



Q. If I am an active employee, how may I expect my claims to process?

A. It is important to understand that many factors influence treatment costs, such as the intensity of the condition and individual physician rates. We encourage you to verify that the price estimate you request accurately reflects the services you will receive.

Description	Covered Service	Copay	Co-insurance
Office Visit	Yes		10%
Screening Colonoscopy	Yes		0%
Blood Test	Yes		10%
Outpatient/Inpatient Hospital Stay	Yes		10%
ER Visit – Facility fee	Yes	\$75	0%
ER Visit – Physician Service	Yes		10%

Please note copay and co-insurance amounts apply, as outlined in your *It's Your Choice* Decision Guide.

Q. What if I am a retiree who is a Medicare Prime member?

A. If you are a Medicare Prime member, your benefits remain under the full-pay plan (just as in 2011). However, your non-Medicare covered dependents will have coverage under the new co-insurance plan.

Q. What is co-insurance?

A. Co-insurance is a percentage of the claim that an individual is required to pay for services. In 2012, your health plan has a 10 percent co-insurance for most covered services.

Q. What is an out-of-pocket maximum?

A. The out-of-pocket maximum is the limit you pay during a policy year before your health plan begins to pay 100 percent of the covered service. The out-of-pocket maximum will never include your monthly premium, non-covered services or certain copayments. You will need to refer to your 2012 *It's Your Choice* Decision Guide for details on what services apply and don't apply to the out-of-pocket maximum.

Q. What is my health plan's annual out-of-pocket maximum?

A. Your health plan has a \$500 single and a \$1,000 family out-of-pocket maximum; the single out-of-pocket maximum is met by one individual while the family out-of-pocket maximum can be met by two or more family members. Your 10 percent co-insurance portion (the amount you've paid) is what accumulates towards the annual out-of-pocket maximum. For example, you'd need to incur \$5,000 of allowed charges in a given year of which you paid 10 percent to meet the \$500 out-of-pocket maximum on an individual level. And a family would need to collectively incur \$10,000 of allowable charges with no one individual contributing more than \$5,000 of incurred allowable charges.

Q. How can I determine how likely it is that I (or my family) will hit the out-of-pocket maximum in 2012?

A. The best way to approach this is to take a look at what services you and/or your family incurred in 2011 and determine if this was a typical year and likely to be similar to 2012. You can do this in two ways: 1) by going into *DeanConnect* (register by going to deancare.com and clicking on the *DeanConnect* icon) or 2) by contacting a Customer Care Specialist via the online request form at deancare.com/contact-us and request a claims itemization for 2011. Please note that you will have access to claims information for yourself and for any child dependents, but you will not be able to access claims information for your spouse or adult children without their prior authorization due to privacy laws. When looking at claims itemization details, you should focus on the allowed amount and paid amount. In situations where the allowed amount and paid amount were equal, this means that the insurance covered 100 percent of the service. In 2012, your insurance would now cover that service at 90 percent and you would be responsible for 10 percent.

Q. If I have a planned medical service in 2012, how can I determine my out-of-pocket expense?

A. Dean Health Plan is dedicated to helping you access information about the cost of your healthcare. We believe providing you with the financial information required will assist you in making informed healthcare choices every day. To get an estimate, call the Customer Care Center with the following information: name of your provider, current procedural Terminology (CPT) code, date or approximate date of service or procedure and the amount your provider is billing. The information you provide will help our Customer Care Specialists give you an approximate cost and your financial responsibility. Once an estimate has been formed, you will be sent a written estimate of costs within five business days of the request.

Q. How can I benefit from using *DeanConnect*?

A. If you have not used *DeanConnect* in the past, we encourage you to start using it in 2012. *DeanConnect* will allow you to check on claims after you've had a service and to view details on what your insurance coverage has paid at any given time and what you are responsible to pay. Please note that *DeanConnect* is tracking your insurance coverage, but does not track any payments you have made to the clinics or providers as this is handled separately through the clinic or provider billing systems.

Q. Will I be required to make the co-insurance payments at the time of service or will I be billed later?

A. You will not be required to make the co-insurance payment at the time of the service. The clinic's billing office will submit the claim to Dean Health Plan; we will process it using the contracted amount, and then apply co-insurance, copayments or other cost sharing to the service, and then we'll make a payment to the provider and send you a document explaining what we have paid and what you owe. At that point, the clinic will be ready to reach out to you via a billing invoice for the amount remaining that you owe to them. You will always pay the clinic (or provider office or hospital) directly for the co-insurance; you will not pay the health plan.

Q. What is an Explanation of Benefits and what do I do if I get one from Dean?

A. An Explanation of Benefits (EOB) is the summary document that you receive from us when we make a payment on your behalf to a provider and there is a remaining amount that you still owe. You should keep the EOB (or summary

document) for a service, and then compare it to the bill you receive later from the provider. Occasionally, there are timing issues or billing errors and it's important for you to pay attention to what has been paid on your behalf by insurance and what you actually owe or expect to owe. Please carefully watch for "date of service" and provider name as this will help you pinpoint which service the document refers to. The last page in the document is a sample EOB that will help you better understand the document.

Q. What may I expect to pay out-of-pocket with an emergency room visit?

A. If you do go to the emergency room you may be required to pay a copay plus co-insurance. These expenses can vary greatly and depend on where you go and what treatment you require. Your primary care physician team is a great source to help you choose what is right for your medical situation—you can describe your symptoms, ask questions and get information that can help you decide whether you should go to the emergency room, urgent care or if your problem can be handled with self-care or a visit to your PCP's office. Dean On Call is another great resource to determine the type of care you need. Call a registered nurse at (800) 57-NURSE 24 hours a day, seven days a week. Making informed choices when you are experiencing a medical issue will result in better care. Of course, sometimes a trip to the emergency room is necessary, so if you have a medical emergency please seek immediate care.

Q. What services are considered preventive care? Is this different than routine care?

A. Preventive care refers to services such as physical exams, mammograms, well-baby care and immunizations (excluding immunizations required for travel). You are not required to pay co-insurance for a preventive care appointment or service. Preventive care and routine care are often used interchangeably; however routine care may imply care for a chronic condition such as diabetes and congestive heart failure; as such, co-insurance would apply. For example, if you routinely see your physician for diagnostic procedures due to a chronic condition, such as diabetes, these office visits and services would be subject to co-insurance.

Q. How long may my eligible dependent remain insured under my policy?

A. State law will align with federal law to allow for coverage of an adult child until the end of the month in which the adult child turns 26 years of age or otherwise loses eligibility, whichever occurs first. The previous age limit was 27.

Q. If I suffer from an accidental injury to my mouth and need dental implants, what kind of a provider should I see?

A. You should see a plan oral surgeon. We encourage you to first have a consultation and ask the provider to submit a pre-treatment estimate to Dean Health Plan. The pre-treatment estimate will be reviewed and notification will be sent to both you and your provider about what services are covered and/or not covered prior to your having the services done. Don't forget that your 10 percent co-insurance will apply and that co-insurance does apply to your out-of-pocket maximum. There is also a maximum benefit limit of \$1,000 per tooth.

**If you have any other questions about your health care coverage, please call the
Dean Health Plan Customer Care Center at (800) 279-1301.**

Sample Explanation of Benefits and Term Glossary

SAM S SXXXXX 9999 NO WHERE DR CITY, WI 53XXX				COVERAGE CONTRACT: 000XXXXXX GROUP NUMBER: 8XXXX CONTRACT YEAR: 2012							
PATIENT NAME: SXXXX, SAM				MEMBER NUMBER: 000XXXXXX							
Services	Description of Services	Service Date	Provider Charge	Amount Allowed	Amount Not Covered	Deductible	Copayment	Coinsurance	Remarks <small>See Explanation Below</small>	Amount Paid*	
1	PROVIDER NUMBER/NAME Jim Jones		2	3	4	ACCOUNT NUMBER: XXXXXXXX		6	CLAIM NUMBER: 20120109ZZ00001		
01	999XXX	Service - non preventative	01/09/XX	170.00	150.00	0.00	0.00	0.00	7	15.00	
TOTALS:				5		9		PATIENT RESPONSIBILITY 15.00 TOTAL PATIENT RESPONSIBILITY 15.00		8	
REMARKS * THIS AMOUNT HAS BEEN PAID TO THE PROVIDER UNLESS A CHECK HAS BEEN SENT TO YOU.											
INDIVIDUAL FAMILY		DEDUCTIBLE YEAR TO DATE		REMAINDER		OUT OF POCKET YEAR TO DATE		REMAINDER		10 27.50 57.23	11 472.50 942.77

1. Name of the provider you were seen by.
2. The amount the provider charged for services provided.
3. The contracted rate by Dean Health Plan. If the allowed amount is less than the provider charge, the provider is responsible for the remaining amount.
4. The cost you are responsible for if you receive a non-covered service.
5. You should never see a balance due under deductible as your plan does not include deductibles.
6. You will only see a balance here if you incur a charge for visiting the emergency room.
7. This amount will always be 10 percent of the Allowed Amount. This reflects the 10 percent co-insurance that you are responsible to pay.
8. This is the amount paid for your service by Dean Health Plan.
9. If the Explanation of Benefits includes more than one claim, each service will be itemized here. Total Patient Responsibility is the total amount you owe to the provider.
10. This is a year-to-date total of all claims paid towards your maximum out-of-pocket. The claim on this Explanation of Benefit will be included in this list.
11. This amount is the remaining balance of your maximum out-of-pocket. Once you reach the \$500 individual or \$1,000 maximum out-of-pocket you will only be responsible for an amount due if you incur an emergency room copay or non-covered service.