

# Summary of Benefits

## Plan Year 2022

Prevea360 Medicare Advantage Plans from Dean Health Plan



## **January 1, 2022 – December 31, 2022**

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](http://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](http://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](http://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, Chippewa, Door, Eau Claire, 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](http://prevea360.com/doctors)
- Pharmacy directory website: [prevea360.com/medicaremembers](http://prevea360.com/medicaremembers)

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

	Prevea360 Essential (HMO-POS)	Prevea360 Harmony (HMO-POS)
<p><b>Monthly Premium</b></p> <p>You must continue to pay your Medicare Part B premium</p>	\$0	\$0
<p><b>Part B Buy Back</b></p> <p>Dean Health Plan provides a credit that will automatically be applied towards your Medicare Part B premium</p>	\$25	\$50
<p><b>Medical Deductible</b></p>	Not Applicable	Not Applicable
<p><b>Maximum Out-of-Pocket Responsibility</b></p> <p>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.</p> <p>(Does not include prescription drugs)</p>	<p>\$4,500 for in-network services</p> <p>\$6,000 for in-network and out-of-network services combined</p>	<p>\$4,500 for in-network services</p> <p>\$6,000 for in-network and out-of-network services combined</p>

# Covered Medical and Hospital Benefits

\*Benefit may require prior authorization

	Prevea360 Essential (HMO-POS)		Prevea360 Harmony (HMO-POS)	
	In Network	Out-of-Network	In Network	Out-of-Network
<b>Inpatient Hospital Coverage*</b> For Medicare-covered stays	\$325 copay each day for days 1 - 5  \$0 each day for days 6 to discharge	\$500 copay each day for days 1 - 7  \$0 each day for days 8 to discharge	\$325 copay each day for days 1 - 5  \$0 each day for days 6 to discharge	\$500 copay each day for days 1 - 7  \$0 each day for days 8 to discharge
<b>Outpatient Hospital Coverage*</b>  Outpatient Hospital: Ambulatory Surgery Center:  Procedure performed during office visit:	\$275 copay  \$175 copay  \$0 - \$35 copay	20% coinsurance  20% coinsurance  \$50 copay	\$275 copay  \$175 copay  \$0 - \$35 copay	20% coinsurance  20% coinsurance  \$50 copay
<b>Doctor Visits</b>  Primary Care Providers:  Specialists:  Palliative Care:	\$0 copay  \$35 copay  \$0 copay	\$50 copay  \$50 copay  \$0 copay	\$0 copay  \$35 copay  \$0 copay	\$50 copay  \$50 copay  \$0 copay
<b>Preventive Care</b>	\$0 copay	\$30 copay	\$0 copay	\$30 copay
<b>Emergency Care</b> In the U.S.  (Waived if admitted)	\$90 copay	\$90 copay	\$90 copay	\$90 copay
<b>Urgently Needed Services</b> 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

	<b>Prevea360 Essential (HMO-POS)</b>		<b>Prevea360 Harmony (HMO-POS)</b>	
	<b>In Network</b>	<b>Out-of-Network</b>	<b>In Network</b>	<b>Out-of-Network</b>
<b>Diagnostic Services / Labs / Imaging*</b>				
Outpatient X-ray:	\$30 copay	20% coinsurance	\$35 copay	20% coinsurance
Laboratory Tests:	\$0 copay	20% coinsurance	\$0 copay	20% coinsurance
Radiation Therapy:	\$35 copay	20% coinsurance	\$35 copay	20% coinsurance
Diagnostic Procedures/Tests:	\$0 copay	20% coinsurance	\$0 copay	20% coinsurance
Diagnostic Mammograms:	\$0 copay	20% coinsurance	\$0 copay	20% coinsurance
Diagnostic Radiology:	\$100 copay	20% coinsurance	\$100 copay	20% coinsurance
<b>Hearing Services</b>				
Medicare-covered-exam to diagnose and treat hearing and balance issues:	\$0 copay	\$60 copay	\$0 copay	\$60 copay
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
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
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  You are responsible for costs beyond the plan limit	Not Covered

	Prevea360 Essential (HMO-POS)		Prevea360 Harmony (HMO-POS)	
	In Network	Out-of-Network	In Network	Out-of-Network
<p><b>Preventive Dental</b></p> <p>Preventive Exams: \$0 copay per visit for 2 visits every calendar year</p> <p>Cleanings: \$0 copay per visit for 2 visits every calendar year</p> <p>X-Ray: \$0 copay per visit for 1 visit every calendar year</p>		Not Covered	\$0 copay per visit for 2 visits every calendar year	Not Covered
<p><b>Comprehensive Dental</b></p> <p>Diagnostic services: \$0 copay</p> <p>Gum disease maintenance and bridge/implants/dentures repairs: \$45 copay</p> <p>Fillings, gum disease treatment, and extractions: \$95 copay</p> <p>Root canals, bridges, implants, dentures, and crowns: \$595 copay</p>		Not Covered	\$0 copay	Not Covered
<p><b>Dental Maximum</b></p> <p>Annual limit that Dean Health Plan will pay for preventive and comprehensive dental services</p> <p>You are responsible for costs beyond the plan limit</p>	\$1,500 every calendar year for dental services	Not Covered	\$1,500 every calendar year for dental services	Not Covered

	<b>Prevea360 Essential (HMO-POS)</b>		<b>Prevea360 Harmony (HMO-POS)</b>	
	In Network	Out-of-Network	In Network	Out-of-Network
<b>Vision Services</b>				
Medicare-covered exam to treat to diagnose and treat diseases and conditions of the eye:	\$0 copay	\$30 copay	\$0 copay	\$30 copay
Medicare-covered eyewear after cataract surgery:	\$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
Eyewear: (eyeglasses, frames, lenses or contact lenses)	Our plan pays up to a total of \$200 every calendar year  You are responsible for costs beyond the plan limit	Not Covered	Our plan pays up to a total of \$200 every calendar year  You are responsible for costs beyond the plan limit	Not Covered
<b>Mental Health Services: Hospital Care*</b> For Medicare-covered stays	\$325 copay each day for days 1 - 5  \$0 each day for days 6 - 90	\$500 copay each day for days 1 - 7  \$0 each day for days 8 - 90	\$325 copay each day for days 1 - 5  \$0 each day for days 6 - 90	\$500 copay each day for days 1 - 7  \$0 each day for days 8 - 90
<b>Mental Health Services: Outpatient Care</b>				
Outpatient Individual Therapy:	\$0 copay	\$30 copay	\$0 copay	\$30 copay
Outpatient Group Therapy:	\$0 copay	\$30 copay	\$0 copay	\$30 copay

	Prevea360 Essential (HMO-POS)		Prevea360 Harmony (HMO-POS)	
	In Network	Out-of-Network	In Network	Out-of-Network
<p><b>Skilled Nursing Facility*</b></p> <p>Our plan covers up to 100 day per benefit period in a SNF:</p> <p>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</p>	<p>\$0 each day for days 1 - 20</p> <p>\$184 each day for days 21 - 100</p>	<p>\$150 each day for days 1 - 100</p>	<p>\$0 each day for days 1 - 20</p> <p>\$184 each day for days 21 - 100</p>	<p>\$150 each day for days 1 - 100</p>
<p><b>Therapy*</b></p> <p>Outpatient physical therapy, speech language pathology, and occupational therapy:</p>	<p>\$35 copay per visit</p>	<p>\$60 copay per visit</p>	<p>\$35 copay per visit</p>	<p>\$60 copay per visit</p>
<p><b>Ambulance</b></p> <p>For each one-way Medicare-covered trip</p>	<p>\$275 copay</p>	<p>\$275 copay</p>	<p>\$275 copay</p>	<p>\$275 copay</p>
<p><b>Transportation</b></p> <p>For rides to medical appointments</p>	<p>\$0 copay per ride for 24 one-way rides every calendar year</p>	<p>Not Covered</p>	<p>\$0 copay per ride for 24 one-way rides every calendar year</p>	<p>Not Covered</p>



	Prevea360 Essential (HMO-POS)		Prevea360 Harmony (HMO-POS)	
	In Network	Out-of-Network	In Network	Out-of-Network
<b>Medicare Part B Drugs*</b>				
Part B Drugs:	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Part B prescription drugs received in the pharmacy:	\$0 copay - \$47 copay	20% coinsurance	\$0 copay - \$47 copay	20% coinsurance

# Medicare Part D Prescription Drug Coverage

	<b>Prevea360 Essential (HMO-POS)</b>	<b>Prevea360 Harmony (HMO-POS)</b>
<b>Part D Deductible</b>	\$250 Applies to Tier 3, Tier 4 and Tier 5	Not Covered
<b>PREFERRED RETAIL 30 day supply</b>		
Tier 1 Preferred Generic	\$0 copay	Not Covered
Tier 2 Generic	\$5 copay	Not Covered
Tier 3 Preferred Brand	\$40 copay	Not Covered
Tier 4 Non-Preferred Drugs	\$90 copay	Not Covered
Tier 5 Specialty Drugs	28% coinsurance	Not Covered
Tier 6 Part D Vaccines	\$0 copay	Not Covered
<b>STANDARD RETAIL 30 day supply</b>		
Tier 1 Preferred Generic	\$7 copay	Not Covered
Tier 2 Generic	\$12 copay	Not Covered
Tier 3 Preferred Brand	\$47 copay	Not Covered
Tier 4 Non-Preferred Drugs	\$100 copay	Not Covered
Tier 5 Specialty Drugs	28% coinsurance	Not Covered
Tier 6 Part D Vaccines	\$0 copay	Not Covered
<b>LONG TERM CARE 31 day supply</b>	See Standard Retail Pharmacy (30 Day)	Not Covered
<b>OUT-OF-NETWORK 29 day supply</b>	See Standard Retail Pharmacy (30 Day)	Not Covered

	<b>Prevea360 Essential (HMO-POS)</b>	<b>Prevea360 Harmony (HMO-POS)</b>
<b>PREFERRED RETAIL 90 day supply</b>		
Tier 1 Preferred Generic	\$0 copay	Not Covered
Tier 2 Generic	\$10 copay	Not Covered
Tier 3 Preferred Brand	\$100 copay	Not Covered
Tier 4 Non-Preferred Drugs	\$270 copay	Not Covered
Tier 5 Specialty Drugs	Not Applicable	Not Covered
Tier 6 Part D Vaccines)	Not Applicable	Not Covered
<b>STANDARD RETAIL 90 day supply</b>		
Tier 1 Preferred Generic	\$7 copay	Not Covered
Tier 2 Generic	\$24 copay	Not Covered
Tier 3 Preferred Brand	\$117.50 copay	Not Covered
Tier 4 Non-Preferred Drugs	\$300 copay	Not Covered
Tier 5 Specialty Drugs	Not Applicable	Not Covered
Tier 6 Part D Vaccines	Not Applicable	Not Covered
<b>Part D Coverage Stages</b>		
<b>Stage 1 Deductible</b>	You pay in full until you reach your deductible. (Applies to Tier 3, Tier 4 and Tier 5 only)	Not Covered
<b>Stage 2 Initial Coverage</b>	You pay copays or coinsurance, and we pay the remainder until together our spending reaches <b>\$4,430</b>	Not Covered
<b>Stage 3 Coverage Gap</b>	Above <b>\$4,430</b> , you pay 25% of the cost for generics and brand drugs until your expenses reach <b>\$7,050</b>	Not Covered
<b>Stage 4 Catastrophic</b>	Above <b>\$7,050</b> you pay the greater of <b>5%</b> or <b>\$3.95</b> for generics and <b>\$9.85</b> for all other drugs and we pay the remainder	Not Covered

## Additional Benefits

	Prevea360 Essential (HMO-POS)		Prevea360 Harmony (HMO-POS)	
	In Network	Out-of- Network	In Network	Out-of- Network
<p><b>In-Home Support</b> 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.</p>	\$0 copay per visit for 10 visits every month	Not Covered	\$0 copay per visit for 10 visits every month	Not Covered
<p><b>Over-the-Counter Allowance for Health and Wellness Products</b> Shop online, in-store, or by catalog.</p>	\$50 quarterly allowance	Not Covered	\$50 quarterly allowance	Not Covered
<p><b>Post Discharge Meals</b> Mom's Meals delivered to your door after you are discharged from the hospital or a skilled nursing facility.</p>	14 meals after an inpatient stay at no cost to you	Not Covered	14 meals after an inpatient stay at no cost to you	Not Covered
<p><b>Fitness Benefit</b> Silver&amp;Fit®</p>	\$0 copay	Not Covered	\$0 copay	Not Covered
<p><b>Routine Chiropractic</b></p>	\$15 copay for an additional 24 routine chiropractic visits every calendar year	\$50 copay for an additional combined 24 routine chiropractic visits every calendar year	\$10 copay for an additional 24 routine chiropractic visits every calendar year	\$50 copay for an additional combined 24 routine chiropractic visits every calendar year

	Prevea360 Essential (HMO-POS)		Prevea360 Harmony (HMO-POS)	
	In Network	Out-of- Network	In Network	Out-of- Network
<b>Living Healthy</b> Rewards for completing healthy activities like receiving a flu shot, going to the dentist and getting an annual physical	\$150 every calendar year	Not Covered	\$150 every calendar year	Not Covered
<b>Worldwide Emergency and Urgent Care</b> Outside the US	\$90 copay No Limit	\$90 copay No Limit	\$90 copay No Limit	\$90 copay No Limit
<b>Nurse Advice Line</b> Nurses are available 24 hours a day, 365 days a year.	\$0 copay	Not Covered	\$0 copay	Not Covered
<b>Virtual Visits</b> See conditions treated and complete an online health interview at <a href="http://prevea360.com/virtualvisit">prevea360.com/virtualvisit</a> .	\$0 copay	Not Covered	\$0 copay	Not Covered