Dean Health Plan, Inc.
SCHEDULE OF BENEFITS
PPO Group Plan

Plan: VAPW
Contract #: 17309

Please see your Health Insurance Benefit Summary (HIBS) document for your contract effective date.

This Schedule of Benefits and the Member Certificate and any riders **together with the Employer Group Master Policy, applications, amendments and any other coverage documents** constitute the contract of insurance. The Member Certificate describes the essential features of your coverage and what rules you must follow to obtain covered services. If necessary, the Schedule of Benefits and the Member Certificate and any riders are replaced on your group's renewal and supersede those which were previously issued. **Keep this Schedule of Benefits with your Member Certificate and any riders and refer to these documents when determining covered services.** Benefits will be administered in accordance with the coverage which was in effect at the time services were rendered and as expressed within this Schedule of Benefits and the Member Certificate. Services must always be Medically Necessary as determined by Dean Health Plan.

The Benefits of the Member Certificate are subject to the following:

Policy Deductible: **In-Network:** $100.00 single, $200.00 family per **Contract Period**
Out-of-Network: $100.00 single, $200.00 family per **Contract Period**

Policy Coinsurance: **In-Network:** 0% coinsurance after deductible
Out-of-Network: 20% coinsurance after deductible

Maximum Out-Of-Pocket Expense: **In-Network:** $100.00 single, $200.00 family per **Contract Period**
Out-of-Network: $600.00 single, $1,200.00 family per **Contract Period**

Copay amounts do not apply to the maximum out-of-pocket expense.

Policy Lifetime Maximum: Unlimited

Pre-Existing Condition Exclusion: Not Applicable. (Never applicable to children under age 19, adopted children, or Annual Dual Choice. Pregnancy is not considered a pre-existing condition.)

Qualified Dependents: Qualified Dependents are covered to the end of the month in which age 27 is attained, unless otherwise specified in your Certificate. Please see the definition of Qualified Dependent for additional details.

Domestic Partner Coverage: Please refer to the Group Master Policy for specific eligibility criteria.

Please note: Some services/procedures require prior authorization, please see your Member Certificate for more details or call the Customer Care Center at (800)279-1301 or TTY (608) 827-4086.

The Member is responsible for all costs that exceed the benefit maximum indicated for that service.
IMPORTANT: *This Schedule of Benefits is only a summary of your coverage. A complete description of the benefits and applicable exclusions and limitations are included in your Certificate. Benefits on this Schedule are provided only when services are received according to the terms set forth in the Certificate. You may view your Certificate any time at deancare.com.*

Benefits	In-Network You Pay	Out-of-Network You Pay
A. General Medical		
Office Visit and Chiropractic Care	0% coinsurance after deductible	20% coinsurance after deductible
Preventive Services	$0 copay	20% coinsurance after deductible

Dean Health Plan, Inc.
SCHEDULE OF BENEFITS

Benefits	In-Network You Pay	Out-of-Network You Pay
Rider – Prescription Drugs	**Tier Option**	**Tier Option**
TIER 1 Outpatient Prescription Drugs	$5 copay	50% coinsurance
TIER 2 Outpatient Prescription Drugs	$10 copay	50% coinsurance
TIER 3 Outpatient Prescription Drugs	$25 copay	Not Covered
Mail Order	90-day supply (Tiers 1 and 2) for 2 copays	Not Covered
Tobacco Cessation	$5 copay	Not Covered
Outpatient Prescription Drugs – Infertility	50% coinsurance; not subject to out-of-pocket maximum	Not Covered
Erectile Dysfunction Drugs (VIAGRA®, LEVITRA®, Cialis®	12 pills per month	

B. Medical Supplies and Durable Medical Equipment, including Diabetic Supplies	0% coinsurance after deductible	20% coinsurance after deductible
Diabetic supplies and glucometers	No deductible/coinsurance/copay	

C. Diagnostic Services		
X-Rays and Labs, including readings	0% coinsurance after deductible	20% coinsurance after deductible
MRI/MRA	0% coinsurance after deductible	20% coinsurance after deductible
CAT Scans	0% coinsurance after deductible	20% coinsurance after deductible
Readings for: MRI/MRA and CAT Scans	0% coinsurance after deductible	20% coinsurance after deductible
PET Scans	0% coinsurance after deductible	20% coinsurance after deductible

D. Hearing & Vision Services		
Hearing Services	0% coinsurance after deductible	20% coinsurance after deductible
Hearing Aids – Adults ***Limited to one aid per ear every 36 months.*** ***$500 benefit maximum per 36-month period***	$0 copay	Not Covered
Hearing Aids – Children under 18 ***Limited to one aid per ear every 36 months.***	$0 copay	$0 copay
Cochlear Implants	0% coinsurance after deductible	20% coinsurance after deductible
Vision Care Exam	0% coinsurance after deductible	20% coinsurance after deductible
Vision Care Services	0% coinsurance after deductible	20% coinsurance after deductible

Dean Health Plan, Inc.
SCHEDULE OF BENEFITS

Benefits	In-Network You Pay	Out-of-Network You Pay
E. Hospital & Surgical Services		
Inpatient Hospital	0% coinsurance after deductible	20% coinsurance after deductible
Outpatient Hospital	0% coinsurance after deductible	20% coinsurance after deductible
Ambulatory Surgical Center	0% coinsurance after deductible	20% coinsurance after deductible
Licensed Skilled Nursing (Excludes Custodial Care and Other Non-Covered Expenses) ***Limited to 120 days per Contract Period***	0% coinsurance after deductible	20% coinsurance after deductible
Home Health Care ***Limited to 40 visits per Contract Period***	0% coinsurance after deductible	20% coinsurance after deductible
Hospice Care	0% coinsurance after deductible	20% coinsurance after deductible
Detoxification Services	0% coinsurance after deductible	20% coinsurance after deductible
Inpatient Rehabilitative Confinement ***Combined benefit limited to 90 days per Member per Contract Period***	0% coinsurance after deductible	20% coinsurance after deductible

F. Emergency Services		
Ambulance Services	$0 copay	$0 copay
Urgent Care Services ***You may be responsible for other charges in addition to the visit copay/deductible/coinsurance****	0% coinsurance after deductible	20% coinsurance after deductible
Emergency Room Services ***You may be responsible for other charges in addition to the facility copay/deductible/coinsurance** Copay is waived if admitted for Observation or Inpatient.***	0% coinsurance after deductible	0% coinsurance after in-network deductible
* Other charges will result from services rendered by other providers who treated you during your urgent care or emergency room visit. These charges include, but are not limited to, physician visits, diagnostic services, procedures/treatments and various medical supplies. The amount charged for these services received from a Non-Plan Provider may exceed the Maximum Allowable Fee in which case you will be responsible for paying the difference between the amount charged and the Maximum Allowable Fee.		

G. Therapies and Rehab Services		
Autism – Intensive ***Unlimited benefit maximum per Contract Period***	0% coinsurance after deductible	20% coinsurance after deductible
Autism – Non-Intensive ***Unlimited benefit maximum per Contract Period***	0% coinsurance after deductible	20% coinsurance after deductible

Dean Health Plan, Inc.
SCHEDULE OF BENEFITS

Benefits	In-Network You Pay	Out-of-Network You Pay
G. Therapies and Rehab Services (continued)		
Physical, Occupational and Speech Therapy ***Unlimited visit maximum per Contract Period (All therapies combined)***	$0 copay per visit per therapy	20% coinsurance after deductible
Limited Benefit for Developmental Delay ***1 evaluation and 3 visits per Contract Period***	$0 copay per visit per therapy	20% coinsurance after deductible
Cardiac Rehab ***18 visits per Contract Period***	0% coinsurance after deductible	20% coinsurance after deductible
Pulmonary Rehab	0% coinsurance after deductible	20% coinsurance after deductible
Radiation Therapy	0% coinsurance after deductible	20% coinsurance after deductible
H. Accidental Injury to Teeth, Oral Surgical and Temporomandibular Disorders (TMD) Services ***$1,250 Non-Surgical TMD Benefit Maximum per Contract Period***		
Initial Repair of Accidental Injury to Natural Teeth	0% coinsurance after deductible	20% coinsurance after deductible
Oral Surgery Consult	0% coinsurance after deductible	20% coinsurance after deductible
Oral Surgical Services	0% coinsurance after deductible	20% coinsurance after deductible
TMD Surgical Services ***$1,250 TMD benefit maximum does not apply to TMD surgical services***	0% coinsurance after deductible	20% coinsurance after deductible
TMD Office Consult	0% coinsurance after deductible	20% coinsurance after deductible
TMD DME	0% coinsurance after deductible	20% coinsurance after deductible
I. Mental Health (MH) and Alcohol and Other Drug Abuse (AODA)		
Outpatient Mental Health and AODA	$0 copay	$0 copay
Day Treatment	$0 copay	$0 copay
Inpatient Care – MH and AODA	$0 copay	$0 copay
J. Transplant and Kidney Disease		
Kidney Disease Treatment ***Unlimited combined benefit maximum per Contract Period***	0% coinsurance after deductible	20% coinsurance after deductible
Transplant Services	0% coinsurance after deductible	20% coinsurance after deductible

Dean Health Plan, Inc.
SCHEDULE OF BENEFITS

Benefits	In-Network You Pay	Out-of-Network You Pay
K. Other Services		
Anesthesia Services	0% coinsurance after deductible	20% coinsurance after deductible
Allergy Injections	0% coinsurance after deductible	20% coinsurance after deductible
Infertility Services ***$2,000 combined lifetime benefit maximum***	50% of $4,000; not subject to out-of-pocket maximum	Not Covered
Maternity Services – Physician Services	0% coinsurance after deductible	20% coinsurance after deductible
Surgical Services	0% coinsurance after deductible	20% coinsurance after deductible

Prescription Drug Rider
For Group Member Certificate

Dean Health Plan, Inc., 1277 Deming Way, Madison, WI 53717
(608) 828-1301 · 1-800-279-1301 · TTY (608) 827-4086

This Prescription Drug Rider is part of your Group Member Certificate issued by Dean Health Plan, Inc. **Please keep this Rider with your Certificate and other important insurance papers.**

This Rider is part of the entire contract as defined by the Policy. It shall continue in force under the same provisions that govern the entire contract. This Rider supersedes any conflicting terms within your Certificate. All other terms, provisions, and conditions of the entire contract remain unchanged except as stated above.

In witness whereof, Dean Health Plan, Inc. has executed this Prescription Drug Rider.

Robert L. Palmer
Chief Executive Officer

Prescription Drug Coverage

IMPORTANT

HERE ARE SOME IMPORTANT THINGS TO KEEP IN MIND ABOUT THESE BENEFITS:

- We cover prescribed drugs and medications according to a drug formulary organized by tiers. A drug formulary is a list of prescribed drugs and medications approved for use and covered under this plan. To find out if a drug is listed or under what tier a drug is placed on the formulary, please visit our website at www.deancare.com under "Dean Health Plan/Members/Pharmacy Information" or contact our Customer Service Department.
- Certain prescription drugs included in the formulary require prior authorization. Please refer to the formulary on www.deancare.com under "Dean Health Plan/Members/Pharmacy Information" or contact our Customer Service Department. **If prior authorization is not obtained when required, no benefits are available.** The drug prior authorization process may be initiated by your treating physician by filling out a Drug Prior Authorization Request form. This form is found on www.deancare.com. Upon receipt of the request form, a determination notification will be mailed to you and the prescribing physician. You may contact your physician for information on a particular drug, or contact our Customer Service Department.
- Updates to the drug formulary are provided in Notables, Dean's quarterly news magazine. Members may also obtain a listing by visiting www.deancare.com under "Dean Health Plan/Members/Pharmacy Information" or contact our Customer Service Department.
- FOR TIERS: If there is no Tier 1 equivalent available, you will still have to pay the Tier 2 cost sharing amount.
- Outpatient prescription drugs purchased in connection with emergency or urgent care services will be paid according to in-network pharmacy benefits.
- Any drug that is covered under this Rider is also covered for use in the treatment of cancer when administered in a clinical trial that meets the definition of "**CLINICAL CANCER TRIAL**" in the **Definitions** section of your Certificate.
- Existing and recent FDA approved drugs may be reviewed by our Pharmacy and Therapeutics Committee to determine coverage.
- Members requesting higher tier drugs when a generic equivalent is available and the physician did not specifically prescribe the requested drug are responsible for the higher tier cost sharing amount plus any difference in cost. This cost difference does not apply to any out-of-pocket maximum.
- Reimbursement: If you receive prescription drugs from a non-network pharmacy in an emergent or urgent situation, please submit your receipts along with a prescription manual claim reimbursement form found on our website at www.deancare.com under "Dean Health Plan/Members/Pharmacy Information".
- ***Please see your Schedule of Benefits for cost sharing amounts.***

Outpatient Prescription Drugs

Covered Services:

- Coverage includes drugs which by law require a written prescription and are prescribed for treatment of a diagnosed illness or injury. This includes investigational drugs for the treatment of HIV.
- Cost-sharing amounts are calculated for each 30-day supply or course of treatment. For each course of treatment or 30 day supply, the member is required to pay (1) one copay. If a prescription lasts greater than a 30-day supply, but less than a 60 day supply the member is required to pay (2) two copays, and if a prescription lasts greater than a 60 day supply but less than or equal to a 90 day supply the Member will be required to pay (3) three copays.
- Single packaged items, except for certain inhalants, are limited to two items or a one month supply , whichever is less, per copay up to a 30 day supply. A single-packaged item includes, but is not limited to: inhalers, blood glucose sticks, eye drops and ear drops. If a single packaged item will last 30 days or longer, the Member is limited to one single package per copay. If the single packaged item lasts less than 30 days, the Member is limited to two single packages per copay. Ointments, creams, gels, solutions and other topical medications are dispensed in the smallest tube or package size that will last 30 days.

- Certain oral inhalants are limited to one item for up to three copays, depending on the day's supply for which the product will last based on drug instructions.
- Drugs dispensed in connection with mandated Home Health Care as listed in the Certificate.
- Insulin, disposable supplies and any prescription medication for the treatment of diabetes. Disposable supplies include: blood or urine glucose strips, control solutions for blood glucose monitors, alcohol swabs, cotton swabs, finger stick devices, lancets and syringes. Single packaged items, such as blood glucose sticks are limited to two items per copay.
- Blood glucose monitors
- Infertility drugs are covered as a separate benefit. Please refer to your Schedule of Benefits for cost sharing amount.
- Erectile disfunction drugs
- Certain drugs have quantity limits. Please refer to the formulary for these limits.
- Please refer to your Schedule of Benefits for non-network pharmacy coverage, if applicable to your plan.

Unless otherwise specified, drugs will be dispensed in maximum quantities as follows:
TIER 1:

Retail Pharmacy – Brand and generic drugs as indicated on the formulary not to exceed a 30-day supply. If a retail provider fills prescriptions with more than a 30-day supply, cost sharing amounts will apply for each 30-day supply obtained.

Mail order – A 90-day supply of prescription medication for two copays. Mail order is available for maintenance medications including treatment for allergies, cholesterol, and blood pressure.

TIER 2:
Retail Pharmacy- Brand and generic drugs as indicated on the formulary not to exceed a 30-day supply. If a retail provider fills prescriptions with more than a 30-day supply, a copay will apply for each 30-day supply obtained.

Mail order – A 90-day supply of prescription medication for two copays. Mail order is available for maintenance medications including treatment for allergies, cholesterol, and blood pressure.
TIER 3:

Retail Pharmacy - Brand and generic drugs as indicated on the formulary not to exceed a 30-day supply. If a retail provider fills prescriptions with more than a 30-day supply, a copay will apply for each 30-day supply obtained.

Mail order – A 90-day supply of prescription medication for three copays. Mail order is available for maintenance medications including treatment for allergies, cholesterol, and blood pressure.

Non-Covered Services:

1. All charges or costs exceeding a benefit maximum.
2. Medication for the treatment of sexual dysfunction and sexual transformation
3. Charges for prescription drugs that require prior authorization and prior authorization is not obtained from our Medical Affairs Division.
4. Charges for medications used for cosmetic purposes, including but not limited to compounded estrogen, progesterone or testosterone products for oral or sublingual administration.
5. Anorexic agents and charges for medications prescribed for weight loss
6. Smoking cessation products.
7. Oral progesterone products, unless specifically included on the formulary.
8. All over the counter drug items, except nicotinic acid, Loratadine and Ceterizine, when your healthcare provider writes a prescription and it is filled at a pharmacy.
9. Dispensing charge for unit dose medications. A unit dose medication is an individually wrapped and labeled drug typically used in hospitals and nursing homes.
10. Lost, stolen or replacement prescription drugs.
11. Certain injections medically required to be administered in a provider's office. These injections are not considered a prescription drug benefit and are governed by the medical coverage provisions as listed in the Certificate.

12. A drug that must be infused or injected by a medical provider may be excluded from coverage under this Rider. Please check your Member Certificate for additional information.

Dean Health Plan, Inc.

Group Member Certificate

PPO Plan

Dean Health Plan, Inc.
1277 Deming Way, Madison, WI 53717
(800) 279-1301 or TTY (608) 827-4086

Mailing Address:
P.O. Box 56099, Madison, WI 53705

deancare.com

IMPORTANT INFORMATION

GROUP PPO MEMBER CERTIFICATE

The Member Certificate is a description of the health insurance benefits provided to Dean Health Plan, Inc. (Dean) Subscribers, and their Qualified Dependents, through the Group Policyholder. This Certificate summarizes the benefits provided under the Group Master Policy. Together, this Certificate, the Group Master Policy, the Schedule of Benefits, the Employer Group Application, any other applications, and any applicable riders, addendums, attachments and/or amendments make up the Policy.

IMPORTANT NOTICE CONCERNING STATEMENTS IN YOUR EMPLOYEE APPLICATION ENROLLMENT FORM

Please read the copy of your employee application provided to you by your employer/ Policyholder or Dean Health Plan, Inc. Omissions or misstatements in your employee application could cause an otherwise valid claim to be denied. Carefully check the employee application and notify us within 10 days if any information shown on the employee application is not correct and complete or if any requested medical history has not been included. This insurance coverage was issued on the basis that the answers to all questions and any other material information shown on the employee application are correct and complete. If you have any questions, please contact our Customer Care Center at the address and telephone numbers shown on the cover of this Certificate.

Every effort has been made to ensure that the information in this Certificate is accurate. Any benefit described is subject to the terms and conditions of the Group Master Policy.

The Group Master Policy is the group health insurance contract issued by Dean Health Plan, Inc. to the employer, association, union or other entity known as the Group Policyholder.

For detailed information about Dean Health Plan, Inc. or the Group Master Policy, please contact the Customer Care Center at the telephone numbers shown on the cover of this Certificate.

Under this Certificate, benefits received from an Out-of-Network Provider are limited to a Maximum Allowable Fee. The Maximum Allowable Fee may be less than the billed amount. If there is a difference between the Maximum Allowable Fee and the amount billed by an Out-of-Network Provider, the Member will be responsible for the difference. Please refer to the **Glossary of Terms** and **Benefits** Sections of this Certificate for further information on Maximum Allowable Fees. If you have any questions, please contact our Customer Care Center.

Benefits listed in this Certificate are only available as long as the Policy and your coverage are in force. The Certificate must be read together with the Schedule of Benefits to ensure accurate information regarding coverage, obligations, and responsibilities under the Policy. If you are unsure if a service is covered, please call the Customer Care Center prior to having the service performed. Our Customer Care Center will attempt to assist you. However, no information provided by the Customer Care Center shall change or alter terms of this Certificate and your Schedule of Benefits. You must consult your Certificate and Schedule of Benefits to verify your coverage, obligations, and responsibilities under the Policy.

TABLE OF CONTENTS

Benefits listed in this Certificate are only available as long as the Policy and your coverage are in force. The Certificate must be read together with the Schedule of Benefits to ensure accurate information regarding coverage, obligations, and responsibilities under the Policy. If you are unsure if a service is covered, please call the Customer Care Center prior to having the service performed. Our Customer Care Center will attempt to assist you. However, no information provided by the Customer Care Center shall change or alter terms of this Certificate and your Schedule of Benefits. You must consult your Certificate and Schedule of Benefits to verify your coverage, obligations, and responsibilities under the Policy.

I. PLAN PROVISIONS

*Certain terms used in this Section are defined throughout and/or in the **Glossary of Terms***

Access to Care

We have numerous preferred provider organization (PPO) Network Providers that can provide you with care. Your Plan also allows you the freedom to see Providers that are outside of the PPO network. You may see the physician of your choice for any covered service. This Plan does not require that you choose a primary care provider or that you obtain a referral to see a specialist. However, some services may require Prior Authorization. You also have access to our free 24-hour nurse line, Dean On Call, (800)-57-NURSE (1-800-576-8773) or (608) 250-1393. Dean On Call nurses do not provide medical care or treatment, and base their advice solely on the information provided at the time of the call. Due to licensing regulations, Dean On Call services are only available to residents of Wisconsin.

Why Use Network Providers?

Network Providers are Providers who are part of the PPO network and are listed in the most current edition of the PPO Provider Directory (which is also located on-line at deancare.com).

If you use a PPO Network Provider, covered charges will be paid based on the contract agreement between Dean Health Plan, Inc. **(**Dean**)** and the Provider (subject to any Deductible, Coinsurance, and Copay provisions). If there is a difference between the amount that we pay and the amount that the Provider bills, you are not responsible for the difference.

Out-of-Network Providers are Providers who are not listed in the most current edition of the PPO Provider Directory. Dean has no liability or responsibility for the quality of care provided by an Out-of-Network Provider.

NOTICE: LIMITED BENEFITS WILL BE PAID WHEN NONPARTICIPATING OR OUT-OF-NETWORK PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a nonparticipating Provider for a covered service, benefit payments to such nonparticipating Providers are not based upon the amount billed. The basis of your benefit payment will be determined according to your Policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the Policy. YOU RISK PAYING MORE THAN THE COINSURANCE, DEDUCTIBLE, AND COPAY AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Nonparticipating Providers may bill enrollees for any amount up to the billed charge after the plan has paid its portion of the bill. Participating Providers have agreed to accept discounted payment for covered services with no additional billing to the enrollee other than Copay, Coinsurance, and Deductible amounts. You may obtain further information about the participating status of Providers and information on out-of-pocket expenses by calling the Customer Care Center at (800) 279-1301 or 1-608-828-1301 or by visiting deancare.com.

Please note that physician/patient relationships will not be affected, or interfered with, by virtue of the fact that Network Providers have entered into participating agreements with Dean. Medical judgments and decisions of a medical nature remain with the Health Care Providers, and they are responsible for all such medical judgments and related treatments. Any plan of treatment recommended by your physician must meet this Policy's benefit provision requirements in order to be covered.

Benefits listed in this Certificate are only available as long as the Policy and your coverage are in force. The Certificate must be read together with the Schedule of Benefits to ensure accurate information regarding coverage, obligations, and responsibilities under the Policy. If you are unsure if a service is covered, please call the Customer Care Center prior to having the service performed. Our Customer Care Center will attempt to assist you. However, no information provided by the Customer Care Center shall change or alter terms of this Certificate and your Schedule of Benefits. You must consult your Certificate and Schedule of Benefits to verify your coverage, obligations, and responsibilities under the Policy.

Prior Authorization

Prior Authorization must be obtained for certain services indicated in this Certificate. Examples of procedures/services requiring Prior Authorization are listed below. This is NOT an all-inclusive list. Members should contact the Customer Care Center at (608) 828-1301 or (800)279-1301 to verify whether a procedure/service requires a Prior Authorization.

Examples of Procedures/Services Requiring Prior Authorization

- Radiology services (in-network and out-of-network)
    - CT scan
    - Nuclear Exercise Tolerance Test (ETT)
    - MRI/MRA
    - PET scan
- Cardiac rehabilitation - Phase II greater than 18 visits
- Pulmonary rehabilitation greater than 16 visits
- Non-emergent ambulance transport and elective air ambulance transport
- Home health care
- Durable medical equipment (DME) greater than $250
- Therapies (physical therapy, occupational therapy, speech therapy)
- Potentially cosmetic procedures (e.g., varicose vein treatments, breast reduction/augmentation, blepharoplasties)
- New technologies not commonly accepted as standard of care
- Hospice
- Transplants (except cornea)
- Elective inpatient surgical procedures
- All hospital admissions, includes observation and inpatient stays
- Select diagnostic testing (e.g. capsule endoscopy)
- Skilled nursing facility/swing beds (SNF)
- Behavioral/mental health services (out-of-network only)
- Surgical procedures related to obesity
- Bariatric surgery
- Home infusion
- Genetic testing
- Follow-up care to urgent/emergent services
    - In some situations, Members might require follow-up care after the initial urgent/emergent care visit outside of the service area. In these cases, follow-up care requires written, approved Prior Authorization by Dean's Medical Affairs Division prior to services being rendered by an Out-of-Network Provider, including an out-of-network facility.

Benefits listed in this Certificate are only available as long as the Policy and your coverage are in force. The Certificate must be read together with the Schedule of Benefits to ensure accurate information regarding coverage, obligations, and responsibilities under the Policy. If you are unsure if a service is covered, please call the Customer Care Center prior to having the service performed. Our Customer Care Center will attempt to assist you. However, no information provided by the Customer Care Center shall change or alter terms of this Certificate and your Schedule of Benefits. You must consult your Certificate and Schedule of Benefits to verify your coverage, obligations, and responsibilities under the Policy.

The process for obtaining Prior Authorization for Services is as follows:

If your Provider recommends that you have a service/procedure that requires Prior Authorization, the Provider ordering or providing the service/procedure should submit a Prior Authorization request form to Dean's Medical Affairs Division. It is the Member's responsibility to be sure that Prior Authorization is obtained. The Prior Authorization request must be received by Dean at least 15 business days prior to the anticipated date of your service/procedure. Approval of an elective inpatient admission to a facility is required prior to the elective services being received.

Please note that a verbal request for Prior Authorization does not guarantee approval. Dean's Medical Affairs Division will notify you in writing of the decision regarding a determination for elective outpatient services.

If your Provider determines that additional care beyond the services specified or the length of time originally authorized is medically indicated, Our Medical Affairs Division must be contacted to request an extension of the original authorization. You and your Provider will be notified whether the request for an extension is approved or denied.

Prior-authorization must be obtained regardless of whether Dean Health Plan, Inc. is your primary or secondary health insurance carrier. Prior Authorization does not guarantee coverage and/or payment if a benefit maximum has been reached or coverage has been terminated.

Urgent/Emergent Care: In some situations Members may need medical attention before the written Prior Authorization process can take place. Examples of urgent/emergent care services include, but are not limited to: broken bones, sprains, minor cuts and burns, drug reactions, and non-severe bleeding. When circumstances such as these occur, you must call the Customer Care Center, by the next business day, at (608) 828-1301 or (800)279-1301.

Concurrent Review: Facility confinements and some specified outpatient services for which initial authorizations have been obtained are reviewed concurrently by our Medical Affairs Division to determine continued medical necessity. If your Provider determines that additional care beyond the length of time originally authorized is medically indicated, our Medical Affairs Division must be contacted by the facility to request an extension. The facility will be notified as to whether the request for an extension has been approved or denied. Failure of a facility or Provider to provide to Dean the information required to perform a concurrent inpatient review will result in a denial of the services. Any amount(s) denied for this reason will not apply toward satisfaction of the maximum out-of-pocket expense.

Failure to Obtain Authorization: If you fail to obtain authorization for any service requiring an authorization, payment will be limited to 50% of covered services up to a $500 maximum per incident. Benefit reduction amount(s) will not apply toward satisfaction of the maximum out-of-pocket expense.

It is the responsibility of the Member to ensure that authorization has been obtained for all facility confinements and/or surgery.

End of Section I.

Benefits listed in this Certificate are only available as long as the Policy and your coverage are in force. The Certificate must be read together with the Schedule of Benefits to ensure accurate information regarding coverage, obligations, and responsibilities under the Policy. If you are unsure if a service is covered, please call the Customer Care Center prior to having the service performed. Our Customer Care Center will attempt to assist you. However, no information provided by the Customer Care Center shall change or alter terms of this Certificate and your Schedule of Benefits. You must consult your Certificate and Schedule of Benefits to verify your coverage, obligations, and responsibilities under the Policy.

II. GLOSSARY OF TERMS

The terms below have special meanings in this Certificate

Active at Work/Active Status:

Means performing your job on a regular, full-time basis, as defined in the Employer Group Application and referenced in the Employer Group Master Policy. Each day of a regular paid vacation and any regular nonworking holiday shall be deemed active status if you were in an active status on your last regular working day. You are still considered active if you are absent from work due to disability, illness, or leave of absence as determined by your employer. Unless coverage is continued as allowed under the law, a Subscriber who leaves employment due to active military service of longer than 30 days will cease to be considered active under the Policy.

Adverse Determination:

A determination by, or on behalf of, Dean Health Plan, Inc. to which all of the following apply:

1. An admission to a health care facility, the availability of care, the continued stay, or other treatment that is a covered benefit has been reviewed.
2. Based on the information provided, the treatment under "1." *(above)* does not meet our requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.
3. Based on the information provided, we reduced, denied or terminated the treatment under "1." or payment for the treatment under "1."
4. The amount of the reduction, or the cost or expected cost, of the denied or terminated treatment or payment exceeds, or will exceed during the course of the treatment, $292.

Certificate:

This insurance document, which is issued to Subscribers of the employer group's Policy and shows your coverage under the Policy.

Clinical Cancer Trial:

A Clinical Cancer Trial must satisfy the following criteria: (1) the purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes; (2) the treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes; (3) the trial has therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology; and (4) the trial does one of the following: (a) tests how to administer a health care service, item, or drug for the treatment of cancer; (b) tests responses to a health care service, item or drug for the treatment of cancer; (c) compares the effectiveness of health care services, items, or drugs for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer; or (d) studies new uses of health care services, items, or drugs for the treatment of cancer.

The clinical trial must be approved by one of the following: a National Institute of Health, or one of its cooperative groups or centers, under the federal Department of Health and Human Services; the federal Food and Drug Administration; the federal Department of Defense; or the federal Department of Veterans Affairs.

Benefits listed in this Certificate are only available as long as the Policy and your coverage are in force. The Certificate must be read together with the Schedule of Benefits to ensure accurate information regarding coverage, obligations, and responsibilities under the Policy. If you are unsure if a service is covered, please call the Customer Care Center prior to having the service performed. Our Customer Care Center will attempt to assist you. However, no information provided by the Customer Care Center shall change or alter terms of this Certificate and your Schedule of Benefits. You must consult your Certificate and Schedule of Benefits to verify your coverage, obligations, and responsibilities under the Policy.

Contract Period:

The period beginning with the Effective Date or the renewal date of the Policy as indicated in the Group Master Policy. All eligible expenses and all payment amounts listed in this Certificate are per Contract Period, unless otherwise stated in the specific benefit subsection within this Certificate.

Coinsurance:

This is a specified percentage of Covered Expenses that a Member or family is required to pay each time covered services are provided, subject to any maximums specified in this Certificate. This amount is applied to the Dean contracted fee or Maximum Allowable Fee. Coinsurance amounts are applied toward the maximum out-of-pocket expense in most circumstances. Please refer to your Schedule of Benefits for exceptions.

Please refer to your Schedule of Benefits for applicable Coinsurance amounts.

Copay:

A specified dollar amount that a Member or family is/are required to pay each time covered services are provided. The Copay amount is applied to Dean Health Plan, Inc.'s contracted fee or Maximum Allowable Fee, and applies at the benefit level. Copay amounts are not applied toward your maximum out-of-pocket expense.

Please refer to your Schedule of Benefits for applicable Copay amounts.

Coverage Denial Determination:

A Coverage Denial Determination means an Adverse Determination; an Experimental Treatment Determination; a Pre-existing Condition exclusion denial determination; or a Rescission.

Covered Expense:

A charge for a service or supply that is Medically Necessary and eligible for payment under this Certificate.

Deductible:

The amount of Covered Expenses that the Member or family must pay each Contract Period before Dean will pay for Covered Expenses as specified in this Certificate. The Deductible is applied to the Dean contracted fee or to the Maximum Allowable Fee.

For family policies, no individual Member under the family coverage will need to meet more than the single Policy Deductible amount. Once two or more Members under the family coverage have met the annual family Deductible amount, other members of the family will not need to pay the Deductible for the remainder of the Contract Period.

Please refer to your Schedule of Benefits for applicable Deductible amounts.

Effective Date:

The effective date of the Group Master Policy or the date the Eligible Employee qualifies and is enrolled for health care coverage. However, coverage for the Eligible Employee and any Qualified Dependents will not become

effective if the Eligible Employee is not Active at Work/Active Status on the effective date due to a reason other than disability, illness, or leave of absence. If the effective date of coverage falls on a non-working day, coverage will become effective if the Eligible Employee was Active at Work/Active Status on his/her last working day.

Eligible Employee:

An employee qualified under the terms of the Group Master Policy between Dean and the employer.

Emergency Detention:

When a law enforcement officer or person authorized to take a child or juvenile into custody has cause to believe that an individual is mentally ill, drug dependent, or developmentally disabled, and the individual evidences any of the conditions included in Wisconsin Statute s. 51.15. Detention includes detainment in a hospital approved as a detention facility by the Wisconsin Department of Health Services or under contract with a county department, an approved public treatment facility, a center for the developmentally disabled, a state treatment facility, or an approved private treatment facility if the facility agreed to detain the individual. Emergency Detention must follow all requirements included in Wisconsin Statute s. 51.15 and any other applicable state regulatory requirements to be covered under this Policy.

Experimental or Investigational Procedures, Treatments, Supplies, Devices or Drugs:

Surgical procedures or medical procedures/treatments, supplies or devices, or drugs which at the time provided or sought to be provided, are in the judgment of the Dean Health Plan, Inc. Medical Directors not currently recognized as accepted medical practice and/or the procedure, treatment, supply, device or drug includes, but is not limited to, one of the following:

- Has not been approved by the appropriate governmental agency, such as, but not limited to, the U.S. Food and Drug Administration for the purpose it is being used for, which includes the patient's medical condition
- Is not demonstrated to be as beneficial as established alternatives
- Failure to demonstrate the procedure, treatment, supply, device or drug is safe and effective for the patient's medical condition
- Based on a review of the current peer reviewed medical literature in the United States, there is a failure to demonstrate, at a minimum, an equivalent clinical outcome when compared to standard/conventional treatment for the condition
- Requires a written investigational or research protocol
- Is a treatment protocol based upon or similar to those used in on-going clinical trials

A procedure, treatment, supply, device or drug may be considered Experimental or Investigational even if the Provider has performed, prescribed, recommended, ordered, or approved it, or if it is the only available procedure or treatment for the condition.

Experimental Treatment Determination:

A determination by, or on behalf of, Dean Health Plan, Inc. to which all of the following apply:

1. A proposed treatment has been reviewed by our Medical Affairs Division.
2. Based on the information provided, the treatment under "1." *(above)* is determined to be Experimental under the terms of the Policy.
3. Based on the information provided, we denied the treatment under "1." or payment for the treatment under "1."
4. The cost, or expected cost, of the denied treatment or payment exceeds, or will exceed during the course of the treatment, $292.

Benefits listed in this Certificate are only available as long as the Policy and your coverage are in force. The Certificate must be read together with the Schedule of Benefits to ensure accurate information regarding coverage, obligations, and responsibilities under the Policy. If you are unsure if a service is covered, please call the Customer Care Center prior to having the service performed. Our Customer Care Center will attempt to assist you. However, no information provided by the Customer Care Center shall change or alter terms of this Certificate and your Schedule of Benefits. You must consult your Certificate and Schedule of Benefits to verify your coverage, obligations, and responsibilities under the Policy.

Full-Time Student:

A Qualified Dependent: (a) who is enrolled in an accredited post-high school academic, professional, or trade school that provides a schedule of courses or classes, and (b) whose principal activity is the procurement of an education.

Full-time status is defined by the school in which the student is enrolled as a Full-Time Student. A Full-Time Student is considered enrolled on the date that person is recognized as a full-time student by the school, which is typically the first day of classes. Student status includes any intervening vacation period if the dependent continues to be a Full-Time Student immediately following such vacation period.

Please refer to your Schedule of Benefits for applicable age limitations.

Gestational Carrier:

A woman who receives a transfer of an embryo created by an ovum and sperm from either the intended parents or a donor(s). A Gestational Carrier is not the source of the ovum for the child with which she is impregnated.

Group Master Policy:

The agreement between Dean and the employer group to provide health insurance coverage to Members. The Group Master Policy is part of the Entire Policy.

Group Policyholder/Policyholder:

The employer or other party that entered into the Group Master Policy pursuant to which this Certificate was issued.

Health Care Providers:

Doctors, hospitals, clinics, and any other person or entity properly licensed, certified or otherwise authorized, pursuant to the law of jurisdiction in which care or treatment is received, to provide one or more benefits listed in this Certificate within the scope of their license.

Immediate Family:

The Member's spouse, as well as dependents, parents, brothers, and sisters of the Member and their spouses.

Late Enrollee:

An Eligible Employee, or dependent of an Eligible Employee, who did not request coverage under the Policy during the enrollment period in which he or she was entitled to enroll in the Policy, is not eligible for a special enrollment period, and who subsequently requests coverage under the Policy.

Long-Term Therapy:

Therapy that is determined by our Medical Affairs Division to be primarily Maintenance Therapy.

Benefits listed in this Certificate are only available as long as the Policy and your coverage are in force. The Certificate must be read together with the Schedule of Benefits to ensure accurate information regarding coverage, obligations, and responsibilities under the Policy. If you are unsure if a service is covered, please call the Customer Care Center prior to having the service performed. Our Customer Care Center will attempt to assist you. However, no information provided by the Customer Care Center shall change or alter terms of this Certificate and your Schedule of Benefits. You must consult your Certificate and Schedule of Benefits to verify your coverage, obligations, and responsibilities under the Policy.

Maintenance Therapy:

Ongoing therapy delivered after the acute phase of an illness or injury has passed. It begins when a patient's recovery has reached a plateau or improvement in his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated. The determination of what constitutes "Maintenance Therapy" is made by our Medical Affairs Division after reviewing an individual's case history or treatment plan submitted by a Health Care Provider.

Maximum Allowable Fee:

Maximum Allowable Fee is the maximum amount Dean allows for a given service/procedure with an Out-of-Network Provider.

This amount may be based on:

- Geographic location;
- Provider specialty;
- Training and experience of provider;
- Date of service;
- Complexity of treatment; and
- Degree of skill required of provider.

If there is a difference between the Maximum Allowable Fee and the amount billed by an Out-of-Network Provider, the Member will be responsible for the difference.

When you are seeking care with an Out-of-Network Provider, you can obtain information about Maximum Allowable Fee prior to receiving care. You need to contact your Out-of-Network Provider for the procedure code(s) and the amount(s) the provider intends to charge. Then provide this information to Dean's Customer Care Center in order for Dean to determine the Maximum Allowable Fee for the service(s) in question. Within 5 business days of receiving your request for Maximum Allowable Fee details, Dean will notify you as to whether the service is covered and if it is subject to Maximum Allowable Fee or any other Policy provisions (e.g. Deductibles or Copays).

Medicaid:

A program instituted pursuant to Title XIX (Grants to States for Medical Assistance Program) of the United States Social Security Act (as added by the Social Security Amendments of 1965 now or hereafter amended).

Medically Necessary:

The services or supplies provided by a hospital or Health Care Provider that are required to identify or treat a Member's illness or injury and which, as determined by our Medical Affairs Division, are: (a) consistent with the illness or injury; (b) in accordance with generally accepted standards of medical practice; (c) not solely for the convenience of a Member, hospital, or other Provider; and (d) the most appropriate supply or level of service that can be safely provided to the Member in the most cost effective manner.

Medicare:

Title XVIII (Health Insurance Act for the Aged) of the United States Social Security Act (as added by the Social Security Amendments of 1965 now or hereafter amended).

Benefits listed in this Certificate are only available as long as the Policy and your coverage are in force. The Certificate must be read together with the Schedule of Benefits to ensure accurate information regarding coverage, obligations, and responsibilities under the Policy. If you are unsure if a service is covered, please call the Customer Care Center prior to having the service performed. Our Customer Care Center will attempt to assist you. However, no information provided by the Customer Care Center shall change or alter terms of this Certificate and your Schedule of Benefits. You must consult your Certificate and Schedule of Benefits to verify your coverage, obligations, and responsibilities under the Policy.

Member:

A Subscriber and/or Qualified Dependent.

Network Provider/Plan Provider:

Please refer to Section I of this Certificate for a definition of "Network Provider/Plan Provider."

Out-of-Network Provider/Non-Plan Provider:

Please refer to Section I of this Certificate for a definition of "Out-of-Network Provider/Non-Plan Provider."

Out-of-Pocket Expense Maximum:

Any Covered Expenses the Member is required to pay. The Out-of-Pocket Expense Maximum includes the Deductible and Policy Coinsurance amounts applied to covered services. Copays, non-covered services, and benefit reduction amounts are not included in the Out-of-Pocket Expense Maximum.

Policy Lifetime Maximum:

The maximum dollar amount, or benefit, that we will pay on behalf of a Member for covered services during his or her lifetime. Payments made by us pursuant to this Certificate shall reduce, by such payments, any Policy Lifetime Maximum benefit contained in any of the Policyholder's certificates, policies, coverages, plans, or plan options available through us. Once a Member reaches the Policy Lifetime Maximum, the Policyholder's certificates, policies, coverages, plans or plan options will not cover any further healthcare expenses incurred by the Member.

Please refer to your Schedule of Benefits for the applicable Policy Lifetime Maximum amount.

Policy/Entire Policy:

Your Policy/Entire Policy consists of the Group Master Policy, the Certificate, the Schedule of Benefits, the Employer Group Application, any other applications in either paper, electronic, or report format, and any applicable riders, addendums, attachments and/or amendments.

Pre-Existing Condition:

A disease or physical or mental condition that manifested itself through medical diagnosis or treatment, in a specified period prior to the enrollment date. Please refer to Section V, **Coverage Information** for information on the limitation.

Please refer to your Schedule of Benefits for the applicability of this exclusion.

Premiums:

The monthly fees established by Dean Health Plan, Inc. and charged to the Group Policyholder to cover the provision of benefits to Members.

Prior Authorization:

A written approval from our Medical Affairs Division prior to the Member receiving services. The Prior Authorization will state the type and extent of the treatment or benefit authorized. A verbal or written request from you or your provider does not constitute Prior Authorization.

Benefits listed in this Certificate are only available as long as the Policy and your coverage are in force. The Certificate must be read together with the Schedule of Benefits to ensure accurate information regarding coverage, obligations, and responsibilities under the Policy. If you are unsure if a service is covered, please call the Customer Care Center prior to having the service performed. Our Customer Care Center will attempt to assist you. However, no information provided by the Customer Care Center shall change or alter terms of this Certificate and your Schedule of Benefits. You must consult your Certificate and Schedule of Benefits to verify your coverage, obligations, and responsibilities under the Policy.

Qualified Dependent:

A Qualified Dependent is:

- The legally married spouse of the Subscriber; or,
- Age 0 – 25: The Subscriber's *married or unmarried* biological child, step child, adopted child, legal ward, and any child placed for adoption (by court order, a licensed county agency, a Wisconsin child welfare agency, or a child welfare agency licensed by another State) through the end of the month in which the child turns 26 years of age. All placements and adoptions must follow Wisconsin's placement and adoptions laws. Please contact the Customer Care Center if you have any questions; or
- Age 26: The Subscriber's *unmarried* biological child, step child, adopted child, legal ward, and any child placed for adoption (by court order, a licensed county agency, a Wisconsin child welfare agency, or a child welfare agency licensed by another State) through the end of the month in which the child turns 27 years of age. All placements and adoptions must follow Wisconsin's placement and adoptions laws. Please contact the Customer Care Center if you have any questions; or
- The Subscriber's *unmarried* biological child, step child, or adopted child who was called to active duty prior to reaching the age of 27 and is a Full-Time Student. The child has up to 12 months after completing active duty to apply for Full-Time Student status at an institution of higher education. If the child has been called to active duty more than once in four years since the first call to active duty, eligibility will be determined based on the child's age at the time of the first call to active duty; or
- A biological child of a Subscriber's dependent until the Subscriber's dependent reaches the age of 18.

Except as defined above, a person is **not** a Qualified Dependent if he/she is:

- Age 26:
    - The Subscriber's *married* child; or
    - The Subscriber's *unmarried* child who is eligible for employer sponsored coverage offered through the child's employer and the amount of the child's premium contribution under the employer-sponsored coverage is less than the premium amount for his or her coverage under this Policy.
- Age 27 or above.
- On active military duty, including national guard or reserves, except for military duty shorter than 31 days.

Additionally, when a child is born to parents who are not married to each other, the father cannot claim the child as a dependent until a judicial court has established paternity, a statement of paternity has been filed with the Wisconsin Department of Health and Family Services, or the father is named on the birth certificate as the legal father.

A dependent child who is over the age of 27 may remain insured as a Qualified Dependent under this Certificate if he/she meets certain requirements, provided family coverage remains in force under this Certificate. The child must:

- Be unable to support himself/herself with a job because of a mental or physical disability; and
- Have become disabled before he/she reached the limiting age; and
- Be unmarried and principally supported by the Subscriber.

Written proof of the child's disabling condition must be given to Dean within 31 days of the dependent reaching the limiting age as described in this Certificate, and is subject to Dean's approval.

Benefits listed in this Certificate are only available as long as the Policy and your coverage are in force. The Certificate must be read together with the Schedule of Benefits to ensure accurate information regarding coverage, obligations, and responsibilities under the Policy. If you are unsure if a service is covered, please call the Customer Care Center prior to having the service performed. Our Customer Care Center will attempt to assist you. However, no information provided by the Customer Care Center shall change or alter terms of this Certificate and your Schedule of Benefits. You must consult your Certificate and Schedule of Benefits to verify your coverage, obligations, and responsibilities under the Policy.

Rescission:

A rescission is a cancellation or discontinuance of coverage that has retroactive effect. However, a cancellation or discontinuance of coverage is not a rescission if:

- The cancellation or discontinuance of coverage has only a prospective effect; or
- The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Schedule of Benefits:

The document that accompanies this Certificate and which details specific benefits and benefit limitations for Covered Expenses provided under the terms of this Certificate.

Social Security Number:

An identifying number assigned to you by the United States Social Security Administration.

Subscriber:

The Eligible Employee enrolled in the Policy.

Traditional Surrogate:

A woman whose own ovum is fertilized using donor sperm or the intended parent's sperm. A Traditional Surrogate contributes half of the genetic material to the child with which she is impregnated.

We, Us, Our:

Dean Health Plan, Inc. (Dean).

End of Section II.

Benefits listed in this Certificate are only available as long as the Policy and your coverage are in force. The Certificate must be read together with the Schedule of Benefits to ensure accurate information regarding coverage, obligations, and responsibilities under the Policy. If you are unsure if a service is covered, please call the Customer Care Center prior to having the service performed. Our Customer Care Center will attempt to assist you. However, no information provided by the Customer Care Center shall change or alter terms of this Certificate and your Schedule of Benefits. You must consult your Certificate and Schedule of Benefits to verify your coverage, obligations, and responsibilities under the Policy.

III. BENEFITS

*Certain terms used in this Section are defined throughout and/or in the **Glossary of Terms***

A. GENERAL MEDICAL

- One second opinion per injury or illness is covered as long as benefits are available.
- No coverage is available for charges for missed appointments or charges for telephone consultation by or between Providers.
- Prior Authorization requirements are listed on our website at deancare.com. Please contact the Customer Care Center if you have any questions.
- Any service that is covered under this subsection is also covered when it is provided for the treatment of cancer when administered in a clinical trial that meets the definition of **"**CLINICAL CANCER TRIAL**"** in the "**Glossary of Terms"** Section of this Certificate.

Chiropractic Services

Covered Expenses (Not an All-Inclusive List):

- Chiropractic services for treatment of those conditions that, in the judgment of the attending Provider, are expected to yield significant patient improvement, as determined by our Medical Affairs Division, and are not considered Maintenance or Long-Term Therapy.

Non-covered Chiropractic Expenses*:

- Maintenance or Long-Term Therapy
- Cervical pillows
- Spinal decompression devices

Please also see General Exclusions and Limitations.

Office Visit

Covered Expenses:

- Office calls and consults in the office or an urgent care center. For mental health, maternity or infertility office visits, please see corresponding subsection within this Certificate.

Preventive Services

Preventive services are defined as routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.

Additionally, in order to be covered under the plan, preventive services must:

Benefits listed in this Certificate are only available as long as the Policy and your coverage are in force. The Certificate must be read together with the Schedule of Benefits to ensure accurate information regarding coverage, obligations, and responsibilities under the Policy. If you are unsure if a service is covered, please call the Customer Care Center prior to having the service performed. Our Customer Care Center will attempt to assist you. However, no information provided by the Customer Care Center shall change or alter terms of this Certificate and your Schedule of Benefits. You must consult your Certificate and Schedule of Benefits to verify your coverage, obligations, and responsibilities under the Policy.

- Be performed by or ordered by a Primary Care Physician; and
- Be expenses for care to evaluate or assess health and wellbeing and screen for possible detection of unrevealed illness on a regular basis; and
- Be provided by a Network Provider; and
- Not be performed for the primary reason of diagnosing or treating an illness or injury. (See Section III Benefits, Part C. Diagnostic Services.)

Covered Expenses:

- Physical health examinations (adult and well-child care through age 17)
- Appropriate screenings and counseling as recommended by the following guidelines:
    - Evidence-based items or services that have a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF); or
    - Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention; or
    - For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); or
    - Evidence-informed preventive care and screenings for women provided for in current HRSA-approved guidelines,

These categories address a broad range of preventive services including, but not limited to, colorectal cancer screenings, cervical cancer screenings (e.g., Pap tests), preventive mammograms, and screening lipid tests.

Laboratory and diagnostic studies may be subject to other plan benefits (diagnostic or treatment benefits) if determined not to be part of a preventive visit. When a Member has symptoms or a history of an illness or injury, laboratory and diagnostic studies relating to that illness or injury are no longer considered part of a preventive visit.

Please refer to the "Diagnostic Services" Section for non-preventive services.

****Please also see General Exclusions and Limitations.***

B. MEDICAL SUPPLIES/DURABLE MEDICAL EQUIPMENT

- The cost-sharing amounts as listed on your Schedule of Benefits apply per purchase or rental.
- Supplies or equipment must be prescribed for treatment of a diagnosed illness or injury and must be medically appropriate and cost effective for such illness or injury. Supplies or equipment require a Prior Authorization from our Medical Affairs Division.
- Supplies or equipment shall either be purchased or rented as determined by our Medical Affairs Division. Supplies or equipment cannot be rented if the cost to rent exceeds the cost to purchase the item.
- If Prior Authorization is not obtained when required, no benefits are available.
- Any item that is covered under this Certificate is also covered for use in the treatment of cancer when administered in a clinical trial that meets the definition of **"**CLINICAL CANCER TRIAL**"** in the **Glossary of Terms** Section of this Certificate.

Benefits listed in this Certificate are only available as long as the Policy and your coverage are in force. The Certificate must be read together with the Schedule of Benefits to ensure accurate information regarding coverage, obligations, and responsibilities under the Policy. If you are unsure if a service is covered, please call the Customer Care Center prior to having the service performed. Our Customer Care Center will attempt to assist you. However, no information provided by the Customer Care Center shall change or alter terms of this Certificate and your Schedule of Benefits. You must consult your Certificate and Schedule of Benefits to verify your coverage, obligations, and responsibilities under the Policy.

Supplies and Durable Medical Equipment

Covered Expenses:

- Medical supplies and durable medical equipment.

Examples include, but are not limited to:

- Wheelchairs
- Enteral nutrition supplies
- Hospital beds
- Infusion therapy
- Oxygen and respiratory equipment
- Walking aids, e.g. walkers, crutches and canes
- Orthopedic products, e.g. braces and splints
- Urological and ostomy supplies
- Orthotics and prosthetics as prior authorized by the Medical Affairs Division
- Other Medical Supplies as determined by our Medical Affairs Division
- Diabetic durable equipment and insulin infusion pumps. Insulin infusion pumps are limited to one pump per Contract Year, and the Member must use the pump for 30 days before purchasing.
- Implantable birth control devices (e.g., Norplant)
- Intrauterine contraceptive device (IUD) received from a clinic or physician

Diabetic Supplies

Covered Expenses:

- Insulin, disposable supplies, and any prescription medication for the treatment of diabetes. Disposable supplies include: blood or urine glucose strips, control solutions for blood glucose monitors, alcohol swabs, cotton swabs, finger stick devices, lancets, and syringes. Single packaged items, such as blood glucose sticks, are limited to two items per Copay.

Tobacco Cessation:

Covered Expenses:

- Tobacco cessation prescription medication and/or Nicotine Replacement Therapy ("the patch")

Non-covered Supplies and Durable Medical Equipment Expenses*:

- Medical supplies and durable medical equipment for comfort, personal hygiene and convenience, regardless of the medical necessity of such items. Examples include, but are not limited to: air conditioners, air cleaners, humidifiers, physical fitness equipment, physician's equipment, disposable supplies, alternative communication devices, and self-help devices not medical in nature.
- Home testing and monitoring supplies and related equipment, except those used in connection with the treatment of diabetes.

Benefits listed in this Certificate are only available as long as the Policy and your coverage are in force. The Certificate must be read together with the Schedule of Benefits to ensure accurate information regarding coverage, obligations, and responsibilities under the Policy. If you are unsure if a service is covered, please call the Customer Care Center prior to having the service performed. Our Customer Care Center will attempt to assist you. However, no information provided by the Customer Care Center shall change or alter terms of this Certificate and your Schedule of Benefits. You must consult your Certificate and Schedule of Benefits to verify your coverage, obligations, and responsibilities under the Policy.

- Equipment, models or devices that have features over and above what is Medically Necessary. Coverage will be limited to the standard model as determined by our Medical Affairs Division.
- Non-prescription elastic support or anti-embolism stockings.
- Shoes or orthotics not custom-made and purchased over the counter.
- Any durable medical equipment or supplies used for work, athletic, or job enhancement purposes.
- Cranial bands (e.g., dynamic orthotic cranioplasty).
- Back-up equipment (a second piece).
- Replacement of lost or stolen items.
- Oral Nutrition: Oral nutrition is not considered a medical item. Dean does not cover nutritional support that is taken orally (i.e., by mouth), unless mandated by state law or covered under a Dean medical policy for a specific condition. Examples include, but are not limited to, over-the-counter nutritional supplements, infant formula, and donor breast milk.

Please also see General Exclusions and Limitations.

C. DIAGNOSTIC SERVICES

Covered Expenses:

- Lab tests
- X-rays
- Lead poisoning levels for children between the ages of birth and 6 years
- Non-preventive colonoscopy
- Non-preventive mammography screening
- Pelvic examinations
- Non-preventive papanicolaou (Pap) tests
- Inpatient diagnostic or ancillary services, including but not limited to services received while admitted to a hospital, skilled nursing facility, or hospice center.
- Outpatient facility MRI, per visit
- Outpatient facility CAT scan, per visit
- Outpatient PET scans

Services of a nurse practitioner are covered in connection with mammography screening, pelvic exams and papanicolaou tests.

D. HEARING & VISION SERVICES

Hearing Services

Covered Expenses:

- Hearing exams to determine if correction is needed.
- One adult hearing aid per ear, including repairs, ear molds and hearing aid dispensing fees. The hearing aid must be repaired by/purchased from Dean Clinic, S.C., or other authorized Providers.

Benefits listed in this Certificate are only available as long as the Policy and your coverage are in force. The Certificate must be read together with the Schedule of Benefits to ensure accurate information regarding coverage, obligations, and responsibilities under the Policy. If you are unsure if a service is covered, please call the Customer Care Center prior to having the service performed. Our Customer Care Center will attempt to assist you. However, no information provided by the Customer Care Center shall change or alter terms of this Certificate and your Schedule of Benefits. You must consult your Certificate and Schedule of Benefits to verify your coverage, obligations, and responsibilities under the Policy.

Please contact the Customer Care Center with questions regarding authorized Providers, or reference our website at deancare.com.

- Infants and children under 18 who are certified as deaf or hearing impaired by a physician or audiologist are eligible for bilateral hearing aids. Benefits are available per benefit period. The benefit period is 36 consecutive months from the date the benefit is first used.
- Cochlear implants, including procedures for implantation.

Non-covered Hearing Expenses*:

- Batteries for hearing aids.

Please also see General Exclusions and Limitations.

Vision Care Services

Covered Expenses:

- An initial lens per surgical eye following cataract surgery.
- Preventive vision exams/services.
- Medically necessary vision exams/services. These include, but are not limited to, one evaluation visit per year to a Low Vision Clinic when a Member has a moderate to total visual impairment that can no longer be corrected by prescription eyeglasses or contact lenses.

Non-covered Vision Expenses*:

- Refractive eye surgery and radial keratotomy.
- Eyeglasses; contact lenses (except as stated otherwise in this subsection), including the fitting of contact lenses; and replacement lenses.
- Orthoptics (e.g., eye exercise training).
- Refraction aids for low vision and instruction in their use.

Please also see General Exclusions and Limitations and your Schedule of Benefits for any additional vision coverage limitations.

E. HOSPITAL & SURGICAL SERVICES

- Inpatient and outpatient hospital services and skilled nursing facility services are covered when they are necessary for the admission, diagnosis, and treatment of a patient as determined by our Medical Affairs Division. Certain services require Prior Authorization from our Medical Affairs Division. Please visit deancare.com or contact the Customer Care Center for a list of current services that require Prior Authorization.
- If you receive inpatient hospital services from an Out-of-Network Provider without obtaining Prior Authorization, a 50% penalty will apply, up to a $500 maximum per occurrence.

Inpatient Hospital

Covered Expenses:

- Hospitals and specialty hospital services for a semi-private room or intensive care unit
- Any other Medically Necessary hospital expenses.

A HOSPITAL is an institution that: is licensed and run according to applicable state laws that apply to hospitals; maintains, at its location, all the facilities needed to provide diagnosis of, and medical and surgical care for, injury and illness; provides this care for fees; provides such care on an inpatient basis; provides continuous 24-hour nursing services by registered graduate nurses; qualifies as a psychiatric or tuberculosis hospital; is a Medicare Provider; and is credentialed by Dean Health Plan, Inc. or accredited as a hospital by the Joint Commission on Accreditation of Hospitals. The term Hospital does NOT mean an institution that is chiefly a place for treatment of chemical dependency, a skilled nursing facility, or a federal hospital. Dean reserves the right to apply this definition to services provided by Out-of-Network Providers.

HOSPITAL ADMISSION, OR BEING ADMITTED IN A HOSPITAL, means being registered as a patient in a hospital on the advice of a Network Provider or receiving emergency care for an illness or injury in a hospital. Hospital swing-bed confinement is considered the same as confinement in a skilled nursing facility.

Please see Benefits, "Accidental Injury to Teeth, Oral Surgery Services and TMD" Section of this Certificate for coverage of inpatient services pertaining to dental care.

Inpatient Rehabilitation

Covered Expenses:

- Inpatient rehabilitative medical confinement resulting from the same or related illness or injury. Benefits are paid per "episode of care", defined as the initial period and following periods of confinement resulting from the same or related illness or injury.

INPATIENT REHABILITATION IS an admission to a specialized facility that is able to deliver the intensity of services required to rehabilitate someone from a serious illness or injury, including but not limited to, stroke, cranial bleed, head injury or spinal cord injury. Inpatient rehabilitation services must be deemed medically necessary by our Medical Affairs Division.

Non-covered Expenses for Inpatient Hospital and Inpatient Rehabilitation*:

- Take home drugs and supplies dispensed by the hospital, unless a written prescription is obtained and filled at a Plan pharmacy.
- Hospital stays that are extended for reasons other than medical necessity (e.g., lack of transportation, lack of caregiver or inclement weather).
- A continued hospital stay, if the attending physician has documented that care could effectively be provided in a less acute care setting (e.g., skilled nursing facility or Member's home).
- Any surgical treatment or hospitalization for the treatment of morbid obesity.
- Separate charges for personal comfort or convenience items.

Benefits listed in this Certificate are only available as long as the Policy and your coverage are in force. The Certificate must be read together with the Schedule of Benefits to ensure accurate information regarding coverage, obligations, and responsibilities under the Policy. If you are unsure if a service is covered, please call the Customer Care Center prior to having the service performed. Our Customer Care Center will attempt to assist you. However, no information provided by the Customer Care Center shall change or alter terms of this Certificate and your Schedule of Benefits. You must consult your Certificate and Schedule of Benefits to verify your coverage, obligations, and responsibilities under the Policy.

Please also see General Exclusions and Limitations.

Outpatient Hospital or Ambulatory Surgical

Covered Expenses:

- Outpatient Hospital or Ambulatory surgical services.
- Surgical procedures provided in a physician's office

AN AMBULATORY SURGERY CENTER is an outpatient surgical facility that provides day surgery services to persons who need less than 24-hour nursing/medical care. The outpatient surgical facility means a registered public or private medical facility that has an organized staff of licensed practitioners and registered professional nursing services with permanent facilities equipped and operating primarily to perform surgery. The facility must be Medicare-certified and licensed or registered to provide the treatment by the state in which it is located, as appropriate.

Skilled Nursing

Covered Expenses:

- Skilled care services.

SKILLED CARE SERVICES are medical services rendered by registered or licensed practical nurses; physical, occupational, and speech therapists. Patients receiving skilled care are usually quite ill and often have been recently hospitalized.

A SKILLED NURSING FACILITY is an institution that is licensed by the State of Wisconsin as a Skilled Nursing Facility. Admission to a swing bed setting in a hospital is considered the same as a Skilled Nursing Facility confinement. Inpatient Rehabilitation services must be deemed medically necessary by our Medical Affairs Division.

The maximum benefit per Contract Period for this coverage includes coverage provided by any health care payor, including Medicare, if applicable.

Non-covered Expenses for Skilled Nursing*:

- Respite and residential care.
- Any nursing facility services other than skilled nursing services, including intermediate care facilities and community re-entry programs.
- Custodial or domiciliary care. Custodial care is the type of care given when the basic goal is to help a person in the activities of daily life, including, but not limited to, help in: (a) bathing; (b) dressing; (c) eating; (d) taking medicines properly; (e) getting in and out of bed; (f) using the toilet; (g) preparing special diets; (h) walking; or (i) 24-hour supervision for potentially unsafe behavior. Examples of custodial (or non-skilled) care provided by "non-skilled" persons include: range of motion exercises, strengthening exercises, wound care, ostomy care, tube and gastrotomy feedings, administration of medications, and maintenance of urinary catheters. This is also referred to as Activities of Daily Living (ADL). Daily care such as assistance with getting out of bed, bathing, dressing, eating, maintenance of bowel and bladder function, preparing special

diets, and assisting patients with taking their medicines, or 24-hour supervision for potentially unsafe behavior, do not require "skilled care" and are considered to be custodial.
- Charges for injectable medications administered in a nursing home when the nursing home stay is not covered by Dean. (These charges may be covered if you have the prescription drug benefit available through your Policy.)
- Tracheostomy care
- Parenteral feeding or tube feeding care

Please also see General Exclusions and Limitations.

Home Health Care

Covered Expenses:

- Home care. The attending physician must certify that (a) hospital confinement, or confinement in a skilled nursing facility, would be needed if home care was not provided; (b) the Member's Immediate Family, or others living with the Member, cannot provide the needed care and treatment without undue hardship; and (c) a state licensed or Medicare certified home health agency or certified rehabilitation agency will provide or coordinate the home care.
- Home health aide services that are given part-time or from time to time. They must be Medically Necessary as part of the home care plan and must consist solely of caring for the patient. A registered nurse or medical social worker must supervise the service provider. Services provided must be skilled services. Home health aides are only covered for skilled nursing services.
- Physical, respiratory, occupational, and speech therapy when Medically Necessary.
- Medical supplies, drugs, and medicines prescribed by a Network Provider, and lab services by or for a hospital. These must be Medically Necessary under the home care plan and are covered to the same extent as if the Member was confined to a hospital.
- Nutritional counseling as Medically Necessary as part of the home care plan and a registered or certified dietitian must give or supervise these services.
- The assessment of the need for a home care plan and its development. A registered nurse, physician's assistant or medical social worker must do this assessment and the attending physician must request or approve this service.
- Prescriptions dispensed in connection with Home Health Care
- Each period of 4 straight hours in a 24-hour period of home health aide services counts as one home care visit.
- Each visit by a qualified person, who provides services under a home care plan, evaluates your needs, or develops a plan, will be considered as one visit.

The attending physician must establish a home health care plan, approve it in writing, and review it at least every 2 months, unless the physician determines less frequent reviews are sufficient.

Non-covered Expenses for Home Health Care*:

- Respite and residential care.
- Private duty nursing, defined as the provision of individual and continuous care (in contrast to part-time or intermittent care) of 4 or more hours provided according to an individual plan of care, including shift care by a registered or licensed practical nurse or a certified nursing assistant.

Benefits listed in this Certificate are only available as long as the Policy and your coverage are in force. The Certificate must be read together with the Schedule of Benefits to ensure accurate information regarding coverage, obligations, and responsibilities under the Policy. If you are unsure if a service is covered, please call the Customer Care Center prior to having the service performed. Our Customer Care Center will attempt to assist you. However, no information provided by the Customer Care Center shall change or alter terms of this Certificate and your Schedule of Benefits. You must consult your Certificate and Schedule of Benefits to verify your coverage, obligations, and responsibilities under the Policy.

- Home care services provided by a family member.

Please also see General Exclusions and Limitations.

Hospice Care

Covered Expenses:

- Hospice Care provided in the home or at a Hospice Care Facility where palliative and supportive medical, social, and psychological services are given to help patients with terminal illness. Hospice care may include routine home care, continuous home care, and inpatient hospice.
- Coverage is provided for hospice care on a case by case basis. Hospice care requires Prior Authorization.

HOSPICE CARE is an agency or organization that:

1. Has hospice care available 24 hours a day, seven days a week
2. Is certified by Medicare as a hospice program, and, if required, is licensed as such by the jurisdiction in which it is located
3. Provides core services, which include:
    - Nursing services 24 hours a day, seven days a week
    - Medical social worker services
    - Dietary, spiritual, and bereavement counseling
4. Provides or arranges for other services as related to the terminal illness when approved by your Provider, which may include:
    - Services of a practitioner, such as a nurse, social worker, or physician
    - Physical, occupational or speech therapy
    - Home health aide services
    - Inpatient care in a facility when needed for pain control and other acute symptom management
    - Pharmacy services, and
    - Durable medical equipment

A HOSPICE FACILITY is a facility or distinct part of a Hospital or Skilled Nursing Facility that:

1. Obtained approval of any required state or governmental certificate of need
2. Provides 24 hours, seven days a week services
3. Has at least one of each of the following personnel:
    - Doctor of Medicine (MD)
    - Registered Nurse (RN)
    - Licensed or certified social worker
    - Pastoral or other counselor
    - Full-time administrator
4. Is responsible for continuing to directly provide core services while the Member is receiving care and services
5. Maintains written or electronic records of services
6. Has been established and operated in accordance with the applicable laws in the area in which it is located.

To be eligible for Hospice Care benefits, the patient must have a life expectancy of six months or less, as confirmed by the attending Provider. Covered services will continue if the Member lives longer than 6 months.

Benefits listed in this Certificate are only available as long as the Policy and your coverage are in force. The Certificate must be read together with the Schedule of Benefits to ensure accurate information regarding coverage, obligations, and responsibilities under the Policy. If you are unsure if a service is covered, please call the Customer Care Center prior to having the service performed. Our Customer Care Center will attempt to assist you. However, no information provided by the Customer Care Center shall change or alter terms of this Certificate and your Schedule of Benefits. You must consult your Certificate and Schedule of Benefits to verify your coverage, obligations, and responsibilities under the Policy.

Non-covered Expenses for Hospice Care*:

- Respite and residential care.
- Services provided by volunteers
- Housekeeping or homemaking services

Please also see General Exclusions and Limitations.

Detoxification Services

Covered Expenses:

- Medically necessary detoxification services provided by an approved Health Care Provider.

You or the Provider must notify us if you are receiving Detoxification services. These services are not applied to the Mental Health/AODA benefit.

F. EMERGENCY SERVICES

- Claim payments for Out-of-Network urgent and emergency care services will be based on our Maximum Allowable Fee. You will be responsible for any fees that exceed this amount.
- If you have a question regarding when to seek emergency or urgent care, you can call our 24-hour nurse access line, Dean On Call, at (800)-57 NURSE (1-800-576-8773) or (608) 250-1393.
- The Dean phone numbers, and instructions on when to call Dean, are on the back of your Dean Identification (ID) card. You should carry your ID card with you at all times.

Ambulance Services

Covered Expenses:

- Established ground ambulance service. Ambulance transportation is covered to or from a hospital when the transportation is an emergency or urgent in nature and medical attention is required en route.
- Coverage of air ambulance will be based on criteria established by our Medical Affairs Division.

Non-covered Ambulance Expenses*:

- All charges or costs exceeding a benefit maximum.
- Ambulance service that is not an emergency transportation, including non-emergency air transportation, unless prior authorized by our Medical Affairs Division.
- Charges for, or in connection with, any other form of travel, unless otherwise stated in this Section.
- Air transportation that does not meet the criteria established by our Medical Affairs Division.

Please also see General Exclusions and Limitations.

Emergency Care

Covered Expenses:

- Emergency room services. Please note that emergency room services provided by an Out-of-Network Provider will be paid based on our Maximum Allowable Fee. You will be responsible for any fees that exceed the Maximum Allowable Fee.
- Copay is waived if admitted for Observation or Inpatient.

What is Emergency Care?

Emergency care is care a Member needs due to the onset of a medical condition that, if the Member does not seek immediate medical attention, could result in serious injury or death. Some examples of conditions that may require emergency care are heart attacks, strokes, severe shortness of breath, and significant blood loss. Emergency care is Medically Necessary care that is needed because the Member's condition manifests acute symptoms of sufficient severity that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of medical attention to result in serious jeopardy to the Member's health, or with respect to a pregnant woman, serious jeopardy to the health of the woman or unborn child.

Emergency care does not include medical conditions that arise as a result of services, treatments or procedures that are not considered eligible expenses under this Certificate.

What to do in case of emergency stay of less than 24 hours:

If your physician feels that your condition presents an emergency, and that delaying care to obtain Prior Authorization could be life threatening or cause serious or permanent impairment, you should seek care immediately. We must be notified of an urgent or emergency admission by the next business day. If notice of an emergency admission cannot be given by the next business day, it must be given as soon as reasonably possible, as determined by Dean Health Plan.

Urgent Care

Covered Expenses:

- Urgent care services. Please note urgent care services provided by an Out-of-Network Provider will be paid based on our Maximum Allowable Fee. You will be responsible for any fees that exceed the Maximum Allowable Fee.

What is Urgent Care?

Urgent care is care that you need sooner than a regular physician's visit. Some examples of conditions that may require urgent care are broken bones, sprains, minor cuts and burns, drug reactions, and non-severe bleeding. If you are outside the service area, go to the nearest appropriate medical facility, unless you can safely return to the service area to receive care from a Network Provider. Urgent care is not follow-up care, unless such care is necessary to prevent your health from getting significantly worse before you can reach your primary care provider or other Network Provider. It does not include care that can be postponed until you can safely travel to the service area to receive care from a Network Provider.

What to do if you need Urgent Care:

Urgent care should be received at the nearest appropriate medical facility, unless you can safely return to the service area or see your PCP. Please call the Customer Care Center as soon as possible after seeing an Out-of-Network Provider. The claim for the services may be reviewed by our Medical Affairs Division to determine if the diagnosis

or symptoms were urgent. Services provided by an Out-of-Network Provider will be paid based on our Maximum Allowable Fee. You will be responsible for any fees that exceed this amount.

If you have a question regarding when to seek emergency or urgent care, you can call our 24-hour nurse access line at (800)-57 NURSE (1-800-576-8773) or (608) 250-1393.

G. THERAPIES & REHABILITATION SERVICES

Autism

Please contact our Customer Care Center for coordination of care assistance.
Please refer to your Schedule of Benefits for benefit information and limitations.

Covered Expenses:

- Services specifically related to a primary verified diagnosis of autism spectrum disorder, which includes autism disorder, asperger's syndrome and pervasive development disorder not otherwise specified. Verified diagnosis must be conducted by a Provider skilled in testing and in the use of empirically validated tools specific for autism spectrum disorders. For the diagnosis to be valid, the evidence must meet the criteria for autism spectrum disorder in the most recent Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. These services include:

    - **Diagnostic testing**, if testing tool is appropriate to the age of the Member and determined through the use of empirically validated tools specific for autism spectrum disorders. Dean reserves the right to require a second opinion with a Provider mutually agreeable to the Member and Dean.

    - **Intensive-Level services**. The Member is eligible for 4 years of intensive level services. Any previous intensive-level services received by the Member will be counted against this requirement under this Policy, regardless of payor.
      Intensive level services must be consistent with the following:
        - Evidence based
        - Provided by a qualified Provider as defined by state law
        - Based on a treatment plan developed by a qualified Provider or professional as defined by state law that includes an average of 20 or more hours per week over a six-month period of time with specific cognitive, social, communicative, self-care or behavioral goals that are clearly defined, directly observed and continually measured. Treatment plans shall require that the Member be present and engaged in the intervention.
        - Provided in an environment most conducive to achieving the goals of the Member's treatment plan
        - Includes training and consultation, participation in team meetings and active involvement of the Member's family and treatment team for implementation of the therapeutic goals developed by the team.
        - Commences after an insured is 2 years of age and before the insured is 9 years of age.
        - Services must be assessed and documented throughout the course of treatment.
        - The Member must be directly observed by the qualified Provider at least once every two months.

- **Nonintensive-Level Services** The Member is eligible for nonintensive-level services, including direct or consultative services, that are evidence-based and are provided by a qualified Provider or qualified paraprofessional if one of following conditions apply:
    - After the completion of intensive-level services and designed to sustain and maximize gains made during intensive-level treatment.
    - To a Member who has not and will not receive intensive-level services but for whom non-intensive level services will improve the Member's condition.

  Nonintensive-Level Services must be consistent with the following:
    - The services are based upon a treatment plan and includes specific therapy goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that the Member be present and engaged in the intervention.
    - Implemented by qualified Providers, qualified supervising Providers, qualified professionals, qualified therapists or qualified paraprofessionals as defined by state law.
    - Provides treatment and services in an environment most conducive to achieving the goals of the Member's treatment plan.
    - Provides training and consultation, participation in team meetings and active involvement of the Member's family in order to implement therapeutic goals developed by the team
    - Provides supervision for qualified professionals and paraprofessionals in the treatment team.
    - Services must be assessed and documented throughout the course of treatment.

Non-covered Autism Expenses*:

- Acupuncture
- Animal-based therapy including hippotherapy
- Auditory integration training
- Chelation therapy
- Child Care fees
- Cost for the facility or location when treatment, therapy or services are provided outside a Member's home.
- Cranial sacral therapy
- Custodial or respite care
- Hyperbaric oxygen therapy
- Provider travel expenses
- Special diets and supplements
- Therapy, treatment or services to a Member residing in a residential treatment center, inpatient treatment or day treatment facilities
- Prescription Drugs and Durable Medical Equipment**

Please also see General Exclusions and Limitations.

These items may be covered under the normal terms and conditions of the Policy and are not covered under the Autism benefit. Please see your Prescription Drug Rider, if applicable, and/or Section III, Benefits, B. Medical Supplies/Durable Medical Equipment for more information.

Outpatient Physical, Speech, and Occupational Therapy

Benefits listed in this Certificate are only available as long as the Policy and your coverage are in force. The Certificate must be read together with the Schedule of Benefits to ensure accurate information regarding coverage, obligations, and responsibilities under the Policy. If you are unsure if a service is covered, please call the Customer Care Center prior to having the service performed. Our Customer Care Center will attempt to assist you. However, no information provided by the Customer Care Center shall change or alter terms of this Certificate and your Schedule of Benefits. You must consult your Certificate and Schedule of Benefits to verify your coverage, obligations, and responsibilities under the Policy.

Covered Expenses:

- Medically Necessary services, as a result of illness or injury.
- Speech and hearing screening examinations are limited to the screening tests for determining the need for correction.

Please refer to your Schedule of Benefits for visit limitations.

These therapy benefits are only for treatment of those conditions that, in the judgment of the attending physicians, are expected to yield significant patient improvement, as determined by our Medical Affairs Division. Therapists must be licensed and must not live in the patient's home or be a family member.

Limited Benefit for Developmental Delay

Covered Expenses:

- Services specifically related to developmental delay, including physical, speech and occupational therapy, for the purpose of providing home instruction and monitoring for long-term and/or maintenance conditions.

Please refer to your Schedule of Benefits for visit limitations.

Non-covered Outpatient Physical, Speech and Occupational Therapy and Developmental Delay Expenses*:

- Vocational rehabilitation, including work hardening programs.
- Long-Term Therapy and Maintenance Therapy. Examples of long-term/maintenance conditions include, but are not limited to: autism and learning disabilities such as: attention deficit, hyperactivity disorder, sensory defensiveness, auditory defensiveness, mental retardation and related conditions, except as listed under the "LIMITED BENEFIT FOR DEVELOPMENTAL DELAY" or "AUTISM" provisions.
- Hearing therapy for communication delay, therapy for perceptual disorders, mental retardation and related conditions, and other long-term special therapy, except as specifically listed under the "LIMITED BENEFIT FOR DEVELOPMENTAL DELAY" or "AUTISM" provisions.
- Therapy services such as recreational or educational therapy, physical fitness or exercise programs.
- Biofeedback, unless Prior Authorization is obtained.
- Services to enhance athletic training or performance.
- Services or treatment received at intermediate care facilities

Please also see General Exclusions and Limitations.

Phase II Cardiac Rehabilitation

Covered Expenses:

- Medically appropriate rehabilitation services for myocardial infarction, coronary by-pass surgery or stable angina pectoris with Prior Authorization.

Pulmonary Rehabilitation

Covered Expenses:

- Medically appropriate rehabilitation services for chronic and restrictive lung disease, as deemed medically necessary by our Medical Affairs Division.

Radiation Therapy

Covered Expenses:

- Accepted therapeutic methods, such as x-rays, radium and radioactive isotopes. Please contact the Customer Care Center for a list of approved Providers. Services may require Prior Authorization.

H. ACCIDENTAL INJURY TO TEETH, ORAL SURGERY & TMD

- There are a limited set of dental, accidental injury, oral and temporomandibular disorder (TMD) related services provided under this Certificate. We do not cover other services except as described in this subsection.
- Services may require Prior Authorization. If Prior Authorization is not obtained when required, a 50% penalty will apply, up to a $500 maximum per occurrence.
- Please visit our website at deancare.com or contact the Customer Care Center if you are unsure whether or not a service requires Prior Authorization

Dental, Extraction of Natural Teeth, and Replacement with Artificial Teeth Due to an Accidental Injury

Covered Expenses:

- Tooth extractions, and replacement with artificial teeth, because of an accidental injury.
- Services for tooth extractions must begin within 18 months after the accident.
- All Medically Necessary hospital or ambulatory surgery center charges incurred, and anesthetics provided in connection with dental care that is provided to a Member in a hospital or ambulatory surgery center, if prior authorized by our Medical Affairs Division, and if any of the following applies:
    a. The Member is a child under age 7;
    b. The Member has a chronic disability, or
    c. The Member has a medical condition that requires hospitalization or general anesthesia for dental care.

To be eligible for coverage, the accident must occur while you are enrolled under this Policy, or repair of teeth after accidental injury was delayed according to a provider evaluation and recommendation, and could not be completed prior to enrollment under this Policy.

A "sound, natural tooth" is a tooth that is fully erupted, lacks clinical evidence of periodontal disease, lacks dental restoration (filling), or minor restoration that does not compromise the strength and integrity of the tooth structure. The tooth must have an excellent long term prognosis.

The term "injured" does not include conditions resulting from eating, chewing or biting. Evaluation and submission of treatment plan must occur within 90 days of the date of the accident.

Oral Surgery

Covered Expenses:

- Surgery consult and/or evaluation
- Surgical procedures as follows:
    - Removal of impacted teeth, tumors, and cysts.
    - Treatment for accidental injuries of the jaw, cheeks, lips, tongue, roof, and floor of mouth.
    - Apicoectomy.
    - Removal of exostoses of the jaw and hard palate.
    - Treatment of fractured facial bones.
    - External and internal incision and drainage of cellulitis.
    - Cutting of accessory sinuses, salivary glands or ducts.
    - Reducing dislocations; alveoloplasty.
    - Frenectomy.
    - Vestibuloplasty.
    - Residual root removal.

Temporomandibular Disorders (TMD)

Covered Expenses:

- Diagnostic procedures and Medically Necessary surgical or non-surgical treatment for the correction of temporomandibular disorders (TMD), if all of the following applies:
    a. the condition is caused by congenital, developmental or acquired deformity, disease or injury; and
    b. under the accepted standards of the profession of the Health Care Provider rendering the service, the procedure or device is reasonable and appropriate for the diagnosis or treatment of this condition. The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.
- Prescribed intraoral splint therapy devices.

Surgical TMD procedures are not subject to the TMD benefit maximum as listed in your Schedule of Benefits

Non-surgical services with a TMD diagnosis code will be subject to the TMD benefit maximum as listed in your Schedule of Benefits. Surgical Services will be covered as indicated within each corresponding section of this Certificate.

Non-covered Expenses for Injury to Teeth, Oral Surgery and TMD*

- All charges or costs exceeding a benefit maximum.
- All dental services, except those listed as covered in this "Accidental Injury to Teeth, Oral Surgery Services and TMD" subsection.
- Surgery performed to correct functional deformities of the mandible or maxilla.
- Correction of malocclusion.
- Hospitalization costs for services not listed in this Section, except those listed in the "Inpatient Hospital" provision, of the Facility Services subsection, for which Prior Authorization is required.
- Cosmetic or elective orthodontic care, periodontic care, or general dental care.

Benefits listed in this Certificate are only available as long as the Policy and your coverage are in force. The Certificate must be read together with the Schedule of Benefits to ensure accurate information regarding coverage, obligations, and responsibilities under the Policy. If you are unsure if a service is covered, please call the Customer Care Center prior to having the service performed. Our Customer Care Center will attempt to assist you. However, no information provided by the Customer Care Center shall change or alter terms of this Certificate and your Schedule of Benefits. You must consult your Certificate and Schedule of Benefits to verify your coverage, obligations, and responsibilities under the Policy.

- Restoration. Examples include but are not limited to crowns and root canals.
- Tooth damage due to eating, chewing or biting.
- Dental implants.

Please also see General Exclusions and Limitations.

I. MENTAL HEALTH & ALCOHOL & OTHER DRUG ABUSE (AODA) SERVICES

- Mental health services are those conditions classified as a mental health disorder by the International Classification of Diseases (ICD-9-CM) published by the American Medical Association and/or the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association.
- Court-ordered services may not be covered unless the services are a result of an Emergency Detention or received on an emergency basis and you or your provider notifies Dean within 72 hours after the initial services.
- Related diagnostic services and prescription drugs are not subject to these mental health and AODA benefits. Please see the "Diagnostic Services" provision, under subsection General Medical and Diagnostic Services, and, if applicable, the Prescription Drug Benefit Rider for benefit information.
- Coverage is in accordance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

Inpatient Mental Health and AODA

Covered Expenses:

- Medically necessary services provided at an in network, inpatient facility.
- Medically necessary inpatient detoxification services are considered medical and, therefore, are NOT applied to this benefit. Please see the "Detoxification Services" provision under the Facility Services (Hospital Inpatient Care, Outpatient Care, and Skilled Nursing Facility), Home Health Care, and Hospice subsection for more information on this coverage.

Outpatient Mental Health and AODA

Covered Expenses:

- Medically necessary outpatient services, including group and individual therapy.
- Office visits with a mental health or AODA in Network Provider.
- **For Full-Time Students attending school in Wisconsin, but outside the service area:**
  A clinical assessment by an Out-of-Network Provider with Prior Authorization from our Medical Affairs Division.

Other Mental Health and AODA

Covered Expenses:

- Medically necessary and prior authorized services for the following treatments and programs:

  1. Mental health services for adults, adolescents, and children in a Day Treatment Program.
  2. Services for persons with chronic mental illness provided through a community program. These programs provide services to people with chronic mental illnesses that, due to history or prognosis, require repeated acute treatment or prolonged periods of inpatient care. Benefits are payable only for charges directly related to treatment of mental illness.
  3. Residential Treatment Programs for alcohol and/or drug dependent persons.
  4. Services for alcoholism and other drug problems provided in a Day Treatment Program.
  5. Intensive outpatient programs for the treatment of drug and alcohol use disorders. Treatment must be provided by specialists in addiction medicine.
  6. Coordinated emergency mental health services for persons who are experiencing a mental health crisis or who are in a situation likely to turn into a mental health crisis if support is not provided. Services are provided by a program certified for the period of time the person is experiencing a mental health crisis until the person is stabilized or referred to other Providers for stabilization. Certified emergency mental health service plans shall provide timely notice to Dean to facilitate coordination of services for persons who are experiencing, or are in a situation likely to turn into, a mental health crisis.

To qualify for coverage under this Plan, the care must be Medically Necessary and prior authorized by our Medical Affairs Division:

- **Medical Necessity** will be reviewed by our Medical Affairs Division. To qualify, the treatment program must be staffed by a multi-disciplinary team, which should include registered nurses, occupational therapists, social workers, psychologists, physicians or other health care professionals. The treatment must be provided by AODA or mental health credentialed professionals and the treatment program must include a quality assurance program to review quality of care.
- **Prior Authorization** will be approved if our Medical Affairs Division determines that the Member requires more intensive treatment than is available through outpatient services and that the care is the most appropriate level of care for the Member. Prior Authorization does not guarantee payment if the services would not otherwise be covered according to the provisions of this Certificate.

Non-covered Mental Health and AODA Expenses*:

- Biofeedback, unless Prior Authorization is obtained.
- Family counseling for non-medical reasons
- Gambling addiction
- Halfway houses, unless Prior Authorization is obtained
- Hypnotherapy
- Long-Term or Maintenance Therapy
- Marriage counseling
- Phototherapy

****Please also see General Exclusions and Limitations.***

Benefits listed in this Certificate are only available as long as the Policy and your coverage are in force. The Certificate must be read together with the Schedule of Benefits to ensure accurate information regarding coverage, obligations, and responsibilities under the Policy. If you are unsure if a service is covered, please call the Customer Care Center prior to having the service performed. Our Customer Care Center will attempt to assist you. However, no information provided by the Customer Care Center shall change or alter terms of this Certificate and your Schedule of Benefits. You must consult your Certificate and Schedule of Benefits to verify your coverage, obligations, and responsibilities under the Policy.

J. TRANSPLANTS & KIDNEY DISEASE SERVICES

- Except for corneal transplants, all transplant services, including transplant work ups require Prior Authorization and must be provided at a Dean-approved facility. If Prior Authorization is not obtained when required, a 50% penalty will apply, up to a $500 maximum per occurrence.
- The appropriateness of all transplants is reviewed by our Medical Affairs Division. Our definition of appropriateness is based upon individual patient considerations and medical literature supportive of the value of this technology.
- Coverage for organ-procurement costs is limited to costs directly related to the procurement of an organ from a cadaver or donor having a blood relationship to the recipient. Organ-procurement costs include the following: organ transportation, compatibility testing, hospitalization, and surgery (when a live donor is involved), and are subject to the lifetime transplant benefit maximum listed in the Schedule of Benefits.

Transplant Services

Covered Expenses:

- Organ and tissue transplants when ordered by a physician. Benefits are currently available for transplants when the transplant meets the definition of a Covered Expense and is not Experimental or Investigational. All transplants require Prior Authorization.

Examples of transplants for which benefits may be available include bone marrow, stem cell, heart, heart/lung, lung, pancreas, liver, and cornea. ***Benefits for pancreas transplants are available only at the time of a kidney transplant for treatment of end-stage renal disease as a result of diabetic complications***.

Donor costs that are directly related to organ procurement for an approved organ transplant are Covered Expenses for which benefits are payable through the organ recipient's coverage under the Policy.

Non-covered Transplant Expenses:

- Health services for organ and tissue transplants unless specifically covered under this Certificate.
- Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal may be payable through the organ recipient's benefits policy).
- Health services for transplants involving permanent mechanical or animal organs.
- Transplant services that are not performed at a designated facility.

Kidney Disease Treatment

Covered Expenses:

- Inpatient and outpatient kidney disease treatment is limited to all services and supplies directly related to kidney disease, including but not limited to: dialysis, transplantation, donor-related charges, and related physician charges.
- Benefits for donor-related charges are only payable if the recipient of the kidney is a Dean Member. The covered donor-related charges (including compatibility testing charges) are those charges related to the

person actually donating the kidney. We are not required to duplicate coverage available to the Member under Medicare or under any other insurance coverage the Member may have.

Non-covered Expenses for Transplant Services and Kidney Disease Treatment*:

- Any transplants and all related expenses not outlined as covered in this subsection.
- Services and supplies in connection with covered transplants when Prior Authorization is not obtained.
- Any Experimental or Investigational transplant
- Transplants involving non-human or artificial organs.

Please also see General Exclusions and Limitations.

K. OTHER SERVICES

Anesthesia Services

Covered Expenses:

- Anesthesia services provided in connection with Covered Expenses under this Certificate.

Non-covered Anesthesia Expenses*:

- Anesthesia services provided for non-Covered Expenses, unless specifically listed as a Covered Expense within this Certificate.

Please also see General Exclusions and Limitations.

Infertility Services

Covered Expenses:

- Services provided in conjunction with the diagnosis and treatment of infertility.
- Infertility Drugs, if administered in a physician's office.

Benefit maximum may apply. Please refer to your Schedule of Benefits.

Please see your Prescription Drug Benefit Rider, if applicable, for self-administered infertility drug benefits

Non-covered Infertility Expenses*:

- Consultation for, or procedures in connection with, in vitro fertilization, embryo transplantation, and/or any other assistive reproductive technique (e.g., GIFT, ZIFT).
- Reversal of voluntary sterilization, and related, procedures.
- All charges or costs relating to donor sperm.
- Services related to surrogacy

Please also see General Exclusions and Limitations.

Maternity Services

Covered Services:

- Medically Necessary physician services.
- Prenatal and postpartum care, including services directly related to deliveries, ectopic pregnancies, Cesarean sections, Medically Necessary abortions and miscarriages.
- Hospital services are covered under the "Inpatient Hospital" provision in subsection "Facility Services."
- Maternity benefits are also available for a Qualified Dependent daughter who is covered as a Member.

Our Medical Affairs Division must be notified in advance of your expected date of delivery for Prior Authorization of your maternity facility confinement, if an Out-of-Network Provider is used. In addition, when you are admitted we must be notified the next business day regardless of whether delivery of your baby has taken place or not (e.g., pre-term labor).

New Members under this Certificate who are in their third trimester and are seeing an Out-of-Network Provider are allowed to continue receiving care with their Out-of-Network Provider for the duration of their pregnancy and until their first postpartum checkup. Services provided by an Out-of-Network Provider require Prior Authorization.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, health insurers such as Dean generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. Federal law does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). If this occurs, Dean will only provide benefits for the shorter stay. Dean may not require you to obtain Prior Authorization for stays that are not in excess of 48 hours (or 96 hours).

Although not required, you may obtain a Prior Authorization for services that would allow you to reduce your out-of-pocket costs. For information on Prior Authorization, please call the Customer Care Center.

Non-covered Maternity Expenses*:

- Amniocentesis or CVS (Chorionic Villi Sampling), performed exclusively for sex determination.
- Birthing classes (e.g., Lamaze).
- Elective abortions.
- Home or intentional out of hospital deliveries (e.g., free standing birthing centers).
- Treatment, services or supplies for a non-Member Traditional Surrogate or Gestational Carrier.

Please also see General Exclusions and Limitations.

Surgical Services

Covered Expenses:

- Surgical procedures required to treat an illness or accidental injury.
    - Covered services include: preoperative and postoperative care, necessary assistant and consultant services, and elective sterilization, unless otherwise specified.
    - If a Member is receiving benefits in connection with a mastectomy, and elects to have breast reconstruction surgery in connection with that mastectomy, we will provide coverage for reconstruction of the breast on which the mastectomy has been performed; surgery and

reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications of all stages of mastectomy, including lymphedema. WHCRA 1998

- Prosthetics are subject to the benefits provided in the "Medical Supplies and Durable and Disposable Medical Equipment" subsection.

Coverage for lymphedema is subject to the benefits provided under the "Outpatient Physical, Speech and Occupational Therapy" provision of this Subsection.

Non-covered Surgical Expenses*:

- Procedures, services, medications and supplies related to sex transformation.
- Reversal of voluntary sterilization procedures and related procedures.
- Cosmetic or plastic surgery, unless representing a medical/surgical necessity. This limitation does not affect coverage provided for breast reconstruction of the affected tissue incident to a mastectomy. Psychological reasons do not represent a medical/surgical necessity.
- Any surgical treatment or hospitalization for the treatment of morbid obesity.

Please also see General Exclusions and Limitations.

End of Section III.

IV. GENERAL EXCLUSIONS & LIMITATIONS

*Certain terms used in this Section are defined throughout and/or in the **Glossary of Terms***

- Acupuncture, dry needling and prolotherapy.
- Autopsy.
- Chelation therapy for atherosclerosis.
- Coma Stimulation programs.
- Court ordered care, unless Medically Necessary and otherwise covered under this Certificate.
- Cytotoxic testing and sublingual antigens in conjunction with allergy testing.
- Services required for administrative examinations such as employment, licensing, insurance, adoption, or participation in athletics.
- Experimental or investigational services, treatments or procedures, and any related complications as determined by our Medical Affairs Division, unless coverage is required by state or federal law.
- Services provided by members of the Subscriber's Immediate Family or any person residing with the Subscriber.
- Holistic medicine and any other form of alternative medicine.
- Massage therapy.
- Swim or pool therapy, unless Prior Authorization is obtained.
- Services and supplies furnished by a government plan, hospital, or institution unless by law you must pay.
- Items or services required as a result of war or any act of war, insurrection, riot, terrorism, or sustained while performing military service.
- Podiatry services or routine foot care rendered in the absence of localized illness, injury, or symptoms in connection with, but not limited to: (a) the examination, treatment or removal of all or part of corns, calluses, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet; (b) the cutting, trimming or other non-operative partial removal of toenails; or (c) for any treatment or services in connection with any of these.
- Any services to the extent a Member receives or is entitled to receive any benefits, settlement, award or damages for any reason of, or following any claim under, any Workers' Compensation Act, employer's liability insurance plan or similar law or act. "Entitled" means the Member is actually insured under Workers' Compensation.
- Treatment, services, and supplies provided in connection with any illness or injury caused by: (a) a Member's engaging in an illegal occupation or (b) a Member's commission of, or an attempt to commit, a felony.
- Treatment, services, and supplies provided to a Member while the Member is held or detained in custody of law enforcement officials, or imprisoned in a local, state or federal penal or correctional institution.
- Hair analysis (unless lead or arsenic poisoning is suspected).
- Obesity-related services, including any weight loss method, unless specifically covered under this Certificate.
- Services or supplies not Medically Necessary, not recommended or approved by a Provider, or not provided within the scope of the Provider's license.
- Any hospital service or medical care not listed in this Certificate.
- Services and supplies rendered outside the scope of the Provider's license.
- An expense incurred before the supply or service is actually provided unless prior approved by the Medical Affairs Division.

Benefits listed in this Certificate are only available as long as the Policy and your coverage are in force. The Certificate must be read together with the Schedule of Benefits to ensure accurate information regarding coverage, obligations, and responsibilities under the Policy. If you are unsure if a service is covered, please call the Customer Care Center prior to having the service performed. Our Customer Care Center will attempt to assist you. However, no information provided by the Customer Care Center shall change or alter terms of this Certificate and your Schedule of Benefits. You must consult your Certificate and Schedule of Benefits to verify your coverage, obligations, and responsibilities under the Policy.

- Services or supplies for, or in connection with, a non-covered procedure or service, including complications, regardless of when a non-covered procedure or service is or was performed; a denied referral or Prior Authorization; or a denied admission.
- All charges or costs exceeding a benefit maximum or Maximum Allowable Fee where applicable.
- Collection and storage of sperm and eggs outside the course of treatment for, and diagnosis of, infertility including for surrogacy or Gestational Carriers.
- All services or supplies provided in conjunction with the treatment of sexual dysfunction or sexual transformation, including, but not limited to, medications, surgical treatment and injections.
- All charges and costs related to internet and phone consultations.
- Oral Nutrition: Oral nutrition is not considered a medical item. Dean does not cover nutritional support that is taken orally (i.e., by mouth), unless mandated by state law or covered under a Dean medical policy for a specific condition. Examples include, but are not limited to, over-the-counter nutritional supplements, infant formula, and donor breast milk.
- Educational services, except for diabetic self-management classes.
- Cosmetic surgery.
- Items of convenience for a Member or a Member's family

End of Section IV.

Benefits listed in this Certificate are only available as long as the Policy and your coverage are in force. The Certificate must be read together with the Schedule of Benefits to ensure accurate information regarding coverage, obligations, and responsibilities under the Policy. If you are unsure if a service is covered, please call the Customer Care Center prior to having the service performed. Our Customer Care Center will attempt to assist you. However, no information provided by the Customer Care Center shall change or alter terms of this Certificate and your Schedule of Benefits. You must consult your Certificate and Schedule of Benefits to verify your coverage, obligations, and responsibilities under the Policy.

V. COVERAGE INFORMATION

*Certain terms used in this Section are defined throughout and/or in the **Glossary of Terms***

Effective Date of Coverage

Coverage will become effective on the latest of the following dates:

For a Subscriber:

1. The Effective Date of the Group Master Policy; or
2. The date the Eligible Employee qualifies, enrolls and is approved for health care coverage with Dean. However, coverage for the Eligible Employee and any Qualified Dependents will not become effective if the Eligible Employee is not Active at Work/Active Status on the effective date due to a reason other than disability, illness, or leave of absence. In this situation, if the effective date of coverage falls on a non-working day, coverage will become effective if the Eligible Employee was actively at work on his/her last working day.

For Qualified Dependents:

1. Qualified Dependents (other than newborns or adopted children) will become effective for coverage on the date the Subscriber acquires one or more such Qualified Dependents. An application must be received within 31 days of such event.
2. In the case of newborns and adopted children, the Subscriber must file an application within 60 days of birth or placement in the home. If we do not receive an application, coverage beyond the 60 days will cease. However, coverage may subsequently continue beyond the 60 days if the Subscriber, within one year, makes all past due Premium payments, including interest at the rate of 5-1/2% per year.
3. A Subscriber must have coverage in effect for a Qualified Dependent's coverage to become effective.

"**Qualified Dependent**" is defined in Section II, "**Glossary of Terms**" in this Certificate.

(Medical expenses incurred prior to your Effective Date of Coverage are excluded.)

Coverage for Full-Time Students on Medical Leave:

If a Qualified Dependent who is a Full-Time Student must take a Medically Necessary leave of absence due to illness or injury, Dean will continue to provide coverage for the Qualified Dependent if the Qualified Dependent, or an individual on his or her behalf, submits documentation and certification of the medical necessity of the leave of absence from his/her attending physician. The date on which the Qualified Dependent ceases to be a Full-Time Student due to the Medically Necessary leave of absence is the date this continuation coverage begins.

Dean will continue to provide coverage until any one of the following events occurs:

1. The Qualified Dependent notifies Dean or the employer that he/she does not intend to return to school full time;
2. The Qualified Dependent becomes employed full time;
3. The Qualified Dependent obtains other health coverage;
4. The Qualified Dependent marries and is eligible for coverage under his/her spouse's health coverage;
5. The Qualified Dependent reaches the age at which Full-Time Student coverage would otherwise terminate;
6. The Subscriber's coverage under this Policy is discontinued or otherwise terminated; or

Benefits listed in this Certificate are only available as long as the Policy and your coverage are in force. The Certificate must be read together with the Schedule of Benefits to ensure accurate information regarding coverage, obligations, and responsibilities under the Policy. If you are unsure if a service is covered, please call the Customer Care Center prior to having the service performed. Our Customer Care Center will attempt to assist you. However, no information provided by the Customer Care Center shall change or alter terms of this Certificate and your Schedule of Benefits. You must consult your Certificate and Schedule of Benefits to verify your coverage, obligations, and responsibilities under the Policy.

7. One year has elapsed since the Qualified Dependent's continuation coverage has begun and the dependent has not returned to school full time.

Coverage of Newborn Infants:

Coverage is provided under this Policy for newly born children of the insured from the moment of birth. The Subscriber must file an application within 60 days of birth. If we do not receive an application, coverage beyond the 60 days will be refused. However, coverage may subsequently continue if the Subscriber, within one year, makes all past due Premium payments, including interest at the rate of 5-1/2% per year. A Subscriber must have coverage in effect for a Qualified Dependent's coverage to become effective. Congenital defects and birth abnormalities are considered an injury or illness under the terms of this Policy. Coverage will apply to the functional repair or restoration of any body part when necessary to achieve normal body functioning for the newborn infant. This does not include cosmetic surgery performed solely for appearance improvement.

Initial Enrollment Period

When an employer group initially becomes insured under Dean, all Eligible Employees and their Qualified Dependents may enroll for coverage within 31 days of the group's Effective Date of Coverage.

Newly Eligible Employees and their Qualified Dependents may also enroll during the term of this agreement between Dean and the employer. Enrollment is accomplished by submitting either a completed and signed application or completing an on-line employee application to Dean within 31 days of becoming eligible.

Persons not enrolled during the initial enrollment period will be subject to up to an 18-month Late Enrollee pre-existing limitation. Please see the "Late Enrollee Policy" provision in this section.

Special Enrollment Period

If an Eligible Employee does not apply for coverage when initially eligible, due to having other creditable coverage, the Eligible Employee may in the future be able to enroll himself/herself or his/her Qualified Dependents in this Policy in the future so long as enrollment is requested within 31 days after the other coverage ends. In addition, if an Eligible Employee acquires a new dependent as a result of marriage, birth, adoption or placement for adoption, the Eligible Employee may be able to enroll himself/herself and his/her Qualified Dependents in this Policy, provided that enrollment is requested within 31 days after the marriage, birth, adoption or placement for adoption.

Late Enrollee Policy

Individuals who did not enroll when initially eligible for coverage, and who are not eligible for a special enrollment period, are considered Late Enrollees. An 18 month waiting period will apply to Late Enrollees under this Certificate.

Dean will apply a Pre-Existing Condition limitation to all Late Enrollee benefits and services related to a disease or physical or mental condition that manifested itself through medical diagnosis or treatment.

The Late Enrollee Pre-Existing Condition limitation, of up to 18 months, is not applicable to newly Eligible Employees or Qualified Dependents who submit a timely application (apply for coverage within 31 days after satisfying any applicable probationary period).

Pre-Existing Condition Limitation

For Members under age 19, no Pre-Existing Condition exclusions will be applied. For Members age 19 and over, Pre-Existing Conditions are not covered for up to 18 months after the enrollment date. Pre-Existing Condition

limitations may be reduced or waived to the extent such limitations were satisfied under previous creditable coverage. This exclusion is never applicable to newborn or adopted children under age 19, pregnancy or Members who are enrolling due to annual dual choice. Please refer to your Schedule of Benefits for the applicability of this exclusion.

Creditable coverage means any of the following:

- Group health plan
- Group or individual health insurance coverage
- Medicare or Medicaid
- Health Insurance Risk Sharing Plan (HIRSP)
- Federal Employees Health Benefits Plan (FEHBP)
- Public health plan
- Military sponsored health care
- A Peace Corps Plan
- Medical care program of the Indian Health Service or
- An American Indian Tribal Organization

Prior coverage is not creditable if there is a break in coverage of 63 or more consecutive calendar days. National health care of another country is not considered creditable coverage.

ID Card Information

Your Dean ID card provides useful information regarding the insured Subscriber and dependent(s), along with important telephone numbers and billing information. The ID card is not a guarantee of coverage or payment of benefits.

Coverage Changes/Notice of Change

As a Member, it is your responsibility to notify us of any changes that might affect your coverage. You should report these changes to your employer or to us immediately. These changes include, but are not limited to:

1. Eligibility for Medicare
2. Loss of eligibility for coverage due to termination of employment, divorce or death of the Subscriber.
3. The addition of any newly acquired Qualified Dependents.
4. Changes in Qualified Dependent status (for details see **Glossary of Terms** Section).

Failure to report these changes to us on a timely basis (31 days from the date the change occurs) may result in an 18-month pre-existing limitation period being imposed, claims being denied, incorrect Premiums being collected, or retroactive termination of coverage under this Policy.

When Coverage Ends

Coverage under this Policy will end on the earliest of the following dates, unless otherwise specified in this Certificate:

1. The end of the month that a Subscriber no longer meets the definition of an Eligible Employee, unless otherwise specified on the Group Master Policy. Coverage for Qualified Dependents will end on the same date.
2. The date of Policy termination or non-renewal.
3. The date the Member is called to active duty status in the military. (Check with your employer to see if it has other requirements.)
4. The date of a Member's disenrollment, as stated in the "Dean Disenrollment" subsection.

Benefits listed in this Certificate are only available as long as the Policy and your coverage are in force. The Certificate must be read together with the Schedule of Benefits to ensure accurate information regarding coverage, obligations, and responsibilities under the Policy. If you are unsure if a service is covered, please call the Customer Care Center prior to having the service performed. Our Customer Care Center will attempt to assist you. However, no information provided by the Customer Care Center shall change or alter terms of this Certificate and your Schedule of Benefits. You must consult your Certificate and Schedule of Benefits to verify your coverage, obligations, and responsibilities under the Policy.

5. For grandchildren of the insured, the date your Qualified Dependent child who is a parent reaches age 18 or otherwise loses eligibility or coverage.
6. For a Qualified Dependent child, on the earliest of the following:
    a. If age 26:
        - The date the child marries; or
        - The date the child obtains employer sponsored coverage offered through the child's employer and the amount of the child's Premium contribution under the employer sponsored coverage is less than the Premium amount for his or her coverage under this Policy.
    b. The end of the month in which the Qualified Dependent child reaches the age of 27, unless otherwise indicated in the Schedule of Benefits
    c. The date a Qualified Dependent child who was called to active duty prior to reaching the age of 27 loses Full-Time Student status.
    d. A mentally or physically disabled child may continue coverage under your family coverage beyond the maximum dependent age stated in this Certificate, as set forth in the definition of "Qualified Dependent". Coverage will terminate at the end of the month in which the disabled child no longer meets the requirements for extended coverage for disabled children.
7. For a divorced spouse or stepchildren, the end of the month in which a divorce judgment is entered.

Important Note: It is each Member's responsibility to notify Dean of any changes that might affect coverage, such as a dependent reaching the limiting age, marital status, or losing Full-Time Student status if the dependent was called to active duty prior to reaching the age of 27. Failure to report these changes on a timely basis may result in claims being denied, incorrect claims being collected or retroactive termination.

Extension of Coverage

Termination of a Member's Coverage (applies only if the Policy remains in force) - If you are confined in the hospital on the date your coverage ends under this Policy, we will continue to cover the charges for Eligible Expenses incurred for inpatient hospital services provided to you during that hospital confinement after the date your coverage ends. Benefits for such hospital services will continue until the earliest of the date in which:

1. Confinement ends;
2. Your benefits available under this Policy are exhausted;
3. 90 consecutive days pass since your coverage under the Policy ended; or
4. Similar coverage is provided under another group health policy for the hospital services.

Termination of the Policy - If, on the date of termination of this Policy, your coverage ends and you are totally disabled, benefits related to the disabling condition will continue during the period of time in which you are totally disabled for up to 12 months. However, coverage will not be extended beyond the date in which:

1. Total disability ends;
2. The benefit period specified in the Group Policy or Certificate ends;
3. The maximum benefit available is exhausted; or
4. Similar coverage is provided under another group health policy for the condition or conditions causing the total disability.

Extended coverage does not cover dental, uncomplicated pregnancy expenses or a condition other than the condition(s) causing the total disability.

"Totally Disabled/Total Disability**"** means a Member is unable, due to illness or injury, to perform any duties of his/her occupation or engage in another one for pay or profit, as determined by us. If the Member does not have a regular occupation, this means the Member's inability, due to illness or injury, to engage in the normal activities of a

person of the same age and gender. The totally disabled Member must be under the regular care of Network Provider. We have the right to require an examination of such person, as often as we reasonably require, to confirm the total disability.

Continuation/Conversion

If your coverage ends as described in this Section's "**When Coverage Ends**" subsection, you may be eligible to continue coverage or convert to an individual conversion policy as described below.

Wisconsin Group Health Continuation and Individual Conversion

You as the Subscriber and any Qualified Dependents may apply, without proof of good health, for a continuation of group coverage or for an individual conversion policy, if you have been covered under this Policy for three consecutive months and you leave your employer group for any reason other than discharge for gross misconduct.

Your employer must notify you of your right to continuation or conversion coverage within 5 days of receiving your notice to terminate coverage. You must then apply for coverage within 31 days of receiving notice of your right to continuation or conversion coverage.
If you choose continuation coverage, your employer is required to give you coverage that is identical to the coverage provided to the other Members under the Policy. You will be responsible for paying the entire Premium due for your coverage.

You are eligible for continuation coverage if you lose your group coverage for any of the following reasons:

1. You are a Subscriber who is no longer eligible for coverage under this Policy, except if your employment was terminated for gross misconduct.
2. You are a Qualified Dependent of a Subscriber who is no longer eligible for coverage under the Policy, except if the Subscriber's employment was terminated for gross misconduct.
3. You are the Subscriber's spouse who is no longer eligible for coverage under the Policy due to divorce or annulment.
4. You are the Subscriber's spouse or dependent who is no longer eligible for coverage under the Policy due to the Subscriber's death.

The group continuation coverage will be available for a maximum of 18 months. You must be a Wisconsin resident, pay timely Premiums, and you cannot be eligible for similar coverage under another group policy. You may apply for an individual conversion policy at the end of the 18-month period, but in order to be eligible, Dean must receive your application within 31 days after your continuation coverage ends.

If you move out of Wisconsin, you are eligible for an out-of-area individual conversion policy. If you would like more information on this Policy, please contact the Customer Care Center.

Federal Group Health Continuation Rights under COBRA

The Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended

Introduction

This provision contains important information about your right to elect COBRA continuation coverage (COBRA), which is a temporary extension of coverage under your group health Policy. This provision generally explains COBRA, when it may become available to you as the Subscriber, and your family, and what you need to do to exercise your right to receive COBRA.

COBRA can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are also covered under your group health Policy if they

would otherwise lose their group health coverage through this Policy. For more information about your rights and obligations, please contact the Group Policyholder.

What is COBRA continuation coverage?

COBRA is a continuation of coverage when coverage would otherwise end because of a life event known as a qualifying event. (Specific qualifying events are described below.) After a qualifying event, COBRA must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if your group health coverage is lost because of a qualifying event. If you elect continuation coverage, you may be responsible for all or part of the Premium payments (as determined by the employer). You do not have to provide proof of good health to elect continuation coverage.

Subscriber

If you are a Subscriber, you have the right to choose COBRA if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct).

Spouse

If you are the spouse of a Subscriber, you have the right to choose COBRA for yourself if you lose group health coverage for any of the following qualifying events:

1. The death of your spouse (Subscriber).
2. Termination of the Subscriber's employment (for reasons other than gross misconduct) or reduction in the Subscriber's hours of employment.
3. Divorce or legal separation from the Subscriber.
4. The Subscriber becomes entitled to Medicare.
5. The Subscriber has retiree coverage and the employer files for bankruptcy (Chapter 11 Reorganization).

Qualified Dependent

In the case of a Qualified Dependent child of a Dean Subscriber, he or she has the right to elect continuation coverage if group health coverage is lost for any of the following reasons (qualifying events):

1. The death of the Subscriber.
2. The termination of the Subscriber's employment (for reasons other than gross misconduct) or reduction in hours of employment.
3. Parent's divorce or legal separation.
4. The Subscriber becomes entitled to Medicare.
5. The dependent child ceases to be a Qualified Dependent.
6. The Subscriber has retiree coverage and the employer files for bankruptcy (Chapter 11 Reorganization).

You must give notice of some Qualifying Events

The Subscriber, spouse or Qualified Dependent is responsible for informing the Policy Administrator/employer of a divorce, legal separation, or a child losing dependent status, within 60 days after the qualifying event. The employer (if the employer is not the Policy Administrator) is responsible for notifying the Policy Administrator of the Subscriber's death, termination of employment, reduction of hours, Medicare entitlement, or commencement of the employer's bankruptcy proceedings, within 30 days of the date coverage ends due to a loss of eligibility. When the Policy Administrator is notified that one of these events has happened, the Policy Administrator will notify you of your right to elect COBRA within 14 days of their receiving notice of your qualifying event.

Benefits listed in this Certificate are only available as long as the Policy and your coverage are in force. The Certificate must be read together with the Schedule of Benefits to ensure accurate information regarding coverage, obligations, and responsibilities under the Policy. If you are unsure if a service is covered, please call the Customer Care Center prior to having the service performed. Our Customer Care Center will attempt to assist you. However, no information provided by the Customer Care Center shall change or alter terms of this Certificate and your Schedule of Benefits. You must consult your Certificate and Schedule of Benefits to verify your coverage, obligations, and responsibilities under the Policy.

If your coverage ends because of one of the qualifying events described, you have up to 60 days from the date your coverage ended to inform the employer that you want to elect continuation coverage. If you do not choose continuation coverage, your coverage under this Policy will terminate.

How is COBRA provided?

Each qualified Member will have an independent right to elect COBRA. Subscribers may elect COBRA on behalf of their spouses, and any parents may elect COBRA on behalf of their children. If you elect continuation coverage, the employer is required to give you coverage that (as of the time coverage is being provided) is identical to the coverage provided under the Policy to other Members. You will be afforded the opportunity to maintain continuation coverage for 3 years from the date of your qualifying event, except for coverage ending because of a termination of employment or reduction in hours. In these cases, the required continuation coverage period is 18 months. However, there are ways in which this 18 month period can be extended:

1. If you or anyone in your family is determined by the Social Security Administration (SSA) to have been disabled within 60 days after the latest of: (a) the date of the SSA disability determination; (b) the date on which the qualifying event occurs; (c) the date on which the qualified beneficiary loses coverage; or (d) the date on which the qualified beneficiary is informed of the obligation to provide disability notice. If you choose to extend your COBRA coverage, you must elect it before the end of the 18-month period by giving written notice of your election to extend COBRA coverage. All Members can receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months.
2. If any of your family experiences a second qualifying event while receiving COBRA coverage, the spouse or dependent children can get up to an additional 18 months of COBRA coverage, for a maximum of 36 months. This extension may be available for the following qualifying events: the Subscriber dies, enrolls in Medicare, gets divorced or legally separated; or for a dependent child, that child is no longer an eligible dependent child, but only if the event would have caused the spouse or dependent child to lose coverage had the first qualify event not occurred. For all these events, you must notify the employer/Policy Administrator within 60 days of the second qualifying event.

Loss of COBRA coverage

Please note your continuation coverage may be cut short for any of the following reasons:

1. The employer no longer provides group health coverage to any of its employees.
2. The Premium for your continuation coverage is not paid. You become an employee covered under another group health Policy.
3. You become entitled to Medicare following the COBRA election date.

At the end of the COBRA coverage period, you have the right to enroll in an individual conversion policy provided by Dean, if you apply and Dean receives your application within 31 days after your continuation coverage ends. Please contact the Customer Care Center if you wish to enroll in our individual conversion policy.

If you have any questions

Requests for additional information, or questions concerning your COBRA rights, should be addressed to your Policy Administrator/employer. For more information about your rights under ERISA, including COBRA and the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health policies, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa.

Benefits listed in this Certificate are only available as long as the Policy and your coverage are in force. The Certificate must be read together with the Schedule of Benefits to ensure accurate information regarding coverage, obligations, and responsibilities under the Policy. If you are unsure if a service is covered, please call the Customer Care Center prior to having the service performed. Our Customer Care Center will attempt to assist you. However, no information provided by the Customer Care Center shall change or alter terms of this Certificate and your Schedule of Benefits. You must consult your Certificate and Schedule of Benefits to verify your coverage, obligations, and responsibilities under the Policy.

In order to protect your family's rights, Members should keep the Policy Administrator/employer, and Dean, informed of any changes in the addresses of family members. You should also keep a copy of any notices you sent to the Policy Administrator/employer, for your records. Please see this Certificate's cover page for information on how to contact Dean.

Continuation Coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA)

If a Subscriber leaves employment due to active military service of longer than 30 days, he or she may elect to continue coverage under the Policy for up to 24 months under the Uniformed Services Employment and Reemployment Rights Act (USERRA) by providing advance notice of the military service and electing to continue coverage. Please contact your employer/Policy Administrator for further information on your rights under this law.

Please note: This provision does not fully describe continuation coverage or other rights under your employer's Policy. More complete information regarding such rights is available from your Policy Administrator/employer.

Dean Disenrollment

A Member may be disenrolled for any of the following reasons:

1. The required Premiums are not paid by the end of the grace period. The grace period ends 31 days from the last unpaid Premium due date.
2. The Member has committed acts of physical or verbal abuse which pose a threat to Providers or other Members of the Dean organization.
3. The Member has allowed a non-Member to use his or her Dean ID card to obtain services.
4. The Member has knowingly provided fraudulent information in applying for coverage, or has fraudulently attempted to obtain benefits.
5. The Member has moved outside the service area.
6. The Member is unable to establish or maintain a satisfactory physician-patient relationship with the physician responsible for the Member's care. A Member can only be disenrolled for this reason if we have provided the Member an opportunity to select another Network Provider, made a reasonable effort to assist the Member in establishing a satisfactory physician-patient relationship, and informed the Member that he/she may file a grievance.

If a Member is disenrolled for any of the above reasons, except for nonpayment of required Premiums, this coverage will be continued until the Member finds his or her own coverage or until the next opportunity to change insurers, whichever comes first.

End of Section V.

Benefits listed in this Certificate are only available as long as the Policy and your coverage are in force. The Certificate must be read together with the Schedule of Benefits to ensure accurate information regarding coverage, obligations, and responsibilities under the Policy. If you are unsure if a service is covered, please call the Customer Care Center prior to having the service performed. Our Customer Care Center will attempt to assist you. However, no information provided by the Customer Care Center shall change or alter terms of this Certificate and your Schedule of Benefits. You must consult your Certificate and Schedule of Benefits to verify your coverage, obligations, and responsibilities under the Policy.

VI. GENERAL PROVISIONS

*Certain terms used in this Section are defined throughout and/or in the **Glossary of Terms***

Benefit Determination and Policy Interpretation

Dean, as the claims administrator, has the exclusive discretionary authority to determine eligibility for benefits and to construe the terms of this Policy. Any such determination or construction shall be final and binding on all parties, unless it is arbitrary and capricious.

Circumstances Beyond Dean's Control

If, due to circumstances not reasonably within our control, such as complete or partial insurrection, labor disputes, disability of a significant part of hospital or medical group personnel or similar causes, the rendition or provision of services and other covered benefits is delayed or rendered impractical, Dean and Network Providers will use their best efforts to provide services and other covered benefits. However, neither Dean nor any Network Provider shall have any other liability or obligation on account of such delay or such failure to provide services or other benefits.

Confidentiality

Dean respects the confidentiality of our Members and will use reasonable efforts to keep confidential all medical information regarding a Member. Please see our "Notice of Privacy Practices" brochure provided with your enrollment packet.

Conformity with Federal and State Laws

Dean complies with all applicable federal and states laws. This Certificate will conform to the minimum requirements of applicable laws if any provision conflicts with the laws of the state in which we issue.

Limit on Assignability of Benefits

This is your personal Certificate. You cannot assign any benefit to anyone other than a physician, hospital or other Provider entitled to receive a specific benefit for you.

Limit of Liability

Dean shall not be held liable for injuries, damages or expenses related to or the result of improper advice, action or omission by any Health Care Provider.

Limitations on Suits

No action can be brought against us to pay benefits until the earlier of 60 days after we have received or waived proof of loss, or the date we have denied full payment. This delay will not cause prejudice against you. No action can be brought more than 3 years after the time we require written proof of claim to be submitted.

Major Disaster or Epidemic

Benefits listed in this Certificate are only available as long as the Policy and your coverage are in force. The Certificate must be read together with the Schedule of Benefits to ensure accurate information regarding coverage, obligations, and responsibilities under the Policy. If you are unsure if a service is covered, please call the Customer Care Center prior to having the service performed. Our Customer Care Center will attempt to assist you. However, no information provided by the Customer Care Center shall change or alter terms of this Certificate and your Schedule of Benefits. You must consult your Certificate and Schedule of Benefits to verify your coverage, obligations, and responsibilities under the Policy.

If a major disaster or epidemic occurs, Network Providers and hospitals will render medical services (and arrange extended care services and home health service), insofar as practical, according to their best medical judgment, and within the limitation of available facilities and personnel. Dean and Network Providers have no liability, or obligation for delay or failure to provide or arrange for such services, if the disaster or epidemic causes unavailability of facilities or personnel. In this case, Members may receive covered services from Out-of-Network Providers.

Fraud and Intentional Misrepresentation: Right of Rescission

Intentional misrepresentations made when applying for coverage could cause an otherwise valid claim to be denied, or your coverage to be rescinded. Carefully check the information provided when you apply for coverage and write to us within 10 days if any information given is not correct and complete or if any medical history has not been included. This Certificate was issued on the basis that the statements, representations, and warranties made when you and any dependents applied for coverage are correct and complete.

We will rescind coverage if information is received that indicates a fraudulent or an intentional misrepresentation was made by you or anyone acting on your behalf when you applied for insurance, if you or the person acting on your behalf knew that the representation was false and either:

1. We relied on the misrepresentation and the misrepresentation was either material or was made with intent to deceive; or
2. The fact misrepresented contributes to a loss under the Policy.

We will notify you within 60 days after acquiring knowledge of a misrepresentation of our intention to either rescind coverage or defend against a claim if one should arise, or within 120 days if we determine that it is necessary to secure additional medical information.

If your coverage is rescinded due to fraud or intentional misrepresentation, you will not be eligible for continuation or conversion coverage.

Oral Statements

No oral statement of any person shall modify or otherwise effect the benefits, limitations, exclusions, and conditions of this contract; convey or void any coverage; increase or reduce benefits described within this Certificate; or be used in the prosecution or defense of a claim under this Policy.

Physician and Hospital Reports

Physicians and hospitals, from time to time, must give us reports to help us determine Member benefits. By accepting coverage under the Policy, you have agreed to authorize Providers to release any necessary records to us. This is a condition of our issuing this contract and paying benefits. Please Note: Expenses billed for the release and review of any records are not covered.

Physical Examination

Dean has the right to request a Member to receive a physical examination to determine eligibility for benefits. We will pay for this expense if we do request such an examination. By accepting coverage under the Policy, you have agreed to consent to any required examination. Please call the Customer Care Center for a listing of doctors who can provide required examinations.

Benefits listed in this Certificate are only available as long as the Policy and your coverage are in force. The Certificate must be read together with the Schedule of Benefits to ensure accurate information regarding coverage, obligations, and responsibilities under the Policy. If you are unsure if a service is covered, please call the Customer Care Center prior to having the service performed. Our Customer Care Center will attempt to assist you. However, no information provided by the Customer Care Center shall change or alter terms of this Certificate and your Schedule of Benefits. You must consult your Certificate and Schedule of Benefits to verify your coverage, obligations, and responsibilities under the Policy.

Proof of Claim

As a Member, it is your responsibility to show your Dean ID card each time you receive services. Failure to notify a Provider of your membership in Dean may result in claims not being filed on a timely basis. This could result in a denial of the claim and you would be billed for the charges involved.

Recovery of Excess Payments

If we pay more than we owe under this Policy, we can recover the excess payment from you. We can also recover from another insurance company or service Policy, or from any other person or entity that has received any excess payment from us.

Refusal to Accept Treatment

If a Member refuses to follow recommended treatment or procedure, this may constitute an unsatisfactory physician-patient relationship and could result in disenrollment. See the "Dean Disenrollment" subsection, in the "**Coverage Information"** Section, for more details.

Right to Collect Needed Information

Members must cooperate with us when we investigate a claim or require information necessary to administer the Policy. Cooperation includes, but is not limited to, the following assistance:

1. Authorizing the release of medical information, including the names of all Providers from whom you received medical attention;
2. Providing information about the circumstances of any injury or accident;
3. Providing information about other insurance coverage and benefits; and
4. Providing a Member's Social Security Number or other personal information.

Your failure to assist us may result in our denial of claims.

Right to Exchange Information

By accepting coverage under the Policy with Dean, each Member gives their permission to Dean, the Network Provider and/or clinic to obtain and share any information (including medical records), when that information is necessary to administer the terms of this Policy. The Member also agrees to provide any pertinent information to Dean, Network Providers and/or clinics, if it is needed to administer the terms of this Policy. The information obtained will be kept confidential, and used only for the purpose of administering this Policy. All Members have a right to access their medical records.

Severability

If any part of this Certificate or the Policy is ever prohibited by law, it will no longer apply. The rest of this Certificate or the Policy will continue in full force.

Subrogation

If you are entitled to special damages for an illness or injury caused by a third party or for which any party is liable, you agree that Dean has a claim for subrogation as to those damages. Our subrogation claim is for the reasonable value of the medical care and services you receive related to that illness or injury. We have the right to recover payments you are entitled to receive from a responsible third party, from the insurance company of the third party,

and from a company that provides medical payment coverage, Workers Compensation coverage, or uninsured or underinsured motorist protection for you.

You agree to honor our subrogation rights, to cooperate with Dean in the enforcement of its subrogation rights, and to take no action which would prejudice the rights and interests of the Policy, without obtaining Dean's prior consent before you take any action, so we may protect our subrogation rights and interests.

Under applicable state law, we may have no right to recover from you if you have not been "made whole." Furthermore, we may be entitled to recover directly from a third party, the third party's insurer or any other liable insurer. You agree to provide us with written notice of any claim or lawsuit that you initiate against a third party, if that claim or lawsuit includes any special damages for an illness or injury. You also agree that any settlement or compromise of a claim or lawsuit will not terminate our rights to subrogation, unless we have provided prior written consent. Before any settlement is reached, you must notify the third party or parties of the amount of Dean's subrogation claim. Dean will not pay for any fees or costs associated with a claim or lawsuit, unless we give prior, express written approval. If Dean erroneously pays for or provides medical services which are the result of a work related illness or injury for which the employee may be eligible for workers' compensation benefits, you agree to reimburse Dean to the extent of the value of such services.

Timely Submission of Claims

If you receive services from a Health Care Provider that require you to submit the claim to us for reimbursement, you must obtain an itemized bill and submit it to:

Dean Health Plan, Inc.
Attention: Claims Department
P.O. Box 56099
Madison, WI 53705

Claims must be submitted within 60 days after the services are received, or as soon as possible. If we do not receive the claim within 12 months after the date it was otherwise required, we may deny coverage of the claim. If you do not notify a Provider that you have coverage with Dean, and this failure results in a claim not being filed in a timely manner, we may deny coverage of the claim. If Dean is the secondary payor, the time limit for timely submission begins with the date of notice of payment or rejection by the primary payor.

End of Section VI.

VII. COORDINATION OF BENEFITS (COB)

*Certain terms used in this Section are defined throughout and/or in the **Glossary of Terms***

Dean Coordination of Benefits Provision

This Coordination of Benefits (COB) provision applies when a Member has coverage through more than one health plan. Please note that Dean coordinates benefits following Wisconsin's requirements.

Definitions: For the purposes of this COB provision only, the following terms are defined:

Allowable Expense is a health care service or expense covered in whole, or in part, by one or more Plans. For example, the cost difference between a private and semi-private hospital room is not an allowable expense, unless it is determined that the person's stay in a private hospital room is Medically Necessary.

Claim Determination Period is a Contract Period. However, this does not include any time of a Contract Period that a person is not covered under This Plan, or any time before this or a similar COB provision became effective.

Plan is any insurance policy, benefit program or other arrangement that provides benefits or services for medical or dental care. This includes:

1. Group or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes any HMOs, IPAs, prepaid group practices, PPOs or other prepayment, group practices or individual practice plans.
2. Governmental plans or coverage that is required or provided by law. This does not include state Medicaid plans, Medicare Supplement policies, or any plan whose benefits by law are in excess to those of any private insurance program or other non-governmental program.
3. Individual automobile "no-fault" contracts

Primary Plan will pay benefits for covered services as if no other coverage were involved.

Secondary Plan will determine its payment based on the benefits paid by the Primary Plan.

"This Plan" means the Dean Certificate you have been issued as a Member.

COB Information

At times we need information to coordinate benefits appropriately. We determine what information is needed and we obtain that information from other organizations or persons. We will only obtain the information needed to apply the COB rules. We may also provide necessary information to another organization or person in order to coordinate benefits. Medical records remain confidential as provided by state and federal requirements.

We may make a payment to another plan if that plan made a payment that Dean should have made. If we make such a payment on behalf of a Member, it will be considered a benefit payment for the Member's plan, and we will not pay that amount again.

Benefits listed in this Certificate are only available as long as the Policy and your coverage are in force. The Certificate must be read together with the Schedule of Benefits to ensure accurate information regarding coverage, obligations, and responsibilities under the Policy. If you are unsure if a service is covered, please call the Customer Care Center prior to having the service performed. Our Customer Care Center will attempt to assist you. However, no information provided by the Customer Care Center shall change or alter terms of this Certificate and your Schedule of Benefits. You must consult your Certificate and Schedule of Benefits to verify your coverage, obligations, and responsibilities under the Policy.

Additionally, we will recover any payment that exceeds the amount that should have been paid. We will recover the excess amount from any person or organization to whom, or on whose behalf, the payment was made.

Order of Benefit Determination Rules

This Plan's benefits will not be reduced if the following rules indicate that This Plan is primary. However, benefits may be reduced if the rules indicate that This Plan is secondary. The first rule that applies is the rule that will determine which insurance plan is primary.

1. **No coordination of benefits provision**
   If the other plan does not have a coordination of benefits provision, that plan will be primary.

2. **Non-dependent/Dependent**
   The plan that covers a person as an employee, Member or Subscriber (other than as a dependent), is primary. The plan that covers a person as the dependent of an employee, Member or Subscriber is secondary.

3. **Coordinating coverage for dependent children**
   If a dependent child has coverage through both parents' plans and the parents are not separated or divorced, the birthday rule is used to determine which plan is primary.

   a. ***The Birthday Rule:*** The plan of the parent whose birthday falls earlier in the calendar year is primary. If both parents have the same birthday, the plan that covered a parent for a longer period of time is primary.
   b. ***Exception to the Birthday Rule:*** If the other plan does not coordinate benefits by the birthday rule, benefits will be coordinated according to the other plan's COB provisions.

4. **Coordinating coverage for dependent children of divorced, legally separated parents or unmarried parents.**
   If a dependent child has coverage through both parents' plans and a court order awards custody of the child to one parent, benefits are coordinated as follows:

   a. First the plan of the parent who has custody of the child; then
   b. The plan of the spouse of the parent who has custody of the child; then
   c. The plan of the parent who does not have custody; then
   d. The plan of the spouse of the parent who does not have custody.

   If a court decree orders one parent to be responsible for health care expenses, the plan of that parent is primary. If a court decree states that both parents share joint custody but does not state which parent is responsible for health care expenses, the order of benefits will be determined by the birthday rule in "3." above. Note: We will only enforce rule "4." when we have actual knowledge of the court-ordered terms. Benefits will be coordinated according to the court-ordered terms only when we receive knowledge of those terms.

5. **Active/Inactive Employee**
   The plan that covers a Subscriber as an employee that is neither laid off or retired or as that employee's dependent is primary over the plan that covers the Subscriber as a laid off or retired employee or as that employee's dependent. If the other plan does not have this rule and as a result the plans do not agree on the order of benefits, this rule is ignored.

6. **Continuation Coverage**

Benefits listed in this Certificate are only available as long as the Policy and your coverage are in force. The Certificate must be read together with the Schedule of Benefits to ensure accurate information regarding coverage, obligations, and responsibilities under the Policy. If you are unsure if a service is covered, please call the Customer Care Center prior to having the service performed. Our Customer Care Center will attempt to assist you. However, no information provided by the Customer Care Center shall change or alter terms of this Certificate and your Schedule of Benefits. You must consult your Certificate and Schedule of Benefits to verify your coverage, obligations, and responsibilities under the Policy.

The plan that covers a Member as an actively at work employee or as that employee's dependent is primary over the plan that covers a Member through a continuation plan issued pursuant to state or federal law. If the other plan does not have this rule and as a result the plans do not agree, this rule will not apply.

7. **Longer/Shorter Length of Coverage**
   If none of the above rules apply, the plan that has covered the person for a longer period of time is primary.

Calculating Benefits When This Plan (Dean) Is Secondary

The benefits of This Plan may be reduced under this Section if there are one or more plans that are determined to be primary.

When we are the Secondary Plan, we will determine our reasonable charge. After the Primary Plan pays, we will pay either what is left of the reasonable charge or our regular benefit, whichever is less. We will not pay more than our reasonable charge. When the benefits of This Plan are reduced as described, each benefit is reduced in proportion and is then charged against any applicable benefit limit of This Plan.

Coordinating Benefits with Medicare

We will coordinate benefits with Medicare when a Member becomes eligible for Medicare benefits. In no case will our payment and Medicare's payment be more than the total allowable expenses. All plan Copays, Coinsurance, Deductibles, maximums, limitations, and exclusions apply to all benefits paid under This Plan.

The three ways a Member can be eligible for Medicare benefits are as follows:

1. **Reaching Age 65**
   A Member who reaches age 65 may become eligible for Medicare Parts A and B. Dean strongly suggests that you contact the employer through which This Plan was obtained and the Social Security office in your area for information regarding enrollment into Medicare before your 65th birthday. Once you reach age 65 and are eligible for Medicare benefits, we will coordinate benefits as follows:

   a. ***Subscriber "is" Active at Work/Active Status***
      If the Subscriber of This Plan is actively working (see definition of Eligible Employee in the **Glossary of Terms** Section) for an employer who is ***not*** subject to the Federal Age Discrimination in Employment Act (ADEA), and is age 65 or older and entitled to Medicare benefits, This Plan will be secondary to Medicare.
      If the Subscriber is Active at Work/Active Status for an employer who ***is*** subject to the ADEA, and a Member is age 65 or older and entitled to Medicare benefits, This Plan will be primary to Medicare.

   b. ***Subscriber is "not" Active at Work/Active Status***
      If the Subscriber of This Plan accepts a severance package, is retired or is on group continuation from an employer and a Member is age 65 or older and entitled to Medicare benefits, This Plan will be secondary to Medicare.

2. **Medicare Disability**
   If the Member is under age 65 and considered Medicare Disabled, and eligible for Medicare Parts A and B, This Plan will be secondary if the Subscriber is retired, not Active at Work/Active Status or if the Subscriber is Active at Work/Active Status for an employer with 99 or fewer employees. Benefits will be coordinated as described in the **Payment of Claims** subsection.

If the Member is under age 65 and considered Medicare Disabled and eligible for Medicare Parts A and B, This Plan will be primary if the Subscriber is Active at Work/Active Status for an employer with 100 or more employees. Benefits will be coordinated as described in the **Payment of Claims** subsection.

3. **End Stage Renal Disease**
   If the Member is diagnosed with End Stage Renal Disease (ESRD), This Plan will be primary to Medicare for 30 months from the initial month of Medicare eligibility.

   After 30 months have passed, Medicare will be primary and This Plan will be secondary. Medicare benefits are not limited to just ESRD treatment. Medicare coverage may end 12 months after maintenance dialysis is no longer needed or 36 months after a successful transplant.

   Please contact the Customer Care Center when you receive notice that you are no longer eligible for Medicare benefits.

   If the federal laws regarding the payment of benefits changes, and the determination of Medicare as a Primary Plan or Secondary Plan changes, This Plan will comply with those changes.

Payment of Claims

1. When we coordinate benefits as the Secondary Plan, we will coordinate after Medicare has processed the claim. If the Member is eligible for Medicare Parts A and B, but did not enroll in Medicare, we will coordinate benefits as if the Member was enrolled in Medicare. The Member will be responsible for all services that would have been covered by Medicare. All plan Copays, Deductibles, maximums, limitations, and exclusions will still apply to benefits coordinated with Medicare.
2. When we coordinate benefits as the Primary Plan, we will process the claims without consideration of what Medicare may cover. All plan Copays, Deductibles, maximums, limitations, and exclusions will apply. If, at any time, Dean becomes the Secondary Plan (e.g., due to retirement or change in employer), we will then coordinate benefits as the Secondary Plan. In the event Dean pays claims as primary, but determines at a later time, whether during or after the termination of This Plan, that Medicare should have paid the claims as primary, Dean will recover such payments. The recovery date of these claims will be retroactive to one year from the date of discovery.

End of Section VII.

VIII. GRIEVANCES AND APPEALS

*Certain terms used in this Section are defined throughout and/or in the **Glossary of Terms***

A. Complaint

A complaint is any expression of dissatisfaction expressed to us by the Member, or a Member's authorized representative, about us or our Providers with whom we have a direct or indirect contract. Dean Health Plan, Inc. **(Dean)** takes all Member complaints seriously and is committed to responding to them in an appropriate and timely manner.

If you have a complaint regarding any aspect of care or decision made by us, please contact the Customer Care Center. We will document and investigate your complaint and notify you of the outcome of your complaint. If your complaint is not resolved to your satisfaction you can file a grievance. Any written expression of dissatisfaction will automatically be addressed as a grievance. (See "**B. Grievance**")

B. Grievance

A Grievance is dissatisfaction with the provision of services or claims practices that is expressed in writing to us by, or on behalf of, a Member. To file a grievance, you must submit it to us in writing within 180 days of the date of service or claims practice being grieved at:

Dean Health Plan, Inc.
Attention: Grievance Committee
P.O. Box 56099
Madison, WI 53705

Upon receipt of the grievance, the Grievance Committee will acknowledge it within 5 business days. Our acknowledgment letter will advise you of your right to submit written comments, documents or other information regarding your grievance; to be assisted or represented by another person of your choice; to appear before the Grievance Committee; and the date and time of the next scheduled meeting, which will not be less than 7 calendar days from the date of your acknowledgment and within 30 calendar days of receiving the grievance. If you choose to appear before the Committee, you must notify us. If you are unable to appear before the Committee, you do have the option of scheduling a conference call.

Your grievance will be documented and investigated. All grievances will be resolved within 30 calendar days of receipt.

C. Urgent Grievance

If the grievance involves the need for urgent care, we will resolve that grievance within 24 hours of receiving it, according to Dean's criteria which is based upon the urgent care grievance provisions of state law. The request may be oral or written.

D. Independent External Review

You may be entitled to an independent external review of a final Coverage Denial Determination involving care that has been determined not to meet the Policy's requirements for medical necessity, appropriateness, health care setting,

level of care, effectiveness of care or where the requested services are considered Experimental or Investigational treatment. Pre-Existing Condition determinations and Policy Rescissions are also eligible for independent external review. You may designate another person or party to appeal on your behalf. However, we will need your written permission to discuss your claim and/or related information with another person or party.

In order to request an independent external review, the following criteria must be met:

1. The amount of the total claim liability must exceed $292.
2. Unless the reason for an independent external review is urgent, the request must be submitted to us in writing and the request must include the name of the certified Independent Review Organization (IRO) you have chosen. You can obtain a list of the certified IROs by calling the Customer Care Center or by contacting the Office of the Commissioner of Insurance at (608) 266-3585, 1-800-236-8517, or by accessing their web site at www.oci.wi.gov
3. The request for an independent external review must be made within 4 months of the date of the completion of the grievance process.
4. You must exhaust all appeal/grievance options before requesting an independent external review. However, if we agree with you that the matter should proceed directly to independent review, or if you need immediate medical treatment and believe that the time period for resolving an internal grievance will cause a delay that could jeopardize your life or health, you may ask to bypass our internal grievance process. In urgent and emergent situations, your request will be processed on an expedited basis.

The decision of the IRO is binding on both Dean and you, except for the decision regarding a Pre-existing Condition exclusion denial determination or a Rescission, which are not binding on you. Requests for benefits beyond those in your benefit package are not eligible for independent external review.

E. Office of the Commissioner of Insurance

You may resolve your problem by taking the steps outlined above. You may also contact the Office of the Commissioner of Insurance, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the Office of the Commissioner of Insurance by writing to:

Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873

or you can call (608) 266-0103 or toll free at 1-800-236-8517, and request a complaint form.

End of Section VIII.

Benefits listed in this Certificate are only available as long as the Policy and your coverage are in force. The Certificate must be read together with the Schedule of Benefits to ensure accurate information regarding coverage, obligations, and responsibilities under the Policy. If you are unsure if a service is covered, please call the Customer Care Center prior to having the service performed. Our Customer Care Center will attempt to assist you. However, no information provided by the Customer Care Center shall change or alter terms of this Certificate and your Schedule of Benefits. You must consult your Certificate and Schedule of Benefits to verify your coverage, obligations, and responsibilities under the Policy.

IX. INDEX

Benefits listed in this Certificate are only available as long as the Policy and your coverage are in force. The Certificate must be read together with the Schedule of Benefits to ensure accurate information regarding coverage, obligations, and responsibilities under the Policy. If you are unsure if a service is covered, please call the Customer Care Center prior to having the service performed. Our Customer Care Center will attempt to assist you. However, no information provided by the Customer Care Center shall change or alter terms of this Certificate and your Schedule of Benefits. You must consult your Certificate and Schedule of Benefits to verify your coverage, obligations, and responsibilities under the Policy.

End of Section IX.

END OF DOCUMENT.