*

Part D Prescription Drug Coverage

Dean Medicare Advantage plans provide comprehensive prescription drug coverage. Our drug formulary covers a wide-ranging list of generic, brand name and specialty drugs, with manageable copays.

Members save money by filling prescriptions in our preferred retail pharmacy network and through our mail order pharmacy.

- All SSM Pharmacies, Walgreens and Walmart pharmacies
- Costco retail and mail order pharmacies – no Costco membership required
- **$0 for 100-day fill at a mail order pharmacy for Tier 1 and Tier 2 drugs**

Members have access to standard retail pharmacy network that includes:

- Most national pharmacy chains, including CVS
- Many retail and grocery store pharmacies
- Many independent, local community pharmacies

Dean Health Plan's Drug Formulary and Pharmacy Directory are available at **deancare.com/medicareadvantagemembers**.

*** Benefits vary by plan. Please see the Summary of benefits for full plan details.*

Part D Prescription Drug Coverage At-a-Glance

Stage 1: Initial Coverage Deductible (Applies to Tiers 3-5) You pay:	**Tier 3 thru Tier 5**	**Essential** (HMO)**: $250** **Assurance: $150** **Balance** (HMO-POS)**: $100** **Complete** (HMO)**: $0** **SSM Presence*** (HMO-POS)**: $250**				
Stage 2: Initial Coverage Copay and Coinsurance You pay:		**1 Month/30 Day**		**3 Month/100 Day**		
		Preferred Retail and Mail Order	**Standard Retail**	**Mail Order**	**Preferred Retail**	**Standard Retail**
	Tier 1	$2	$7	$0	$2	$7
	Tier 2	$10	$15	$0	$20	$30
	Tier 3	$42	$47	$117.50	$117.50	$130
	Tier 4	$95	$100	$285	$285	$300
	Tier 5	Cost Sharing Varies by Plan: **Essential: 29%** **Assurance: 30%** **Balance: 31%** **Complete: 33%** **SSM Presence*: 29%**		Not applicable		
Stage 3: Coverage Gap (Donut Hole) You pay:		**25% coinsurance**				
Stage 4: Catastrophic Coverage You pay:		Generic: 5% or $4.15 Brand: 5% or $10.35				

Drug dispensing fees may apply.

** SSM Presence (HMO-POS) is only available to residents of Fond du Lac and Dodge Counties.*

Harmony (HMO-POS) MA-Only

Dean Advantage Harmony does not offer Part D Prescription Drug coverage. This is an excellent choice if you already have prescription drug coverage through Wisconsin's Senior Care Prescription Drug Assistance Program, TRICARE for Life, the VA or an employer plan. You cannot have a Medicare Part D Prescription Drug plan if you enroll in the Harmony plan.

Part D Prescription Drug Coverage At-a-Glance (continued)

Maintenance Drugs Savings

Save time and money by purchasing a three-month supply of maintenance drugs in one transaction via the Costco mail-order pharmacy. No Costco membership required.

$0 Part D Vaccines

You pay $0 in all stages for all covered Part D vaccines – including Shingles and Tdap. These $0 vaccines are listed in our formulary as Tier 6.

Insulin Savings

You will pay a $30 copay per prescription at a preferred pharmacy or a $35 copay per prescription at a standard pharmacy. These savings apply through the deductible and copay stages and the donut hole.

Stages of Part D Coverage

Stage 1: Initial Coverage Deductible	You pay full price for drugs on Tiers 3-5 until you meet your deductible You pay Stage 2 copays for Tiers 1&2 immediately (no deductible)
Stage 2: Initial Coverage Copay and Coinsurance	You pay copays or a percentage of the drug's total cost (coinsurance) You stay in this stage until you and Dean Advantage have paid $4,660 within a plan year
Stage 3: Coverage Gap (Donut Hole)	Once your total drug costs reach $4,660 you pay 25% of the cost of the drug You stay in this stage until your total out-of-pocket costs reaches $7,400 (not counting the amount that Dean Advantage has also paid) within a plan year
Stage 4: Catastrophic Coverage	After your total out-of-pocket costs reach $7,400 you pay a small copay or 5% coinsurance, whichever amount is larger You stay in this stage for the remainder of the plan year

Your Notes

Summary of Benefits | Plan Year 2023
Plan Year 2023

Medicare Advantage Plans from Dean Health Plan

Essential (HMO)
Assurance (HMO-POS)
Balance (HMO-POS)
Complete (HMO)
Harmony (HMO-POS) MA-Only
SSM Presence (HMO-POS)

January 1, 2023 – December 31, 2023
This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. See the Evidence of Coverage to get a complete list of services we cover. The Evidence of Coverage is available to view on deancare.com/medicareadvantagemembers. You can also request a printed copy of any of these materials by calling our Customer Care Center.

If you want to know more about the coverage and costs of Original Medicare, look in the current "Medicare & You" handbook. View it online at medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year. You must continue to pay your Part B premium.

This document is available in other formats such as Braille and large print. This document may be available in a non-English language. For additional information, call us at 1-877-232-7566 (TTY: 711).

Dean Health Plan, Inc. is a HMO/HMO-POS with a Medicare contract. Enrollment in Dean Health Plan, Inc. depends on contract renewal. Dean Health Plan markets under the names Dean Advantage and Prevea360 Medicare Advantage.

Hours of Operation

- From October 1 to March 31, you can call us 7 days a week from 8 am – 8 pm Central time
- From April 1 to September 30, you can call us Monday through Friday from 8 am – 8 pm Central time.

Dean Advantage Phone Numbers and Website

- If you are a member of this plan, call toll-free 1-877-232-7566 (TTY: 711).
- If you are not a member of this plan, call toll-free 1-877-234-0126 (TTY: 711).
- Our website: deancare.com/medicare

Who can join?

To join a **Dean Advantage** plan, you must be enrolled in Medicare Part A and Medicare Part B and live in our service area.

What is the Service Area?

Dean Advantage Essential, Assurance, Balance, Complete and Harmony:

Our service area includes the following counties in Wisconsin: **Columbia, Dane, Dodge, Fond du Lac, Green, Iowa, Jefferson, Rock and Sauk**. You must live in one of these counties to be eligible to enroll.

Dean Advantage SSM Presence:

Our service area includes the following counties in Wisconsin: **Dodge and Fond du Lac**. You must live in one of these counties to be eligible to enroll.

Which doctors, hospitals and pharmacies can I use?

Dean Advantage has a network of doctors, hospitals, pharmacies and other providers. For some services you can use providers that are not in our network.

- You can see our plan's provider directory at our website, deancare.com/doctors.
- You can see our plan's pharmacy directory at our website deancare.com/medicareadvantagemembers.

Monthly Premium, Deductibles, and Limits on How Much You Pay for Covered Services

	Essential (HMO)	Assurance (HMO-POS)	Balance (HMO-POS)	Complete (HMO)	Harmony (HMO-POS)	SSM Presence (HMO-POS)
Monthly Premium You must continue to pay your Medicare Part B premium	**$0**	**$50**	**$97**	**$251**	**$0**	**$0**
Part B Buy Back Dean Health Plan provides a credit that will automatically be applied towards your Medicare Part B premium	Not Applicable	Not Applicable	Not Applicable	Not Applicable	$20	Not Applicable
Medical Deductible	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Maximum Out-of-Pocket Responsibility If you reach the limit on out-of-pocket costs, you will keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. (Does not include prescription drugs)	$5,500 for in-network services	$4,500 for in-network and out-of-network services combined	$3,650 for in-network and out-of-network services combined	$2,000 for in-network services	$4,500 for in-network and out-of-network services combined	$4,900 for in-network and out-of-network services combined

Covered Medical and Hospital Benefits

*Benefit may require prior authorization

	Essential (HMO)	Assurance (HMO-POS)		Balance (HMO-POS)
	In Network	In Network	Out-of-Network	In Network
Inpatient Hospital Coverage* For Medicare-covered stays	$350 copay each day for days 1 - 5 $0 each day for days 6 to discharge	$350 copay each day for days 1 - 5 $0 each day for days 6 to discharge	$600 copay each day for days 1 - 7 $0 each day for days 8 to discharge	$350 copay each day for days 1 - 5 $0 each day for days 6 to discharge
Outpatient Hospital Coverage*				
Outpatient Hospital:	$350 copay	$350 copay	40% coinsurance	$350 copay
Ambulatory Surgery Center:	$350 copay	$350 copay	40% coinsurance	$350 copay
Procedure performed during office visit:	$0 - $50 copay	$0 - $40 copay	$60 - $60 copay	$0 - $30 copay
Doctor Visits				
Primary Care Providers:	$0 copay	$0 copay	$60 copay	$0 copay
Specialists:	$50 copay	$40 copay	$60 copay	$30 copay
Palliative Care:	$0 copay	$0 copay	$0 copay	$0 copay
Preventive Care	$0 copay	$0 copay	$30 copay	$0 copay
Emergency Care In the U.S. (Waived if admitted)	$110 copay	$110 copay	$110 copay	$125 copay
Urgently Needed Services In the U.S.	$50 copay Your cost may be reduced based on level of treating provider	$40 copay Your cost may be reduced based on level of treating provider	$40 copay	$30 copay Your cost may be reduced based on level of treating provider

Balance (HMO-POS)	Complete (HMO)	Harmony (HMO-POS)		SSM Presence (HMO-POS)	
Out-of-Network	In Network	In Network	Out-of-Network	In Network	Out-of-Network
$600 copay each day for days 1 - 7 $0 each day for days 8 to discharge	$350 copay each day for days 1 - 5 $0 each day for days 6 to discharge	$350 copay each day for days 1 - 5 $0 each day for days 6 to discharge	$600 copay each day for days 1 - 7 $0 each day for days 8 to discharge	$350 copay each day for days 1 - 5 $0 each day for days 6 to discharge	$600 copay each day for days 1 - 7 $0 each day for days 8 to discharge
40% coinsurance	$350 copay	$350 copay	40% coinsurance	$350 copay	40% coinsurance
40% coinsurance	$350 copay	$350 copay	40% coinsurance	$350 copay	40% coinsurance
$60 - $60 copay	$0 - $10 copay	$0 - $35 copay	$75 - $75 copay	$0 - $40 copay	$60 - $60 copay
$60 copay	$0 copay	$0 copay	$75 copay	$0 copay	$60 copay
$60 copay	$10 copay	$35 copay	$75 copay	$40 copay	$60 copay
$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$60 copay
$30 copay	$0 copay	$0 copay	$30 copay	$0 copay	$30 copay
$125 copay	$125 copay	$110 copay	$110 copay	$90 copay	$90 copay
$30 copay	$10 copay Your cost may be reduced based on level of treating provider	$35 copay Your cost may be reduced based on level of treating provider	$35 copay	$40 copay Your cost may be reduced based on level of treating provider	$40 copay

	Essential (HMO)	Assurance (HMO-POS)		Balance (HMO-POS)	Balance (HMO-POS)	Complete (HMO)	Harmony (HMO-POS)		SSM Presence (HMO-POS)	
	In Network	In Network	Out-of-Network	In Network	Out-of-Network	In Network	In Network	Out-of-Network	In Network	Out-of-Network
Diagnostic Services / Labs / Imaging*										
Outpatient X-ray:	$30 copay	$30 copay	40% coinsurance	$30 copay	40% coinsurance	$30 copay	$30 copay	40% coinsurance	$30 copay	40% coinsurance
Laboratory Tests:	$0 copay	$0 copay	20% coinsurance	$0 copay	20% coinsurance	$0 copay	$0 copay	20% coinsurance	$0 copay	20% coinsurance
Radiation Therapy:	20% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Diagnostic Procedures/Tests:	$5 copay	$5 copay	20% coinsurance	$5 copay	20% coinsurance	$5 copay	$30 copay	20% coinsurance	$25 copay	20% coinsurance
Diagnostic Mammograms:	$0 copay	$0 copay	40% coinsurance	$0 copay	40% coinsurance	$0 copay	$0 copay	40% coinsurance	$0 copay	40% coinsurance
Diagnostic Radiology:	$175 copay	$175 copay	40% coinsurance	$175 copay	40% coinsurance	$175 copay	$175 copay	40% coinsurance	$175 copay	40% coinsurance
Hearing Services										
Medicare-covered- exam to diagnose and treat hearing and balance issues:	$35 copay	$35 copay	$60 copay	$35 copay	$60 copay	$35 copay	$35 copay	$60 copay	$35 copay	$60 copay
Routine hearing exam:	$0 copay per exam for 1 exam every calendar year	$0 copay per exam for 1 exam every calendar year	Not Covered	$0 copay per exam for 1 exam every calendar year	Not Covered	$0 copay per exam for 1 exam every calendar year	$0 copay per exam for 1 exam every calendar year	Not Covered	$0 copay per exam for 1 exam every calendar year	Not Covered
Hearing aid fitting / evaluation:	$0 copay per fitting for 1 fitting every calendar year	$0 copay per fitting for 1 fitting every calendar year	Not Covered	$0 copay per fitting for 1 fitting every calendar year	Not Covered	$0 copay per fitting for 1 fitting every calendar year	$0 copay per fitting for 1 fitting every calendar year	Not Covered	$0 copay per fitting for 1 fitting every calendar year	Not Covered

	Essential (HMO)	Assurance (HMO-POS)		Balance (HMO-POS)
	In Network	In Network	Out-of-Network	In Network
Hearing aid allowance:	$0 copay Our plan pays up to $750 both ears combined every calendar year for hearing aids You are responsible for costs beyond the plan limit	$0 copay Our plan pays up to $750 both ears combined every calendar year for hearing aids You are responsible for costs beyond the plan limit	Not Covered	$0 copay Our plan pays up to $750 both ears combined every calendar year for hearing aids You are responsible for costs beyond the plan limit
Preventive Dental				
Preventive exams:	$0 copay per visit for 2 visits every calendar year	$0 copay per visit for 2 visits every calendar year	Not Covered	$0 copay per visit for 2 visits every calendar year
Cleanings:	$0 copay per visit for 2 visits every calendar year	$0 copay per visit for 2 visits every calendar year	Not Covered	$0 copay per visit for 2 visits every calendar year
X-Ray:	$0 copay per visit for 1 visit every calendar year	$0 copay per visit for 1 visit every calendar year	Not Covered	$0 copay per visit for 1 visit every calendar year

	Balance (HMO-POS)	Complete (HMO)	Harmony (HMO-POS)		SSM Presence (HMO-POS)	
	Out-of-Network	In Network	In Network	Out-of-Network	In Network	Out-of-Network
Hearing aid allowance:	Not Covered	$0 copay Our plan pays up to $750 both ears combined every calendar year for hearing aids You are responsible for costs beyond the plan limit	$0 copay Our plan pays up to $750 both ears combined every calendar year for hearing aids You are responsible for costs beyond the plan limit	Not Covered	$0 copay Our plan pays up to $750 both ears combined every calendar year for hearing aids Additional allowance included in FlexSpend benefit You are responsible for costs beyond the plan limit	Included in FlexSpend benefit
Preventive Dental						
Preventive exams:	Not Covered	$0 copay per visit for 2 visits every calendar year	$0 copay per visit for 2 visits every calendar year	Not Covered	$0 copay per visit for 2 visits every calendar year	Not Covered
Cleanings:	Not Covered	$0 copay per visit for 2 visits every calendar year	$0 copay per visit for 2 visits every calendar year	Not Covered	$0 copay per visit for 2 visits every calendar year	Not Covered
X-Ray:						Not Covered
	Not Covered	$0 copay per visit for 1 visit every calendar year	$0 copay per visit for 1 visit every calendar year	Not Covered	$0 copay per visit for 1 visit every calendar year	

	Essential (HMO)	Assurance (HMO-POS)		Balance (HMO-POS)	Balance (HMO-POS)	Complete (HMO)	Harmony (HMO-POS)		SSM Presence (HMO-POS)	
	In Network	In Network	Out-of-Network	In Network	Out-of-Network	In Network	In Network	Out-of-Network	In Network	Out-of-Network
Comprehensive Dental										
Diagnostic services:	$0 copay	$0 copay	Not Covered	$0 copay	Not Covered	$0 copay	$0 copay	Not Covered	0% coinsurance	Not Covered
Gum disease maintenance and bridge/implants/dentures repairs:	$45 copay	$45 copay	Not Covered	$45 copay	Not Covered	$45 copay	$45 copay	Not Covered	50% coinsurance	Not Covered
Fillings, gum disease treatment, and extractions:	$95 copay	$95 copay	Not Covered	$95 copay	Not Covered	$95 copay	$95 copay	Not Covered	50% coinsurance	Not Covered
Root canals, bridges, implants, dentures, and crowns:	$595 copay	$595 copay	Not Covered	$595 copay	Not Covered	$595 copay	$595 copay	Not Covered	50% coinsurance	Not Covered
Dental Maximum Annual limit that Dean Health Plan will pay for preventive and comprehensive dental services You are responsible for costs beyond the plan limit	$1,500 every calendar year for dental services	$1,500 every calendar year for dental services	Not Covered	$1,500 every calendar year for dental services	Not Covered	$1,500 every calendar year for dental services	$1,500 every calendar year for dental services	Not Covered	$300 every calendar year for dental services Additional allowance included in FlexSpend benefit	Included in FlexSpend benefit
Vision Services										
Medicare-covered exam to treat to diagnose and treat diseases and conditions of the eye:	$35 copay	$35 copay	$60 copay	$35 copay	$60 copay	$35 copay	$35 copay	$75 copay	$35 copay	$60 copay
Medicare-covered eyewear after cataract surgery:	$0 copay	$0 copay	Not Covered	$0 copay	Not Covered	$0 copay	$0 copay	Not Covered	$0 copay	Not Covered
Routine eye exam:	$0 copay per exam for 1 exam every calendar year	$0 copay per exam for 1 exam every calendar year	Not Covered	$0 copay per exam for 1 exam every calendar year	Not Covered	$0 copay per exam for 1 exam every calendar year	$0 copay per exam for 1 exam every calendar year	Not Covered	$0 copay per exam for 1 exam every calendar year	Not Covered

	Essential (HMO)	Assurance (HMO-POS)		Balance (HMO-POS)	Balance (HMO-POS)	Complete (HMO)	Harmony (HMO-POS)		SSM Presence (HMO-POS)	
	In Network	In Network	Out-of-Network	In Network	Out-of-Network	In Network	In Network	Out-of-Network	In Network	Out-of-Network
Eyewear: (eyeglasses, frames, lenses or contact lenses)	Our plan pays up to a total of $150 every calendar year You are responsible for costs beyond the plan limit	Our plan pays up to a total of $150 every calendar year You are responsible for costs beyond the plan limit	Not Covered	Our plan pays up to a total of $150 every calendar year You are responsible for costs beyond the plan limit	Not Covered	Our plan pays up to a total of $150 every calendar year You are responsible for costs beyond the plan limit	Our plan pays up to a total of $150 every calendar year You are responsible for costs beyond the plan limit	Not Covered	Included in FlexSpend benefit	Included in FlexSpend benefit
Mental Health Services: Hospital Care* For Medicare-covered stays	$350 copay each day for days 1 - 5 $0 each day for days 6 - 90	$350 copay each day for days 1 - 5 $0 each day for days 6 - 90	$600 copay each day for days 1 - 7 $0 each day for days 8 - 90	$350 copay each day for days 1 - 5 $0 each day for days 6 - 90	$600 copay each day for days 1 - 7 $0 each day for days 8 - 90	$350 copay each day for days 1 - 5 $0 each day for days 6 - 90	$350 copay each day for days 1 - 5 $0 each day for days 6 - 90	$600 copay each day for days 1 - 7 $0 each day for days 8 - 90	$350 copay each day for days 1 - 5 $0 each day for days 6 - 90	$600 copay each day for days 1 - 7 $0 each day for days 8 - 90
Mental Health Services: Outpatient Care*										
Outpatient Individual Therapy:	$0 copay	$0 copay	$60 copay	$0 copay	$60 copay	$0 copay	$20 copay	$60 copay	$0 copay	$60 copay
Outpatient Group Therapy:	$0 copay	$0 copay	$60 copay	$0 copay	$60 copay	$0 copay	$20 copay	$60 copay	$0 copay	$60 copay
Skilled Nursing Facility* Our plan covers up to 100 day per benefit period in a SNF: A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row	$0 each day for days 1 - 20 $196 each day for days 21 - 100	$0 each day for days 1 - 20 $196 each day for days 21 - 100	$150 each day for days 1 - 100	$0 each day for days 1 - 20 $196 each day for days 21 - 100	$150 each day for days 1 - 100	$0 each day for days 1 - 20 $196 each day for days 21 - 100	$0 each day for days 1 - 20 $196 each day for days 21 - 100	$150 each day for days 1 - 100	$0 each day for days 1 - 20 $196 each day for days 21 - 100	$150 each day for days 1 - 100

	Essential (HMO)	Assurance (HMO-POS)		Balance (HMO-POS)
	In Network	In Network	Out-of-Network	In Network
Therapy* Outpatient physical therapy, speech language pathology, and occupational therapy:	$40 copay per visit	$40 copay per visit	$60 copay per visit	$40 copay per visit
Ambulance For each one-way Medicare-covered trip	$275 copay	$275 copay	$275 copay	$275 copay
Transportation For rides to medical appointments	$0 copay per ride for 24 one-way rides every calendar year	$0 copay per ride for 24 one-way rides every calendar year	Not Covered	$0 copay per ride for 24 one-way rides every calendar year
Medicare Part B Drugs*				
Part B Drugs:	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Part B prescription drugs received in the pharmacy:				
Beneficiary coinsurance for certain Part B rebatable drugs may be subject to a lower coinsurance beginning on April 1, 2023.	$2 copay - $47 copay	$2 copay - $47 copay	20% coinsurance	$2 copay - $47 copay
For Part B insulin furnished through an insulin pump, you will pay no more than a $35 copay for a one-month supply, effective July 1, 2023.				

Balance (HMO-POS)	Complete (HMO)	Harmony (HMO-POS)		SSM Presence (HMO-POS)	
Out-of-Network	In Network	In Network	Out-of-Network	In Network	Out-of-Network
$60 copay per visit	$40 copay per visit	$40 copay per visit	$75 copay per visit	$40 copay per visit	$60 copay per visit
$275 copay	$275 copay	$275 copay	$275 copay	$275 copay	$275 copay
Not Covered	$0 copay per ride for 24 one-way rides every calendar year	$0 copay per ride for 24 one-way rides every calendar year	Not Covered	$0 copay per ride for 24 one-way rides every calendar year	Not Covered
20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
20% coinsurance	$2 copay - $42 copay	$2 copay - $47 copay	20% coinsurance	$2 copay - $47 copay	20% coinsurance

Medicare Part D Prescription Drug Coverage

	Essential (HMO)	Assurance (HMO-POS)	Balance (HMO-POS)	Complete (HMO)	Harmony (HMO-POS)	SSM Presence (HMO-POS)
Part D Deductible	$250 Applies to Tier 3, Tier 4 and Tier 5	$150 Applies to Tier 3, Tier 4 and Tier 5	$100 Applies to Tier 3, Tier 4 and Tier 5	$0	Not Covered	$250 Applies to Tier 3, Tier 4 and Tier 5
PREFERRED RETAIL 30 day supply						
Tier 1 Preferred Generic	$2 copay	$2 copay	$2 copay	$2 copay	Not Covered	$2 copay
Tier 2 Generic	$10 copay	$10 copay	$10 copay	$10 copay	Not Covered	$10 copay
Tier 3 Preferred Brand	$42 copay	$42 copay	$42 copay	$42 copay	Not Covered	$42 copay
Tier 4 Non-Preferred Drugs	$95 copay	$95 copay	$95 copay	$95 copay	Not Covered	$95 copay
Tier 5 Specialty Drugs	29% coinsurance	30% coinsurance	31% coinsurance	33% coinsurance	Not Covered	29% coinsurance
Tier 6 Part D Vaccines	$0 copay	$0 copay	$0 copay	$0 copay	Not Covered	$0 copay
STANDARD RETAIL 30 day supply						
Tier 1 Preferred Generic	$7 copay	$7 copay	$7 copay	$7 copay	Not Covered	$7 copay
Tier 2 Generic	$15 copay	$15 copay	$15 copay	$15 copay	Not Covered	$15 copay
Tier 3 Preferred Brand	$47 copay	$47 copay	$47 copay	$47 copay	Not Covered	$47 copay
Tier 4 Non-Preferred Drugs	$100 copay	$100 copay	$100 copay	$100 copay	Not Covered	$100 copay
Tier 5 Specialty Drugs	29% coinsurance	30% coinsurance	31% coinsurance	33% coinsurance	Not Covered	29% coinsurance
Tier 6 Part D Vaccines	$0 copay	$0 copay	$0 copay	$0 copay	Not Covered	$0 copay
LONG TERM CARE 31 day supply	See Standard Retail Pharmacy (30 Day)				Not Covered	See Standard Retail Pharmacy (30 Day)
OUT-OF-NETWORK 29 day supply	See Standard Retail Pharmacy (30 Day)				Not Covered	See Standard Retail Pharmacy (30 Day)

	Essential (HMO)	Assurance (HMO-POS)	Balance (HMO-POS)	Complete (HMO)	Harmony (HMO-POS)	SSM Presence (HMO-POS)
PREFERRED RETAIL 100 day supply						
Tier 1 Preferred Generic	$2 copay	$2 copay	$2 copay	$2 copay	Not Covered	$2 copay
Tier 2 Generic	$20 copay	$20 copay	$20 copay	$20 copay	Not Covered	$20 copay
Tier 3 Preferred Brand	$117.50 copay	$117.50 copay	$117.50 copay	$117.50 copay	Not Covered	$117.50 copay
Tier 4 Non-Preferred Drugs	$285 copay	$285 copay	$285 copay	$285 copay	Not Covered	$285 copay
Tier 5 Specialty Drugs	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Covered	Not Applicable
Tier 6 Part D Vaccines	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Covered	Not Applicable
STANDARD RETAIL 100 day supply						
Tier 1 Preferred Generic	$7 copay	$7 copay	$7 copay	$7 copay	Not Covered	$7 copay
Tier 2 Generic	$30 copay	$30 copay	$30 copay	$30 copay	Not Covered	$30 copay
Tier 3 Preferred Brand	$130 copay	$130 copay	$130 copay	$130 copay	Not Covered	$130 copay
Tier 4 Non-Preferred Drugs	$300 copay	$300 copay	$300 copay	$300 copay	Not Covered	$300 copay
Tier 5 Specialty Drugs	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Covered	Not Applicable
Tier 6 Part D Vaccines	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Covered	Not Applicable
Part D Coverage Stages						
Stage 1 Deductible	You pay in full until you reach your deductible. (Applies to Tier 3, Tier 4 and Tier 5 only)	You pay in full until you reach your deductible. (Applies to Tier 3, Tier 4 and Tier 5 only)	You pay in full until you reach your deductible. (Applies to Tier 3, Tier 4 and Tier 5 only)	There is no deductible. You begin in the initial coverage stage.	Not Covered	You pay in full until you reach your deductible. (Applies to Tier 3, Tier 4 and Tier 5 only)
Stage 2 Initial Coverage	You pay copays or coinsurance, and we pay the remainder until together our spending reaches **$4,660**	You pay copays or coinsurance, and we pay the remainder until together our spending reaches **$4,660**	You pay copays or coinsurance, and we pay the remainder until together our spending reaches **$4,660**	You pay copays or coinsurance, and we pay the remainder until together our spending reaches **$4,660**	Not Covered	You pay copays or coinsurance, and we pay the remainder until together our spending reaches **$4,660**

	Essential (HMO)	Assurance (HMO-POS)	Balance (HMO-POS)	Complete (HMO)	Harmony (HMO-POS)	SSM Presence (HMO-POS)
Stage 3 Coverage Gap	Above **$4,660** , you pay 25% of the cost for generics and brand drugs until your expenses reach **$7,400**	Above **$4,660** , you pay 25% of the cost for generics and brand drugs until your expenses reach **$7,400**	Above **$4,660** , you pay 25% of the cost for generics and brand drugs until your expenses reach **$7,400**	Above **$4,660** , you pay 25% of the cost for generics and brand drugs until your expenses reach **$7,400**	Not Covered	Above **$4,660** , you pay 25% of the cost for generics and brand drugs until your expenses reach **$7,400**
Stage 4 Catastrophic	Above **$7,400** you pay the greater of **5%** or **$4.15** for generics and **$10.35** for all other drugs and we pay the remainder	Above **$7,400** you pay the greater of **5%** or **$4.15** for generics and **$10.35** for all other drugs and we pay the remainder	Above **$7,400** you pay the greater of **5%** or **$4.15** for generics and **$10.35** for all other drugs and we pay the remainder	Above **$7,400** you pay the greater of **5%** or **$4.15** for generics and **$10.35** for all other drugs and we pay the remainder	Not Covered	Above **$7,400** you pay the greater of **5%** or **$4.15** for generics and **$10.35** for all other drugs and we pay the remainder
100 day fills at mail order pharmacies	$0 Tier 1 and Tier 2 three-month supplies through Costco mail-order pharmacy. You do not need to be a Costco member to access the pharmacy	$0 Tier 1 and Tier 2 three-month supplies through Costco mail-order pharmacy. You do not need to be a Costco member to access the pharmacy	$0 Tier 1 and Tier 2 three-month supplies through Costco mail-order pharmacy. You do not need to be a Costco member to access the pharmacy	$0 Tier 1 and Tier 2 three-month supplies through Costco mail-order pharmacy. You do not need to be a Costco member to access the pharmacy	Not Covered	$0 Tier 1 and Tier 2 three-month supplies through Costco mail-order pharmacy. You do not need to be a Costco member to access the pharmacy

Additional Benefits

	Essential (HMO)	Assurance (HMO-POS)		Balance (HMO-POS)	Balance (HMO-POS)	Complete (HMO)	Harmony (HMO-POS)		SSM Presence (HMO-POS)	
	In Network	In Network	Out-of-Network	In Network	Out-of-Network	In Network	In Network	Out-of-Network	In Network	Out-of-Network
FlexSpend Benefit Allowance on a prepaid debit card to spend on dental services, vision services, eyewear, hearing services and hearing aids You can use your FlexSpend allowance at: • In-network and out-of-network dental offices • In-network eyeglass locations and freestanding vision centers • In-network hearing aid locations and freestanding hearing centers	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	$650 yearly	
In-Home Support We partnered with Papa, a company that connects you with screened and trained Papa Pals who provide assistance with organization, light housework, technology and transportation.	$0 copay per visit for 120 visits yearly	$0 copay per visit for 120 visits yearly	Not Covered	$0 copay per visit for 120 visits yearly	Not Covered	$0 copay per visit for 120 visits yearly	$0 copay per visit for 120 visits yearly	Not Covered	$0 copay per visit for 120 visits yearly	Not Covered
Over-the-Counter Allowance for Health and Wellness Products Shop online, in-store, or by catalog.	$50 quarterly allowance	$50 quarterly allowance	Not Covered	$50 quarterly allowance	Not Covered	$50 quarterly allowance	$50 quarterly allowance	Not Covered	$50 quarterly allowance	Not Covered
Post Discharge Meals Mom's Meals delivered to your door after you are discharged from the hospital or a skilled nursing facility.	Two meals per day for 7 days after an inpatient stay at no cost to you	Two meals per day for 7 days after an inpatient stay at no cost to you	Not Covered	Two meals per day for 7 days after an inpatient stay at no cost to you	Not Covered	Two meals per day for 7 days after an inpatient stay at no cost to you	Two meals per day for 7 days after an inpatient stay at no cost to you	Not Covered	Two meals per day for 7 days after an inpatient stay at no cost to you	Not Covered

	Essential (HMO)	Assurance (HMO-POS)		Balance (HMO-POS)
	In Network	In Network	Out-of-Network	In Network
Fitness Benefit One Pass™ Fitness Program	$0 copay	$0 copay	Not Covered	$0 copay
Routine Chiropractic	$20 copay for an additional 24 routine chiropractic visits every calendar year	$20 copay for an additional 24 routine chiropractic visits every calendar year	$60 copay for an additional combined 24 routine chiropractic visits every calendar year	$20 copay for an additional 24 routine chiropractic visits every calendar year
Acupuncture	You pay $50 copay per treatment for 12 treatments every calendar year	You pay $40 copay per treatment for 12 treatments every calendar year	Not Covered	You pay $30 copay per treatment for 12 treatments every calendar year
Living Healthy Rewards for completing healthy activities like receiving a flu shot, going to the dentist and getting an annual physical	$150 every calendar year	$150 every calendar year	Not Applicable	$150 every calendar year
Worldwide Emergency and Urgent Care Outside the US	$110 copay No Limit	$110 copay No Limit	$110 copay No Limit	$125 copay No Limit
Nurse Line Nurses are available 24 hours a day, 365 days a year.	$0 copay	$0 copay	Not Covered	$0 copay
Virtual Visits See conditions treated and complete an online health interview at deancare.com/virtualvisit.	$0 copay	$0 copay	Not Covered	$0 copay
Smoking and tobacco use cessation – Quit for Life Program This supplemental program is designed to help you overcome physical, psychological, and behavioral addictions using a seamlessly integrated mix of medication, one-on-one coaching, group video sessions and digital tools for support.	$0 copay	$0 copay	Not Covered	$0 copay

Balance (HMO-POS)	Complete (HMO)	Harmony (HMO-POS)		SSM Presence (HMO-POS)	
Out-of-Network	In Network	In Network	Out-of-Network	In Network	Out-of-Network
Not Covered	$0 copay	$0 copay	Not Covered	$0 copay	Not Covered
$60 copay for an additional combined 24 routine chiropractic visits every calendar year	$20 copay for an additional 24 routine chiropractic visits every calendar year	$20 copay for an additional 24 routine chiropractic visits every calendar year	$75 copay for an additional combined 24 routine chiropractic visits every calendar year	$20 copay for an additional 24 routine chiropractic visits every calendar year	$60 copay for an additional combined 24 routine chiropractic visits every calendar year
Not Covered	You pay $10 copay per treatment for 24 treatments every calendar year	You pay $35 copay per treatment for 12 treatments every calendar year	Not Covered	You pay $40 copay per treatment for 12 treatments every calendar year	Not Covered
Not Applicable	$150 every calendar year	$150 every calendar year	Not Applicable	$150 every calendar year	Not Applicable
$125 copay No Limit	$125 copay No Limit	$110 copay No Limit	$110 copay No Limit	$90 copay No Limit	$90 copay No Limit
Not Covered	$0 copay	$0 copay	Not Covered	$0 copay	Not Covered
Not Covered	$0 copay	$0 copay	Not Covered	$0 copay	Not Covered
Not Covered	$0 copay	$0 copay	Not Covered	$0 copay	Not Covered

Your Notes

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Dean Health Plan is an HMO/HMOPOS with a Medicare contract. Enrollment in Dean Health Plan depends on contract renewal. Dean Health Plan markets under the names Dean Advantage and Prevea360 Medicare Advantage. This information is not a complete description of benefits. Call **877-234-0126 (TTY: 711)** for more information. You must continue to pay your Medicare Part B premium.

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