2023 Medicare Enrollment Guide

Your partner in **wellness**

Essential (HMO-POS)

FlexSpend (HMO-POS)

Harmony (HMO-POS) MA-Only

PREVEA360 Medicare Advantage

from Dean Health Plan

Contents

Ready to Enroll?

You can enroll with Prevea360 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 **prevea360.com/medicare2023**

VISIT

In Person
Call **877-234-0126 (TTY: 711)** to schedule an enrollment appointment with a Medicare sales consultant.

LEARN

Register online
Find our upcoming seminars at **prevea360.com/seminars**

Discover Prevea360 Medicare Advantage

Thank you for your interest in Prevea360 Medicare Advantage, offered by Dean Health Plan. Prevea360 Medicare Advantage offers 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 Prevea360 Health Plan, leading to a streamlined and simpler experience for members.

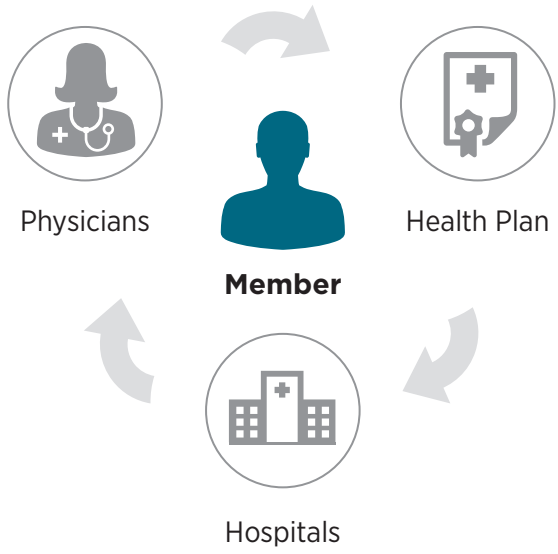
Local: Our roots are local. Our health plan employees are your friends and neighbors. You'll find your primary care provider just down the road.

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 benefit and more.

PREVEA360 Medicare Advantage
from Dean Health Plan

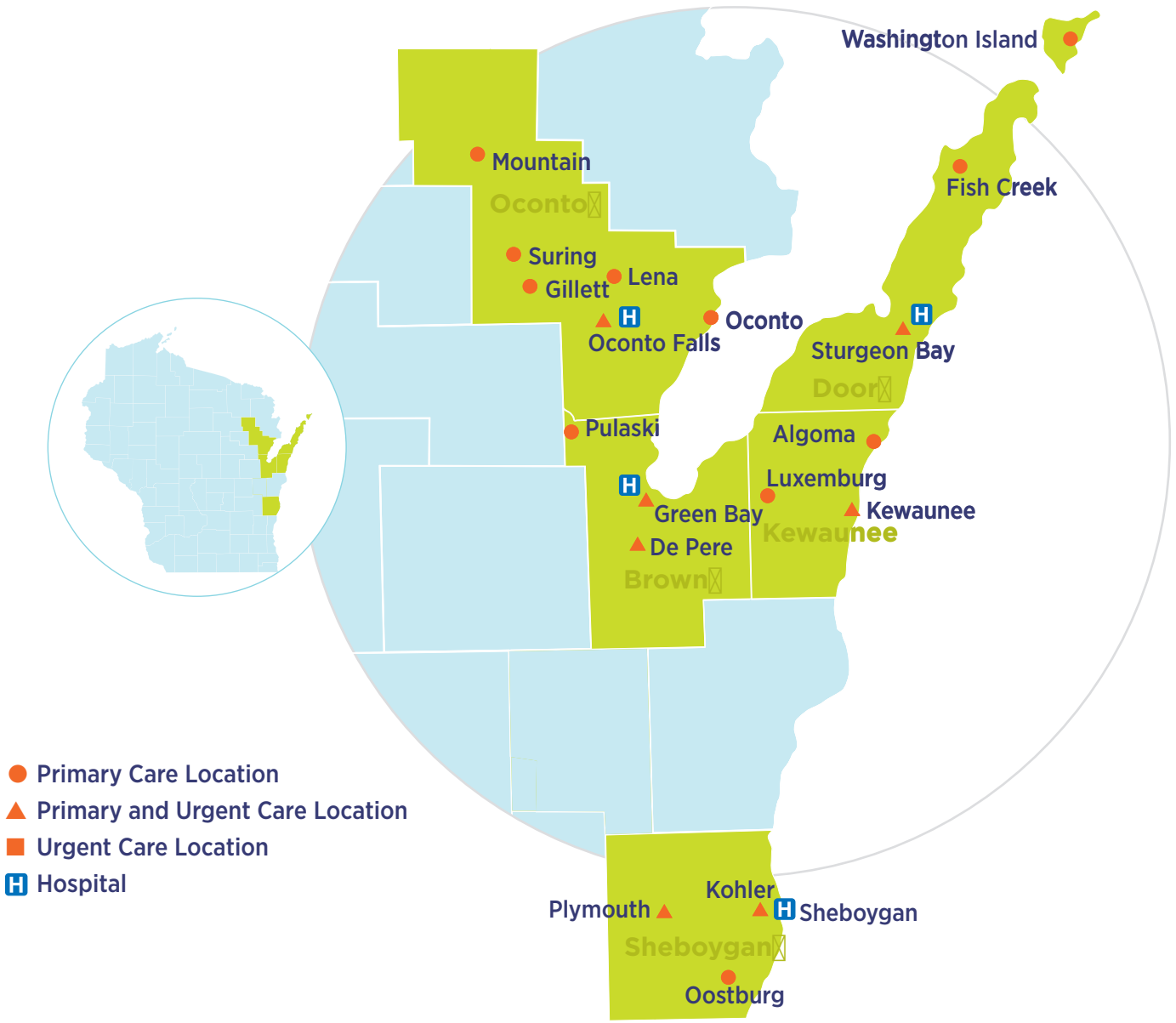
Coordinated Network



Prevea360 Medicare Advantage Service Area

The service area for Prevea360 Medicare Advantage is Brown, Door, Kewaunee, Oconto and Sheboygan counties. You must live in one of these counties to join a Prevea360 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.

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 previous 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.

Prevea360 Medicare Advantage Plans At-a-Glance

Great benefits come standard on all Prevea360 Medicare Advantage plans.

		Essential (HMO-POS)	FlexSpend (HMO-POS)	Harmony (HMO-POS) MA-Only
Monthly Premium		**$0** per month		
Hospital Copay	In-Network	$350/day for days 1-5		
	Out-of-Network	$600/day for days 1-7		
Primary Care Copay	In-Network	$0		
	Out-of-Network	$60		
Specialist Copay	In-Network	$35		
	Out-of-Network	$60		
Emergency Room Copay	In- and Out-of-Network	$95	$95	$110
Urgent Care Copay	In- and Out-of-Network	$35		
Ground Ambulance	In- and Out-of-Network	$275		
Therapy: Physical, Occupational, Speech	In-Network	$40		
	Out-of-Network	$60		
Outpatient Surgery	In-Network	$350		
	Out-of-Network	40% Coinsurance		
Maximum Out-of-Pocket (per year)	In-Network	$4700		
	Out-of-Network	$6000		

Preventive care is covered at 100%

Additional Savings

Make our additional savings work for you.

	Essential (HMO-POS)	**FlexSpend** (HMO-POS)	**Harmony** (HMO-POS) MA-Only
Part B Premium Reduction We lower the Part B premium you pay - giving you money back into your Social Security check	**$20** monthly	Not included	**$45** monthly
FlexSpend Benefit Prepaid allowance on your Prevea 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.	Not included	**$650** yearly	Not included
Dental We partnered with Delta Dental to provide you dental benefits with no waiting periods or deductibles	**$1500 of dental** services per year • Preventive and diagnostic services: **$0 copay** • Gum disease maintenance and bridge/implant/denture repairs: **$45 copay** • Fillings, gum disease treatment and extractions: **$95 copay** • Root canals, bridges, implants, dentures, crowns and surgical gum disease treatments: **$595 copay** **In-Network only**	**$300 of dental** services per year • Preventive and diagnostic services: **$0 copay** • Comprehensive services: **50% coinsurance**	**$1500 of dental** services per year • Preventive and diagnostic services: **$0 copay** • Gum disease maintenance and bridge/implant/denture repairs: **$45 copay** • Fillings, gum disease treatment and extractions: **$95 copay** • Root canals, bridges, implants, dentures, crowns and surgical gum disease treatments: **$595 copay** **In-Network only**
Eyeglasses Eyeglasses, frames, lenses or contact lenses from a freestanding vision center	Not included	**FlexSpend Benefit**	Not included
Hearing Aids Hearing aids when purchased from an in-network hearing aid provider	**$750** In-Network only	**$750** In-Network only **+ FlexSpend Benefit**	**$750** In-Network only

Extra Benefits Not covered by Original Medicare

Prevea360 Medicare Advantage plans are dedicated to our members' well-being.

Learn more at...

Find more information about our extra benefits at **prevea360.com/extrabenefits23**

Over-the-Counter

Your Prevea360 Wallet Card includes $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 over the phone
- Mail-order catalog

Fitness

The One Pass™ program includes:

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

Chiropractic Care

We cover 12 additional chiropractic benefits to help you stay healthy and active.

Dental / Vision / Hearing

Please see page 7 for benefit information.

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.

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.

Prevea Care After Hours
Experienced registered nurses are always available to answer your questions and concerns. Nurses are available 24 hours a day, 365 days a year. If you're not sure you need to see a doctor—or you're wondering if you have a problem—give us a call.

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

$0 Benefits

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

Diabetic Benefits

Prevea360 understands the special needs of individuals with diabetes. Our Medicare Advantage plans offer specific benefits geared toward those needs.

$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 Screening
- Diabetes Screenings, Testing Supplies and Self-Management Training
- Virtual 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
- $0 Continuous Glucose Monitors (Freestyle Libre and Dexcom)
- $0 PCP
- $0 Diabetic Testing and Insulin Supplies
- 20% Coinsurance for Insulin Pumps
- 2 Additional Dental Cleanings Per Year
- $200 yearly Over-the-Counter Benefit Includes Coverage for Products Like Diabetic Socks and Glucose Tablets

Prevea360 Medicare Advantage Part D Prescription Drug Coverage

Prevea360 Essential and Prevea360 FlexSpend plans provides 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 Walgreens and Walmart pharmacies
- Costco retail and mail order pharmacies. You do not need to be a Costco member to use the Costco Pharmacy.
- **$0 100-day fills at a Costco 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

Prevea360 Medicare Advantage's Drug Formulary and Pharmacy Directory are available at **prevea360.com/medicaremembers**

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 You do not need to be a Costco member to use the Costco Pharmacy.

$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.

Part D Prescription Drug Coverage At-a-Glance

Essential (HMO-POS)

FlexSpend (HMO-POS)

Stage 1: Initial Coverage Deductible You pay:	**Deductible (Applies to Tiers 3-5)**					
	$250					
Stage 2: Initial Coverage Copay and Coinsurance You pay:		**1 Month/30 Day**		**3 Month/100 Day**		
		Preferred Retail	**Standard Retail**	**Mail Order**	**Preferred Retail**	**Standard Retail**
	Tier 1	$2	$7	$0	$2	$7
	Tier 2	$5	$10	$0	$10	$20
	Tier 3	$42	$47	$117.50	$117.50	$130
	Tier 4	$95	$100	$285	$285	$300
	Tier 5	Cost Sharing: 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.

Harmony (HMO-POS) MA-Only

Prevea360 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.

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 Prevea360 Medicare 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 Prevea360 Medicare 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

Summary of Benefits Plan Year 2023

Prevea360 Medicare Advantage Plans from Dean Health Plan

Essential (HMO)

FlexSpend (HMO-POS)

Harmony (HMO-POS) MA-Only

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 prevea360.com/medicaremembers. 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.

Prevea360 Medicare 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: prevea360.com/medicare

Who can join?

To join a **Prevea360 Medicare 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?

Our service area includes the following counties in Wisconsin: **Brown, Door, Kewaunee, Oconto, and Sheboygan**

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.

- Provider directory website: prevea360.com/doctors
- Pharmacy directory website: prevea360.com/medicaremembers

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

	Prevea360 Essential (HMO-POS)	Prevea360 FlexSpend (HMO-POS)	Prevea360 Harmony (HMO-POS)
Monthly Premium You must continue to pay your Medicare Part B premium	**$0**	**$0**	**$0**
Part B Buy Back Dean Health Plan provides a credit that will automatically be applied towards your Medicare Part B premium	$20	Not Applicable	$45
Medical Deductible	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)	$4,700 for in-network services $6,000 for in-network and out-of-network services combined	$4,700 for in-network services $6,000 for in-network and out-of-network services combined	$4,700 for in-network services $6,000 for in-network and out-of-network services combined

Covered Medical and Hospital Benefits

*Benefit may require prior authorization

	Prevea360 Essential (HMO-POS)		Prevea360 FlexSpend (HMO-POS)		Prevea360 Harmony (HMO-POS)	
	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network
Inpatient Hospital Coverage* For Medicare-covered stays	$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	$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
Outpatient Hospital Coverage*						
Outpatient Hospital:	$350 copay	40% coinsurance	$350 copay	40% coinsurance	$350 copay	40% coinsurance
Ambulatory Surgery Center:	$300 copay	40% coinsurance	$300 copay	40% coinsurance	$350 copay	40% coinsurance
Procedure performed during office visit:	$0 - $35 copay	$60 - $60 copay	$0 - $35 copay	$60 - $60 copay	$0 - $35 copay	$60 - $60 copay
Doctor Visits						
Primary Care Providers:	$0 copay	$60 copay	$0 copay	$60 copay	$0 copay	$60 copay
Specialists:	$35 copay	$60 copay	$35 copay	$60 copay	$35 copay	$60 copay
Palliative Care:	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Preventive Care	$0 copay	$30 copay	$0 copay	$30 copay	$0 copay	$30 copay
Emergency Care In the U.S. (Waived if admitted)	$95 copay	$95 copay	$95 copay	$95 copay	$110 copay	$110 copay
Urgently Needed Services In the U.S.	$35 copay Your cost may be reduced based on level of treating provider	$35 copay	$35 copay Your cost may be reduced based on level of treating provider	$35 copay	$35 copay Your cost may be reduced based on level of treating provider	$35 copay

	Prevea360 Essential (HMO-POS)		Prevea360 FlexSpend (HMO-POS)		Prevea360 Harmony (HMO-POS)	
	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network
Diagnostic Services / Labs / Imaging*						
Outpatient X-ray:	$30 copay	40% coinsurance	$30 copay	40% coinsurance	$30 copay	40% coinsurance
Laboratory Tests:	$0 copay	20% coinsurance	$0 copay	20% coinsurance	$0 copay	20% coinsurance
Radiation Therapy:	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Diagnostic Procedures/Tests:	$25 copay	20% coinsurance	$25 copay	20% coinsurance	$30 copay	20% coinsurance
Diagnostic Mammograms:	$0 copay	40% coinsurance	$0 copay	40% coinsurance	$0 copay	40% coinsurance
Diagnostic Radiology:	$150 copay	40% coinsurance	$150 copay	40% coinsurance	$150 copay	40% coinsurance
Hearing Services						
Medicare-covered- exam to diagnose and treat hearing and balance issues:	$35 copay	$60 copay	$35 copay	$60 copay	$35 copay	$60 copay

	Prevea360 Essential (HMO-POS)		Prevea360 FlexSpend (HMO-POS)		Prevea360 Harmony (HMO-POS)	
	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network
Routine hearing exam:	$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	Not Covered
Hearing aid fitting / evaluation:	$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	Not Covered
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	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	$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
Preventive Dental						
Preventive Exams:	$0 copay per visit for 2 visits every calendar year	Not Covered	$0 copay per visit for 2 visits every calendar year	Not Covered	$0 copay per visit for 2 visits every calendar year	Not Covered

	Prevea360 Essential (HMO-POS)		Prevea360 FlexSpend (HMO-POS)		Prevea360 Harmony (HMO-POS)	
	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network
Cleanings:	$0 copay per visit for 2 visits every calendar year	Not Covered	$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:	$0 copay per visit for 1 visit every calendar year	Not Covered	$0 copay per visit for 1 visit yearly	Not Covered	$0 copay per visit for 1 visit every calendar year	Not Covered
Comprehensive Dental						
Diagnostic services:	$0 copay	Not Covered	0% coinsurance	Not Covered	$0 copay	Not Covered
Gum disease maintenance and bridge/implants/dentures repairs:	$45 copay	Not Covered	50% coinsurance	Not Covered	$45 copay	Not Covered
Fillings, gum disease treatment, and extractions:	$95 copay	Not Covered	50% coinsurance	Not Covered	$95 copay	Not Covered
Root canals, bridges, implants, dentures, and crowns:	$595 copay	Not Covered	50% coinsurance	Not Covered	$595 copay	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	Not Covered	$300 every calendar year for dental services Additional allowance included in FlexSpend benefit	Included in FlexSpend benefit	$1,500 every calendar year for dental services	Not Covered

	Prevea360 Essential (HMO-POS)		Prevea360 FlexSpend (HMO-POS)		Prevea360 Harmony (HMO-POS)	
	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network
Vision Services Medicare-covered exam to treat to diagnose and treat diseases and conditions of the eye:	$35 copay	$60 copay	$35 copay	$60 copay	$35 copay	$60 copay
Medicare-covered eyewear after cataract surgery:	$0 copay	Not Covered	$0 copay	Not Covered	$0 copay	Not Covered
Routine eye exam:	$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	Not Covered
Eyewear: (eyeglasses, frames, lenses or contact lenses)	Not Covered	Not Covered	Included in FlexSpend benefit	Included in FlexSpend benefit	Our plan pays up to a total of $150 every calendar year	Not Covered
Mental Health Services: Hospital Care* For Medicare-covered stays	$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	$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	$60 copay	$0 copay	$60 copay	$20 copay	$60 copay
Outpatient Group Therapy:	$0 copay	$60 copay	$0 copay	$60 copay	$20 copay	$60 copay

	Prevea360 Essential (HMO-POS)		Prevea360 FlexSpend (HMO-POS)		Prevea360 Harmony (HMO-POS)	
	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network
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	$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	$150 each day for days 1 - 100
Therapy* Outpatient physical therapy, speech language pathology, and occupational therapy:	$40 copay per visit	$60 copay per visit	$40 copay per visit	$60 copay per visit	$40 copay per visit	$60 copay per visit
Ambulance For each one-way Medicare-covered trip	$275 copay	$275 copay	$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	Not Covered	$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

	Prevea360 Essential (HMO-POS)		Prevea360 FlexSpend (HMO-POS)		Prevea360 Harmony (HMO-POS)	
	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network
Medicare Part B Drugs*						
Part B Drugs:	20% coinsurance	20% coinsurance	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	20% coinsurance	$2 copay - $47 copay	20% coinsurance	$2 copay - $47 copay	20% coinsurance
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.						

Medicare Part D Prescription Drug Coverage

	Prevea360 Essential (HMO-POS)	Prevea360 FlexSpend (HMO-POS)	Prevea360 Harmony (HMO-POS)
Part D Deductible	$250 Applies to Tier 3, Tier 4 and Tier 5	$250 Applies to Tier 3, Tier 4 and Tier 5	Not Covered
PREFERRED RETAIL 30 day supply			
Tier 1 Preferred Generic	$2 copay	$2 copay	Not Covered
Tier 2 Generic	$5 copay	$5 copay	Not Covered
Tier 3 Preferred Brand	$42 copay	$42 copay	Not Covered
Tier 4 Non-Preferred Drugs	$95 copay	$95 copay	Not Covered
Tier 5 Specialty Drugs	29% coinsurance	29% coinsurance	Not Covered
Tier 6 Part D Vaccines	$0 copay	$0 copay	Not Covered
STANDARD RETAIL 30 day supply			
Tier 1 Preferred Generic	$7 copay	$7 copay	Not Covered
Tier 2 Generic	$10 copay	$10 copay	Not Covered
Tier 3 Preferred Brand	$47 copay	$47 copay	Not Covered
Tier 4 Non-Preferred Drugs	$100 copay	$100 copay	Not Covered
Tier 5 Specialty Drugs	29% coinsurance	29% coinsurance	Not Covered
Tier 6 Part D Vaccines	$0 copay	$0 copay	Not Covered
LONG TERM CARE 31 day supply	See Standard Retail Pharmacy (30 Day)		Not Covered
OUT-OF-NETWORK 29 day supply	See Standard Retail Pharmacy (30 Day)		Not Covered
PREFERRED RETAIL 100 day supply			
Tier 1 Preferred Generic	$2 copay	$2 copay	Not Covered
Tier 2 Generic	$10 copay	$10 copay	Not Covered
Tier 3 Preferred Brand	$117.50 copay	$117.50 copay	Not Covered
Tier 4 Non-Preferred Drugs	$285 copay	$285 copay	Not Covered

	Prevea360 Essential (HMO-POS)	Prevea360 FlexSpend (HMO-POS)	Prevea360 Harmony (HMO-POS)
Tier 5 Specialty Drugs	Not Applicable	Not Applicable	Not Covered
Tier 6 Part D Vaccines)	Not Applicable	Not Applicable	Not Covered
STANDARD RETAIL 100 day supply			
Tier 1 Preferred Generic	$7 copay	$7 copay	Not Covered
Tier 2 Generic	$20 copay	$20 copay	Not Covered
Tier 3 Preferred Brand	$130 copay	$130 copay	Not Covered
Tier 4 Non-Preferred Drugs	$300 copay	$300 copay	Not Covered
Tier 5 Specialty Drugs	Not Applicable	Not Applicable	Not Covered
Tier 6 Part D Vaccines	Not Applicable	Not Applicable	Not Covered
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)	Not Covered
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**	Not Covered
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**	Not Covered
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	Not Covered
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		Not Covered

Additional Benefits

	Prevea360 Essential (HMO-POS)		Prevea360 FlexSpend (HMO-POS)		Prevea360 Harmony (HMO-POS)	
	In Network	Out-of-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	$650 yearly		Not Covered	Not Covered
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	Not Covered	$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	Not Covered	$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	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	Not Covered

	Prevea360 Essential (HMO-POS)		Prevea360 FlexSpend (HMO-POS)		Prevea360 Harmony (HMO-POS)	
	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network
Fitness Benefit One Pass™ Fitness Program	$0 copay	Not Covered	$0 copay	Not Covered	$0 copay	Not Covered
Routine Chiropractic	$20 copay for an additional 12 routine chiropractic visits every calendar year	$60 copay for an additional combined 12 routine chiropractic visits every calendar year	$20 copay for an additional 12 routine chiropractic visits every calendar year	$60 copay for an additional combined 12 routine chiropractic visits every calendar year	$20 copay for an additional 12 routine chiropractic visits every calendar year	$60 copay for an additional combined 12 routine chiropractic visits 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	Not Applicable	$150 every calendar year	Not Applicable	$150 every calendar year	Not Applicable
Worldwide Emergency and Urgent Care Outside the US	$95 copay No Limit	$95 copay No Limit	$95 copay No Limit	$95 copay No Limit	$110 copay No Limit	$110 copay No Limit
Nurse Line Nurses are available 24 hours a day, 365 days a year.	$0 copay	Not Covered	$0 copay	Not Covered	$0 copay	Not Covered
Virtual Visits See conditions treated and complete an online health interview at prevea360.com/virtualvisit.	$0 copay	Not Covered	$0 copay	Not Covered	$0 copay	Not Covered
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	Not Covered	$0 copay	Not Covered	$0 copay	Not Covered

Follow us on LinkedIn and Facebook

Prevea360 Medicare Advantage

PO Box 56099
Madison WI 53705-9399
Toll-free **877-234-0126 (TTY: 711)**
prevea360.com/medicare2023

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.

Prevea360 Medicare Advantage
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PREVEA360 Medicare Advantage
from Dean Health Plan

Non-Discrimination & Language Assistance Access

For assistance understanding these materials in a language other than English, call 1-877-317-2410 (TTY: 711), and a Customer Care Center representative will assist you.

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sex, or religion. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, or religion.

We provide free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, or other formats).

We provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, or religion, you can file a grievance with the organization's Civil Rights Coordinator. If you need help filing a grievance, the Civil Rights Coordinator for the Health Plan is available to help you. You can file a written grievance in person, by mail, or by email at:

Civil Rights Coordinator
1277 Deming Way
Madison, Wisconsin 53717
1-608-828-2216 (TTY: 711)
civilrightscoordinator@deancare.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, by mail, or phone at:
U.S. Department of Health and Human Services
200 Independence Ave, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019 or 1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

For help to translate or understand this or other documents, please call 1-877-317-2410 (TTY: 711).

Español: tenemos servicios gratuitos de interpretación para responder a cualquier consulta sobre nuestro plan de atención médica o de cobertura de medicamentos. Para solicitar un intérprete, llame al 1-877-317-2410 (TTY:711). Un hablante de español puede ayudarle. Este servicio es gratuito.

Somali- Waxaan bixinaa adeegyada bilaashka ah si looga jawaabo su'aalo kasta ood ka qabi karto caymiskaaga caafimaadka ama daawada. Si aad u hesho turjumaan, keliya nagasoo wac 1-877-317-2410 (TTY: 711), Qof ku hadla luuqada af-Soomaaliga ayaa ku caawin kara. Kani waa adeeg bilaash ah.

Tagalog- Mayroon kaming mga libreng serbisyo ng interpreter para sagutin ang anumang tanong na maaaring mayroon ka tungkol sa aming plano sa kalusugan o gamot. Para makakuha ng interpreter, tumawag lamang sa amin sa 1-877-317-2410 (TTY: 711). Matutulungan ka ng isang taong nagsasalita ng Tagalog. Isa itong libreng serbisyo.

Gujarati- અમારી સ્વાસ્થ્ય કે દવા યોજના વિશે જો આપને કોઈ પ્રશ્ન હોય તો તેનો જવાબ આપવા અમારી પાસે મફત દુભાષિયા સેવા ઉપલબ્ધ છે. ગુજરાતી બોલીને આપને મદદ કરી શકે એવો દુભાષિયો મેળવવા માટે, માત્ર અમને 1-877-317-2410 (TTY: 711) પર કોલ કરો. આ મફત સેવા છે.

Hindi- हमारे पास हमारे स्वास्थ्य या औषधि योजना से संबंधित आपके किसी भी प्रश्न का उत्तर देने के लिए नि:शुल्क दुभाषिया सेवाएं हैं। दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-317-2410 (TTY: 711)

पर कॉल करें, कोई व्यक्ति जो हिंदी बोलता है, आपकी मदद कर सकता है। यह एक निःशुल्क सेवा है।

Hmong- Peb muaj cov kws txhais lus dawb los teb txhua nqi lus nug uas koj muaj hais txog peb li phiaj xwm kho mob los sis tshuaj muaj yees. Txhawm rau muaj tus kws pab txhais lus, thov hu rau peb tus xov tooj 1-877-317-2410 (TTY: 711), Yuav muaj tus hais ua lus Hmoob pab koj. No yog kev pab dawb.

Polish- Oferujemy bezpłatne usługi tłumacza, aby móc odpowiedzieć na wszelkie pytania dotyczące naszego planu opieki zdrowotnej lub planu lekowego. Aby skorzystać z pomocy tłumacza, wystarczy zadzwonić pod numer 1-877-317-2410 (TTY: 711). Osoba, która mówi po polsku, udzieli Państwu pomocy. Usługa jest bezpłatna.

Korean- 저희의 무료 통역 서비스를 통해 당사의 의료 보험 또는 의약품 보험에 대해 알고 싶으신 점을 질문하시고 답변을 받으십시오. 통역사가 필요하실 때는 1-877-317-2410 (TTY: 711)으로 전화 주십시오. 한국어가 가능한 직원이 도움을 드릴 것입니다. 무료로 이용하실 수 있습니다.

Russian- Мы предоставляем бесплатные услуги устного перевода, чтобы ответить на любые вопросы о нашем плане медицинского страхования или плане страхования стоимости лекарств. Чтобы получить помощь русского переводчика, просто позвоните по номеру 1-877-317-2410 (TTY: 711). Эта услуга является бесплатной.

French- Nous proposons des services d'interprétation gratuits pour répondre à toutes vos questions à propos de notre régime d'assurance maladie ou d'assurance médicaments. Pour bénéficier d'un(e) interprète, appelez simplement le 1 877 317 2410 (TTY: 711). Une personne parlant français pourra vous aider. Ce service est gratuit.

Italian- Offriamo servizi gratuiti di interpretazione per rispondere a eventuali domande in merito alla nostra assicurazione sanitaria o al nostro piano farmacologico. Per avvalersi dell'aiuto di un interprete in lingua italiana, chiamare il numero 1-877-317-2410 (TTY: 711). Il servizio è gratuito.

Chinese- 我们提供免费的口译服务，可回答您关于我们健康或药物计划的任何疑问。如需安排口译员，请致电 1-877-317-2410 (TTY: 711) 与我们联系，申请安排说中文的人员为您提供协助。此为免费服务。

Vietnamese- Chúng tôi có dịch vụ thông dịch viên miễn phí để trả lời các câu hỏi của quý vị về chương trình bảo hiểm sức khỏe hoặc thuốc. Nếu quý vị cần thông dịch viên, chỉ cần gọi cho chúng tôi theo số 1-877-317-2410 (TTY: 711), sẽ có nhân viên nói tiếng Việt có thể hỗ trợ quý vị. Đây là dịch vụ miễn phí.

Arabic-

لدينا خدمات مترجم فوري للإجابة ىع أي أسئلة قد تكون لديك حول خطتنا الدوائية أو الصحية. للحصول على مترجم فوري، فقط اتصل بنا على الرقم 1-877-317-2410، وستجد امصّخش يتحدث اللغة العربية يمكن أن يساعدك. هذه هي خدمة مجانية.

German- Wir bieten einen kostenlosen Dolmetscher-Service für Sie an, damit wir Ihre Fragen bezüglich unseres Gesundheits- oder Medikationsplans beantworten können. Rufen Sie uns einfach unter der Nummer 1 877 317 2410 (TTY: 711) an, um einen Dolmetscher anzufordern. Ihnen wird dann auf Deutsch weitergeholfen. Dies ist ein kostenloser Service.

Urdu-

ہمارے ہیلتھ یا ڈرگ پلان کے بارے میں آپ کے کسی بھی سوال کا جواب دینے کے لیے ہمارے پاس مفت مترجم کی خدمات دستیاب ہیں۔ مترجم حاصل کرنے کے لیے، ہمیں صرف 1-877-317-2410 (TTY: 711) پر کال کریں، اردو بولنے والا کوئی شخص آپ کی مدد کر سکتا ہے۔ یہ ایک مفت سروس ہے۔