Dean Health Plan, Inc.

Individual Member Policy and Benefit Summary

Dean Health Plan, Inc
1277 Deming Way, Madison, WI 53717
(608) 828-1301, (800)-279-1301 or TTY at (877) 733 - 6456

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

www.deancare.com

IMPORTANT INFORMATION

INDIVIDUAL PLAN
HMO MEMBER POLICY

IMPORTANT NOTICE CONCERNING STATEMENTS IN THE APPLICATION FOR YOUR INSURANCE

Please read the copy of your Application you received when you were approved for this Plan. Omissions or misstatements in your Application could cause an otherwise valid claim to be denied. Carefully check the Application and notify us within 10 days of receipt of your Application if any information shown on the Application is not correct and complete or if any requested medical history has not been included. The Application is part of your contract. The insurance contract was issued on the basis that the answers to all questions, and any other material information shown on the Application, are correct and complete. This policy is subject to rescission for 2 years after submission of your Application should it be determined that a member made material misrepresentations on the Application.

YOUR RIGHT TO RETURN THIS POLICY

Please read this Policy immediately. If you are not satisfied with it for any reason, you can return it within 10 days from receipt of this Policy. Upon return, this Policy becomes invalid. We will refund any premium payments you have made.

GUARANTEED RENEWABILITY

This Policy is guaranteed renewable, unless one of the exceptions in the **When Coverage Ends** subsection in the **Coverage Information** Section of this Policy becomes applicable. Dean cannot change any of the terms of your Policy without your approval unless the change is required by law, except premium rates may change as stated in the **Changes in Premium** subsection in the **Policy Renewal and Premium Payment Terms** Section of this Policy.

This Policy limits Eligible Expenses received from a non-plan provider to a maximum allowable fee. The maximum allowable fee may be less than the billed amount. Please refer to the **Benefit Provisions** Section of this Policy for further information on maximum allowable fees. If you have any questions, please contact our Customer Care Center.

HEALTH SAVINGS ACCOUNT

NOTE: If you obtain a Health Savings Account (HSA) after your initial enrollment in this Individual Policy, please contact our Customer Care Center for further information about how this Policy works with HSAs. You may call (800)-279-1301 or TTY at (877) 733 - 6456.

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I. Managed Care Provisions

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

Why Choose Dean?

ACCESS TO CARE

The Dean Health Plan, Inc. (Dean) service area includes 20 counties over southern Wisconsin. We have numerous plan providers in our service area that can provide you with care. You also have access to our free 24-hour nurse line, Dean-On-Call, at 1-800-57-NURSE (1-800-576-8773) or (608) 250-1393. Please note that Dean-On-Call nurses do not provide medical care or treatment, and base their advice on information provided at the time of the call. The service area is the geographic area included within the boundaries of Adams, Columbia, Crawford, Dane, Dodge, Fond du Lac, Grant, Green, Green Lake, Iowa, Jefferson, Juneau, Lafayette, Marquette, Richland, Rock, Sauk, Walworth, Waukesha, and Vernon counties in the State of Wisconsin. The service area is subject to change. If there is a change, notification will be sent out in our quarterly member newsletter, Notables.

PLAN PROVIDERS

Dean uses providers in a specific geographic area. Being part of Dean means that you agree to use providers that are part of our provider network. Any care that you need should be provided by plan doctors, specialists, and hospitals.

When you become a member of Dean, you may choose one of these plan providers to be your primary care provider (PCP). A PCP is a plan provider who evaluates the member's total health needs and provides personal medical care in one or more medical fields. When medically needed, the PCP preserves the continuity of care. The PCP is also in charge of coordinating other provider health services.

Please note that physician/patient relationships will not be affected, or interfered with, by virtue of the fact that plan 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 the Policy's benefit provision requirements in order to be covered.

Why Choose a Plan Provider?

Please see the **Benefit Provisions** Section for more information.

Plan Providers sign a Participating Provider Agreement with Dean Health Systems to provide one or more benefits and are listed in the most current edition of our Dean Provider Directory (which is also located on-line at www.deancare.com). Plan Providers include, but are not limited to: physicians (MD), dentists (DDS), podiatrists (DPM), optometrists (OD), chiropractors (DC), hospitals, doctors of osteopathy (DO), and pharmacies.

If you use our plan providers, covered charges will be paid based on the contract agreement between Dean and the plan provider (subject to any deductible, coinsurance, and copay provisions outlined in this Policy). If there is a difference between our contracted amount and the amount that the provider bills us, you will not be responsible for that amount.

Non-Plan Providers are providers who do not have a signed Participating Provider Agreement, and they are not listed in the most current edition of our Dean Provider Directory. Dean has no ability to monitor the quality of care provided by a non-plan provider.

If you see a non-plan provider, or you are out of the service area, for emergency or urgent care, charges will be paid up to our maximum allowable fee (see the Benefit Provisions Section). If there is a difference between the amount we pay and the amount that the provider bills, you will be responsible for that amount. If you receive care from a non-plan provider that you cannot obtain from a plan provider and have an authorized written referral to see this non-plan provider, payment for covered charges will be based on the actual charges, and not the maximum allowable fee.

Prior authorization by our Medical Affairs Division is required both to determine medical appropriateness and whether services can be provided by plan providers.

Important Note: Dean generally [requires/allows] the designation of a Primary Care Provider. You have the right to designate any Primary Care Provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Dean designates one for you. For information on how to select a Primary Care Provider, and for a list of the participating Primary Care Providers, contact Dean at (800)279-1301 or TTY (608) 827-4086. For children, you may designate a pediatrician as the Primary Care Provider. You do not need Prior Authorization from Dean or from any other person (including a Primary Care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Dean at (800)279-1301 or TTY (608) 827-4086.

Prior Authorization

Please follow the instructions below when seeking services from Non-Plan Providers:

Prior Authorization must be obtained for certain procedures/services 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

- All Non-Plan Provider services
- 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 than16 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 a Non-Plan Provider, including a non-plan facility.

The process for obtaining Prior Authorization for Services <u>provided by Non-Plan Providers</u> 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 for Non-Plan Providers: 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 for Non-Plan Providers: If you fail to obtain Prior Authorization for any service requiring such an authorization, you, the Member, will be responsible for 100% of the total cost of services received from any Non-Plan Provider. It is the responsibility of the Member to ensure that Prior Authorization has been obtained for all services, including facility confinements and/or surgery.

End of Section I.

II. Glossary of Terms

The terms below have special meanings in this Policy.

ADVERSE DETERMINATION:
A determination by, or on behalf of, Dean 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." 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, $[296].

CLINICAL CANCER TRIAL:
A clinical cancer trial must satisfy the following criteria: (1) a 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.

CONFINEMENT/CONFINED:
(a) The period of time between admission to and discharge from an inpatient or outpatient hospital, AODA residential center, skilled nursing facility, or licensed ambulatory surgical center on the advice of your physician, and discharge there from; or (b) the time spent in a hospital receiving emergency care for illness or injury. Hospital swing bed confinement is considered the same as confinement in a skilled nursing facility. If the member is transferred to another facility for continued treatment of the same or related condition, it is one confinement.

CONTRACT YEAR:
The 12-month period beginning with the Effective Date or the Renewal Date of the Policy. All Eligible Expenses and all payment amounts listed in this Certificate are per Contract Year, unless otherwise stated in the specific benefit section within this Policy.

COPAY:
This is 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's contracted fee or maximum allowable fee, and applies at the benefit level. Copay amounts are not applied toward the Policy maximum out-of-pocket expense.

COVERAGE DENIAL DETERMINATION:
Coverage denial determination means an Adverse Determination, an Experimental Treatment Determination, a preexisting condition exclusion denial determination, or the Rescission of a policy or certificate.

COVERED EXPENSE:
A charge for a service or supply that is medically necessary and eligible for payment under the Plan.

EFFECTIVE DATE:
The date that a Dean subscriber, or any qualified dependent, becomes enrolled and entitled to the benefits specified in this Policy, as shown on the records of Dean

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 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 51.15 and any other applicable state regulatory requirements to be covered under this policy.

EXPERIMENTAL OR INVESTIGATIONAL SERVICES, TREATMENTS OR PROCEDURES:
Those services, treatments or procedures that are determined by our Medical Affairs Division (with input from the Utilization Management Committee or the Quality Improvement Committee, as part of our quality improvement structure) to meet, as of the date of treatment, one or more of the following criteria:
1. The services, treatments or procedures involve the administration of a drug or the use of a device that is not approved by the U.S. Food and Drug Administration for treatment of the medical condition or symptoms for which the drug is being administered or the device is being used.
2. Reliable evidence shows that the services, treatments or procedures are subject to ongoing Phase I, II or III clinical trials or under study to determine their maximum tolerated dose, their toxicity, their safety, their efficacy or their efficacy as compared with a standard means of treatment or diagnosis.
3. Reliable evidence shows that the prevailing opinion among experts regarding the services, treatments or procedures is that further clinical trials are necessary to determine their maximum tolerated dose, their toxicity, their safety, their efficacy or their efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence shall mean only published reports and articles in authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or by another facility studying substantially the same services, treatments or procedures; or the written informed consents used by the treating facility or by another facility studying substantially the same services, treatments or procedures.

EXPERIMENTAL TREATMENT DETERMINATION:
A determination by, or on behalf of, Dean 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." is determined to be experimental under the terms of the health benefit plan.
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, $[296].

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 shares no genetic material with the child with which she is impregnated.

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 Plan benefits within the scope of their license.

HOSPICE CARE:
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
Provides core services, which include:
   a. Nursing services 24 hours a day, seven days a week
   b. Medical social worker services
   c. Dietary, spiritual, and bereavement counseling
3. Provides or arranges for other services as related to the terminal illness when approved by your provider, which may include:
   a. Services of a practitioner, such as a nurse, social worker or physician
   b. Physical, occupational or speech therapy
   c. Home health aide services
   d. Inpatient care in a facility when needed for pain control and other acute symptom management
   e. Pharmacy services, and
   f. Durable medical equipment

HOSPICE FACILITY:
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:
   a. Doctor of Medicine (MD)
   b. Registered Nurse (RN)
   c. Licensed or certified social worker
   e. Pastoral or other counselor
   f. 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.

IMMEDIATE FAMILY:
The member's spouse, as well as dependents, parents, brothers, and sisters of the member and their spouses.

LONG-TERM THERAPY:
Therapy extending beyond 2 months that is determined, by our Medical Affairs Division, to be primarily maintenance therapy.

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:
Please refer to the Benefit Provisions Section for the definition of Maximum Allowable Fee under this Plan.

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 acceptable 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.

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).

MEMBER:
A subscriber and/or dependent.

POLICY:
The Policy, Application, and any other applicable documents issued to the subscriber.

PREMIUMS:
The monthly fees established by Dean, and charged to the subscriber 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 authorization will state the type and extent of the treatment or benefit authorized. A verbal or written request does not constitute prior authorization.

PROOF OF GOOD HEALTH:
The review of you and your dependents medical history as listed in the health history section of your Application. On the basis of this information, Dean has the authority to provide, or not to provide, you and any of your dependents with the health insurance offered through this Policy. Dean has the authority to retract our prior acceptance if your answers are not truthful. We will attach a copy of the Application to your Policy.

QUALIFIED DEPENDENT:
Please refer to the **Benefit Provisions** Section, "Qualified Dependents" provision for the definition of Qualified Dependent under this Plan.

REFERRAL REQUEST:
A request form that is filled out by a primary care provider and recommends treatment for a member by another health care provider. The completed form is submitted to our Medical Affairs Division for approval. A verbal request for treatment does not constitute a referral request. Payment of services is subject to any Policy limitations. A referral request does not guarantee payment of services received.

RENEWAL DATE:
The date on which this Policy renews coverage. The Renewal Date for this Policy is July 1. This means that the first period of coverage under this Policy may be less than 12 months in duration.

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.

SOCIAL SECURITY NUMBER:
An identifying number which was assigned to you by the United States Social Security Administration.

SUBSCRIBER:
An individual, whose complete Application and prepaid premium are accepted by Dean and who has been approved through medical underwriting.

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

End of Section II.

III. Benefit Provisions

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

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 the terms of your Policy. You must consult this document to verify your coverage, obligations and responsibilities under the Policy.

If this Policy has a deductible or coinsurance amount it will be indicated below. [Policy deductible and maximum out-of-pocket expense amounts are combined between Plan and Non-Plan Providers.]

Policy Deductible:* This is the amount of Covered Services that the Member or family must pay, during the period until your Renewal Date and during each Contract Year thereafter, before Dean will pay for Covered Services as specified in this Policy. The deductible is applied to either the Dean contracted fee [or to the maximum allowable fee]. * If you purchased this Policy in connection with a Health Savings Account, and you selected family coverage, the full family deductible must be satisfied before benefits are payable under this Policy.	**$5,000 Single** **$10,000 Family**
Policy Coinsurance: This is a specified percentage of Covered Expenses that a Member or family is required to pay, during the period until your Renewal Date and during each contract year thereafter, each time covered services are provided, subject to any maximums specified in this Policy. The coinsurance amount is subject to any maximums specified in this Policy. This amount is applied to the Dean contracted fee [or maximum allowable fee]. Coinsurance amounts are applied toward the Policy maximum out-of-pocket expense.	**0%**
Maximum Out-of-Pocket Expense: This is the maximum out-of-pocket amount, per Contract Year. This amount includes the deductible and plan coinsurance amounts applied to covered services. Copays, non-covered services, and benefit reduction amounts are not included in this maximum out-of-pocket expense.	**$5,000 Single** **$10,000 Family**
Pre-Existing Condition Exclusion: *(Not applicable to children under age 19 or adopted children.)* This is a disease or physical or mental condition that manifested itself through medical diagnosis or treatment, in the 6 month period prior to the enrollment date. [Pre-existing conditions will be covered 12 months after the enrollment date.]	**[Applicable]**
Policy Lifetime Maximum:	**[Unlimited]**
Maximum Allowable Fees: This means the maximum amount payable based upon the average charge for the same service provided by other providers of a similar type, training, and experience, in the same or similar geographical area, and should not exceed the fees that the provider would charge any other payor for the same services. Other	

factors (e.g., complexity, degree of skill, or type of provider) may also determine a maximum allowable fee.
You may obtain information about maximum allowable fees prior to having a service performed. Ask your provider for the procedure code(s) and the amount(s) the provider will charge. Then, call our Customer Care Center and request information regarding maximum allowable fees. Within 5 days of receiving your request, we will notify you whether the service is covered and if it is subject to any Plan provisions (e.g., deductibles, copays, maximum allowable fees or pre-existing conditions).

Benefits listed in this Policy are only available as long as this Policy is in force.

Complications of Pregnancy:

Maternity services are not covered under this Policy. However, complications of pregnancy are treated the same as any other medical illness or sickness and benefits for these services are available under this Policy as they would be for any related illness or sickness. For specific information on how a particular service is covered, please read through the benefit information provided in this **Benefit Provisions** Section.

A "complication of pregnancy" means a condition requiring a hospital confinement, the diagnosis of which is distinct from pregnancy but may be adversely affected by pregnancy, such as medical and surgical conditions not caused by the pregnancy. "Complication of pregnancy" will also include non-elective cesarean section, treatment of ectopic pregnancy, and spontaneous loss of pregnancy, occurring during a period of gestation in which viable outcome is **not** possible. The term "complication of pregnancy" will NOT include conditions caused by or associated with the management of a pregnancy, such as hyperemesis gravidarum, pre-eclampsia or other similar conditions.

Should a delivery and hospital stay occur as a result of a complication of pregnancy, please make sure to read the below "Newborns' and Mothers' Health Protection Act of 1996," information. Also, please note coverage for newborns will only be provided if the newborn is added to the Policy as a covered dependent.

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 pre-certification for services that would allow you to reduce your out-of-pocket costs. For information on pre-certification, please call Dean's Customer Care Center.

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 of 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 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.

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.

[**Full-time student**: The qualified dependent: (a) must be enrolled in an accredited post-high school academic, professional or trade school that provides a schedule of courses or classes, and (b) his or her principal activity is the procurement of an education.]

[**Full-time status** is defined by the institution 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 institution (usually 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.]

Dental, Accidental Injury to Teeth, Oral Surgery Services and TMD

IMPORTANT	**HERE ARE SOME IMPORTANT THINGS TO KEEP IN MIND ABOUT THESE BENEFITS:** ► There are a limited set of dental, accidental injury, oral, and temporomandibular disorder related services provided under this Policy. We do not cover any of these services unless described in this subsection. ► All services must be arranged and/or provided by plan providers, including dentists or TMD providers, unless otherwise stated in this subsection. ► Services for TMD must be prior authorized by our Medical Affairs Division.	IMPORTANT

Dental, Extraction of Natural Teeth, and Replacement with Artificial Teeth due to an Accidental Injury.	**You Pay**
Covered Services: Dental services that are provided by a plan provider and are required to treat sound natural teeth* that are injured while you are covered under this Policy. 1. Tooth extractions and replacement with artificial teeth because of an accidental injury. 2. Services for tooth extractions must begin within 18 months after the accident. A "sound natural tooth" refers to 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.	**"Nothing after deductible is met"**

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. 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. *Also, see "Non-Covered Services" at the end of this subsection.* All medically necessary hospital and 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: • The Member is a child under the age of 5; • The Member has a chronic disability, or • The Member has a medical condition that requires hospitalization or general anesthesia for dental care.	
Temporomandibular Disorders (TMD)	
Covered Services: Surgical Services. We will cover diagnostic procedures and medically necessary surgical or non-surgical treatment for the correction of TMD, if both the following apply: 1. The condition is caused by congenital, developmental or acquired deformity, disease or injury; and 2. The procedure or device is reasonable and appropriate for the diagnosis or treatment of this condition, and the purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction. This includes coverage for prescribed intraoral splint therapy devices. Nonsurgical services will be covered as indicated within each corresponding section of this Policy.	**"Nothing after deductible is met"** **There is a $1,250 combined nonsurgical benefit maximum for all TMD services.**
Non-Covered Services for Dental, Accidental Injury to Teeth, Oral Surgery Services and TMD	**You Pay**
1. Any dental or oral surgery procedure not listed in this subsection. 2. All services performed by dentists and other dental services, except those listed as covered in this Dental, Accidental Injury to Teeth, Oral Surgery Services and TMD section. 3. Correction of malocclusion. 4. Cosmetic or elective orthodontic care, periodontic care or general dental care. 5. Restoration, such as crowns and root canals. 6. Tooth damage due to eating, chewing or biting. 7. All charges or costs exceeding a benefit maximum. 8. Dental implants.	**[100%]**

Emergency Care, Urgent Care and Out-of-Plan Care

IMPORTANT	HERE ARE SOME IMPORTANT THINGS TO KEEP IN MIND ABOUT THESE BENEFITS: ► All services must be arranged and/or provided by a plan provider, whenever possible, when you are in the service area. ► Claim payments for non-plan 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 1-800-57 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.	IMPORTANT

Emergency Care	You Pay
Emergency Room (facility charge) [copay is waived once you have stayed in the hospital for 24 hours or longer] You may be responsible for other charges in addition to this facility copay. All other services received in conjunction with an emergency room visit will be paid in accordance with the corresponding sections of this Policy.	**"Nothing after deductible is met"**
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, as determined by our Medical Affairs Division, that is needed because the Member's condition exhibits 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 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 Policy. **What to do in case of emergency:** EMERGENCIES OUTSIDE OUR SERVICE AREA: If you require emergency care while you are outside the service area and cannot return, please go to the nearest medical facility. You must notify our Customer Care Center as soon as possible when you receive emergency care from a non-plan provider. EMERGENCIES WITHIN OUR SERVICE AREA: Most of the time, you will be able to receive emergency care from a plan provider. However, if you are unable to reach a plan provider, you should go to the nearest medical facility for assistance. If you seek emergency or urgent care from a non-plan provider, call our Customer Care Center as soon as possible and tell us where you are receiving emergency	

care. **If any emergency care results in a hospital admission to a non-plan hospital**, you or the hospital must call us by the next business day following the admission. Failure to notify Dean, when notification is reasonably possible, could result in you being financially responsible for part or all of the services.	
Urgent Care	**You Pay**
Covered Services: Urgent care services You may be responsible for other charges in addition to this facility copay. All other services received in conjunction with an urgent care visit will be paid in accordance with the corresponding sections of this Certificate.	**"Nothing after deductible is met"**

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 plan 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. It does not include care that can be postponed until you can safely travel to the service area to receive care from a plan 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. Please call our Customer Care Center as soon as possible after seeing a non-plan provider. When we receive a claim for the services, it will be reviewed by our Medical Affairs Division to determine if the diagnosis or symptoms were urgent. If the diagnosis or symptoms were urgent, payment 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 at 1-800-57 NURSE (1-800-576-8773) or (608) 250-1393.

Emergent or Urgent Out-of-Plan Care	**You Pay**
Covered Services: If a member is temporarily outside the service area the following services will be covered subject to maximum allowable fees, as explained in the Managed Care and Benefit Provisions sections, and to any applicable copays, deductibles, and/or coinsurance amounts: 1. The initial emergency or urgent care services are covered, subject to Policy provisions. For follow-up care, please see below.	**"Nothing after deductible is met"**
2. The urgent care services are covered, subject to Policy provisions. For follow-up care, please see below.	**"Nothing after deductible is met"**
3. Non-emergency or non-urgent care will be covered if the care is medically necessary and prior authorized by our Medical Affairs Division. Dean has no ability to monitor the quality of care provided by a non-plan provider if the member elects not to return to the service area for care from a plan provider.	**"Once deductible is met, then 50% coinsurance -**

	Does not apply to out of pocket max"
Wisconsin Full-time Student Mental Health Out-of-Plan Care	**You Pay**
Outpatient mental health and AODA services: If a full-time student, attending school in Wisconsin but outside the service area, chooses not to see an out-of-area designated provider, we will provide benefits for a clinical assessment by a non-plan provider if prior authorized by our Medical Affairs Department. Please see the "**OUTPATIENT Mental Health and AODA" provision, under subsection "Mental Health and Alcohol and Other Drug Abuse (AODA) Services,**" for service and benefit maximum.	**[Nothing up to 5 visits]**

Wisconsin Full-time Student 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 the plan 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 Subscriber's coverage under this Plan is discontinued or otherwise terminated; or
6. One year has elapsed since the Qualified Dependent's continuation coverage has begun and the dependent has not returned to school full time.

Follow-up Care	**You Pay**
Follow-up care is care that is received after the initial emergency or urgent condition has been stabilized. Follow-up care is subject to the maximum allowable fees, as explained in the **Managed Care** and **Benefit Provisions** sections. Follow-up care must be prior authorized before it is received outside of the service area. **Covered Services:** All follow-up care, other than the initial urgent and emergency services outside the service area, will be covered if the care is prior authorized. No coverage is available for follow-up care that is not prior authorized.	**"Once deductible is met, then 50% coinsurance - Does not apply to out of pocket max"**

Facility Services (Hospital Inpatient Care, Outpatient Care and Skilled Nursing Facility), Home Health and Hospice

IMPORTANT	**HERE ARE SOME IMPORTANT THINGS TO REMEMBER ABOUT THESE BENEFITS:** ► All services must be arranged and/or provided by a plan provider, unless otherwise stated in this subsection. ► 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 when provided by a plan provider. ► Follow-up care to treat the same injury may require a written referral request from your primary care provider (PCP) in order to be covered, if the services are not provided by your PCP.	IMPORTANT

Inpatient Hospital	You Pay
Covered Services: Hospitals and specialty hospital services for a semi-private room, ward or intensive care unit, and any medically necessary miscellaneous hospital expenses. Please see Benefit Provisions, "Dental, Accidental Injury to Teeth, Oral Surgery Services and TMD" section of this Policy for coverage of inpatient services pertaining to dental care. Inpatient rehabilitative admission. An initial period, and following periods, of inpatient rehabilitative medical confinement resulting from the same or related illness or injury is an "episode of care."	**"Nothing after deductible is met"** **[Coverage limited to 90 days confinement per episode of care]**

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 the above definition to non-plan services.

HOSPITAL CONFINEMENT, OR BEING CONFINED IN A HOSPITAL, means being registered as a patient in a hospital on the advice of a plan 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.	
Non-Covered Services: 1. Take home drugs and supplies dispensed at the time of hospital discharge. 2. Hospital stays that are extended for reasons other than medical necessity (e.g., lack of transportation, lack of caregiver or inclement weather). 3. 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). 4. Any surgical treatment or hospitalization for the treatment of morbid obesity. 5. Personal comfort or convenience items such as in-hospital television, telephone, private room, housekeeping and homemaker services, and meal services as part of home health care. 6. All charges or costs exceeding a benefit maximum	**[100%]**
Outpatient Hospital or Ambulatory Surgical Center Services	**You Pay**
Covered Services: Surgical services This surgical benefit may also include services provided in a physician's office.	**"Nothing after deductible is met"**
AMBULATORY SURGICAL CENTER: 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 center must be Medicare-certified and licensed or registered to provide the treatment by the state in which it is located, as appropriate.	
Skilled Nursing Facility	**You Pay**
Covered Services: [*copay waived when admitted directly from hospital*] 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. Care must meet our definition of skilled care and a written referral request is required if services are provided by someone other than the PCP. The maximum benefit per Contract Year for this coverage includes coverage provided by any health care payor, including Medicare, if applicable.	**[Coverage limited to 30 days confinement per Contract Year]** **"Nothing after deductible is met"**
SKILLED CARE IS: 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. Examples of patients who may require skilled care are those with complicated diabetes, recent stroke resulting in speech or ambulatory difficulties, fractures of the hip, and patients requiring complicated wound care. In the majority of cases, "skilled care" is necessary for only a limited period of time. After that, most patients have recuperated enough to be cared for by "non-skilled" persons such as spouses, children or other family or relatives. 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. Coverage for skilled care services are determined by our Medical Affairs Division.	
Non-Covered Services: 1. Any nursing facility services other than skilled nursing services. This includes community re-entry programs. 2. Respite and residential care. 3. 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; and (i) 24-hour supervision for potentially unsafe behavior. 4. Charges for injectable medications administered in a nursing home when the nursing home stay is not covered by Dean. 5. All charges or costs exceeding a benefit maximum	**[100%]**
Home Health Care	**You Pay**
Covered Services: 1. Each period of 4 straight hours, in a 24-hour period of home health aide services, counts as one home care visit. 2. 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. 3. Home care, if a physician certifies 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; or (c) a state licensed or Medicare certified home health agency or certified rehabilitation agency will provide or coordinate the home care. 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.	**"Nothing after deductible is met"** **, Limited to 40 visits]**
HOME CARE means one or more of the following: 1. Home nursing care that is given part-time or from time to time. It must be given or supervised by a registered nurse. 2. Home health aide services that are given part-time or from time to time. Services 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. 3. Physical, respiratory, occupational, and speech therapy. 4. Medical supplies, drugs, and medicines prescribed by a plan physician 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. 5. Nutritional counseling that is medically necessary as part of the home care plan and provided or supervised by a registered or certified dietitian. 6. 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.	
Non-Covered Services: 1. All charges or costs exceeding a benefit maximum. 2. Respite and Residential care.	**[100%]**

3. 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.	
Detoxification Services	**You Pay**
Covered Services: 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 as detoxification services.	**"Nothing after deductible is met"**
Hospice Care	**You Pay**
HOSPICE CARE: 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 Provides core services, which include: a. Nursing services 24 hours a day, seven days a week b. Medical social worker services c. Dietary, spiritual, and bereavement counseling 3. Provides or arranges for other services as related to the terminal illness when approved by your provider, which may include: a. Services of a practitioner, such as a nurse, social worker or physician b. Physical, occupational or speech therapy c. Home health aide services d. Inpatient care in a facility when needed for pain control and other acute symptom management e. Pharmacy services, and f. Durable medical equipment **HOSPICE FACILITY:** 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: a. Doctor of Medicine (MD) b. Registered Nurse (RN) c. Licensed or certified social worker e. Pastoral or other counselor f. 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.	**"Nothing after deductible is met** **Prior authorization required"**

General Medical and Diagnostic Services

IMPORTANT	**HERE ARE SOME IMPORTANT THINGS TO REMEMBER ABOUT THESE BENEFITS:** ► All services must be arranged and/or provided by a plan provider, unless otherwise stated in this subsection. ► Second opinions are covered as long as there are benefits available and the covered services are provided by a plan provider and a written referral request is obtained if needed. Prior authorization from our Medical Affairs Division is required if out of network second opinion(s) are requested. ► To receive maximum coverage you must receive medically necessary covered services from your primary care provider (**PCP**) or from a plan specialty provider. ► No coverage is available for charges for missed appointments, or charges for telephone consultation by or between providers. ► Any service that is covered under this Policy 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 Policy.	IMPORTANT

Ambulance Services	**You Pay**
Covered Services: 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.	**"Nothing after deductible is met"**
Non-Covered Services: 1. All charges or costs exceeding a benefit maximum 2. Ambulance service that is not an emergency transportation, including non-emergency air transportation, unless prior authorized by our Medical Affairs Division. 3. Charges for, or in connection with, any other form of travel, unless otherwise stated in this Section. 4. Air transportation that does not meet the criteria established by our Medical Affairs Division.	**[100%]**
Anesthesia Services	**You Pay**
Covered Services: Anesthesia services provided in connection with covered services under this Policy.	**"Nothing after deductible is met"**
Non-Covered Services: Any anesthesia services provided for non-covered services, unless specifically listed as a covered benefit within this Policy.	**[100%]**
Autism	**You Pay**
Please contact our Customer Care Center for coordination of care assistance. **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	**"Nothing after deductible is met"**

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.	**[Unlimited or Coverage limited to $50,000 per Contract Year for intensive-level services and $25,000 per Contract Year for non-intensive-level services]**

• 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 of for the use of 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 Limitations and Exclusions*** ****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 Rx Rider, if applicable, and/or Section III, BENEFIT PROVISIONS, Medical Supplies, Durable and Disposable Medical Equipment, Insulin and Disposable Diabetic Supplies for more information***	
Chiropractic Services	**You Pay**
Covered Services: 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	**"Nothing after deductible is met"**
Non-Covered Services: 1. Maintenance or long-term therapy. 2. Cervical pillows 3. Spinal decompression devices 4. Chiropractic services performed by a non-plan provider, unless otherwise stated above.	**[100%]**
Diagnostic & Ancillary Services	**You Pay**
Covered Services: 1. Lab tests 2. X-rays 3. Lead poisoning levels for children between the ages of birth and 6 years. 4. Non-preventive colonoscopy	**"Nothing after deductible is met"**

5. Non-preventive mammography screening 6. Pelvic examinations 7. Non-preventive papanicolaou (Pap) tests Services of a nurse practitioner are covered in connection with mammography screening, pelvic exams and pap tests	
Outpatient Facility MRI, per visit	**"Nothing after deductible is met"**
Outpatient Facility CAT Scan, per visit	**"Nothing after deductible is met"**
Outpatient Pet Scans	**"Nothing after deductible is met"**
Hearing Services	**You Pay**
Covered Services: • Hearing exams to determine if correction is needed. • 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 for infants and children under 18, including procedures for implantation, with Prior Authorization by our Medical Affairs Division	**"Nothing after deductible is met"**
Non-Covered Services: 1. Hearing aids and batteries for hearing aids. 2. All charges or costs exceeding a benefit maximum.	**[100%]**
Office Visits	**You Pay**
Covered Services: Office calls and consults in the office or an urgent care center (other than mental health services).	**"Nothing after deductible is met"**

Well child care through age 17.	**[Nothing][**
Outpatient Physical, Speech and Occupational Therapy	**You Pay**
Covered Services: Medically necessary services, as a result of illness or injury. 1. 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, within [12 months] after the beginning of treatment. 2. Speech and hearing screening examinations are limited to screening tests for determining the need for correction. 3. Therapists must be licensed.	**"Nothing after deductible is met"; Limited to 50 visits per contract year**
LIMITED BENEFIT FOR DEVELOPMENTAL DELAY	
Covered Services: 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. Benefits are limited to an evaluation visit and 3 follow-up visits, per therapy, per Contract Year.	**"Nothing after deductible is met"; Limited to 4 visits per contract year**
Non-Covered Services for Outpatient Physical, Speech and Occupational Therapy and Developmental Delay:	**You Pay**
1. Vocational rehabilitation, including work hardening programs. 2. 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 this "LIMITED BENEFIT FOR DEVELOPMENTAL DELAY" provision. 3. 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 this "LIMITED BENEFIT FOR DEVELOPMENTAL DELAY" provision. 4. Therapy services such as recreational or educational therapy, physical fitness or exercise programs. 5. Biofeedback, except when prior authorized by the Medical Affairs Division. 6. Services to enhance athletic training or performance. 7. Services or treatment received in an intermediate care facility. 8. All charges or costs exceeding a benefit maximum	**[100%]**
Phase II Cardiac Rehabilitation	**You Pay**
Covered Services: Up to 18 visits that include rehabilitation services for myocardial infarction, coronary by-pass surgery or stable angina pectoris.	**"Nothing after deductible is met"**
Preventive Services	**You Pay**
Preventive services are defined as routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.	**Nothing**

Additionally, in order to be covered under the plan, preventive services must: • 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 Plan Provider; and • Not be performed for the primary reason of diagnosing or treating an illness or injury. (See Diagnostic Services Section.) **Covered Expenses:** • Physical health examinations (adult and well-child care through age 17) • Appropriate screenings and counseling as recommended by the following guidelines: o 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 o 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 o 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 o 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.***	
Pulmonary Rehabilitation	**You Pay**
Covered Services: Up to 16 visits that include medically appropriate rehabilitation services for chronic and restrictive lung disease, pulmonary vascular disease or lung resections.	**"Nothing after deductible is met"**
Radiation Therapy	**You Pay**
Covered Services: Accepted therapeutic methods, such as x-rays, radium and radioactive isotopes. Please contact Dean Customer Care Center for a list of approved providers.	**"Nothing after deductible is met"**

Surgical Services	You Pay
Covered Services Surgical procedures required to treat an illness or accidental injury. 1. Covered services include: preoperative and postoperative care, necessary assistant and consultant services, and elective sterilization, unless otherwise specified. 2. If a member elects to have breast reconstruction surgery in connection with a 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.	**"Nothing after deductible is met"**
Non-Covered Services: 1. Procedures, services, medications and supplies related to sex transformation. 2. Reversal of voluntary sterilization procedures and related procedures. 3. 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. 4. Any surgical treatment or hospitalization for the treatment of morbid obesity.	**[100%]**
Vision Care Services	**You Pay**
Covered Services: An initial lens per surgical eye following cataract surgery is covered if purchased from a plan provider. Preventive vision exams/services	**"Nothing after deductible is met"**
Non-Covered Services: 1. Refractive eye surgery and radial keratotomy. Astimatic Kerototomy is covered when prior authorized by the Medical Affairs Division. 2. Eyeglasses; contact lenses (except as stated otherwise in this provision), including the fitting of contact lenses; and replacement lenses. 3. Orthoptics (e.g., eye exercise training). 4. All charges or costs exceeding a benefit maximum.	**[100%]**

Medical Supplies, Durable and Disposable Medical Equipment, Insulin and Disposable Diabetic Supplies

IMPORTANT	HERE ARE SOME IMPORTANT THINGS TO REMEMBER ABOUT THESE BENEFITS: ► Copays apply per purchase or rental. ► Supplies or equipment must be prescribed for treatment of a diagnosed illness or injury, and arranged and/or provided by, or purchased from, a plan durable medical equipment provider. 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. ► Diabetic self-management educational programs must be prior authorized by our Medical Affairs Division. ► Any item that is covered under this Policy 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 Policy.	IMPORTANT

Medical Supplies	You Pay
Covered Services: Medical supplies and durable and disposable equipment. Examples include: 1. Wheelchairs 2. Enteral nutrition supplies 3. Hospital beds 4. Infusion therapy 5. Skin and wound care supplies 6. Oxygen and respiratory equipment 7. Walking aids, e.g. walkers, crutches and canes 8. Orthopedic products, e.g. braces and splints 9. Urological and ostomy supplies 10.Orthotics and prosthetics as prior authorized by the Medical Affairs Division 11.Intrauterine contraceptive devices (IUD) received from a clinic or physician 12. Implantable birth control devices (e.g., Norplant). 13. Other Medical Supplies as determined by our Medical Affairs Division.	**"Nothing after deductible is met"**
INSULIN AND DISPOSABLE DIABETIC SUPPLIES	
Covered Services: Insulin, supplies, and any prescription medication, must be for the treatment of diabetes, purchased from plan providers, and are subject to copays and dispensed in a [30-day] quantity. 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. Diabetic durable equipment, insulin infusion pumps, and blood glucose monitors are subject to the durable medical equipment guidelines and copay specified in this Policy. Insulin infusion pumps are limited to one pump per Contract Year, and the member must	**"Nothing after deductible is met"**

use the pump for 30 days before purchasing.	
Tobacco Cessation	**You Pay**
Covered Services: Prescription medication and/or Nicotine Replacement Therapy ("the patch"), and refill, as approved by Dean.	**[$10 copay per fill]**
Non-Covered Services for Medical Supplies	**You Pay**
1. Medical supplies and durable medical equipment for comfort, personal hygiene and convenience, regardless of the medical necessity of such items, such as, but 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 2. Home testing and monitoring supplies and related equipment, except those used in connection with the treatment of diabetes 3. 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 4. Back up equipment (a second piece) 5. Replacement of lost or stolen items 6. All charges or costs exceeding a benefit maximum 7. Elastic support or anitiembolism stockings 8. Shoes or orthotics not custom-made or that are purchased over the counter. 9. Any durable medical equipment or supplies used for work, athletic or job enhancement purposes 10. Cranial bands for misshapen heads (e.g., Dynamic Orthotic Cranioplasty) 11. 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.	**[100%]**

Mental Health and Alcohol and Other Drug Abuse (AODA) Services

IMPORTANT	**HERE ARE SOME IMPORTANT THINGS TO KEEP IN MIND ABOUT THESE BENEFITS:** ► 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. ► The benefit for Mental Health and AODA Services is combined for Outpatient and Inpatient care, and is limited as stated in this Policy. ► Court-ordered services may not be covered if those services are NOT performed by a plan provider, unless the services are a result of an Emergency Detention or on an emergency basis, and you or your provider notifies Dean within 72 hours after the initial services. ► All services must be arranged and/or provided by a plan provider, unless otherwise stated in this subsection. ► Related diagnostic services are not subject to these mental health and AODA benefits. Please see the "Diagnostic Services" provision, under subsection General Medical and Diagnostic Services, for benefit information. ► Mental Health and AODA benefits have a combined annual benefit maximum	IMPORTANT

OUTPATIENT Mental Health and AODA	**You Pay**
Covered Services: Medically necessary services up to the maximum number of days; 2 group therapy visits equal 1 individual therapy visit.	**"Nothing after deductible is met; $1,000 max benefit per contract year"**
INPATIENT CARE Mental Health and AODA	**You Pay**
Covered Services: Medically necessary services, as determined by our Medical Affairs Division. Medically necessary inpatient detoxification services are considered medical and are, therefore, NOT applied to this limitation. Please see Detoxification provision under the Facility Services (Hospital Inpatient Care, Outpatient Care and Skilled Nursing Facility), Home Health and Hospice Subsection for benefit information.	**"Nothing after deductible is met; $2,000 max benefit per contract year"**
Follow-up Outpatient Services	**You Pay**
Covered Services: One prior authorized post discharge outpatient follow-up visit with a plan provider if you have exhausted your Mental Health/AODA benefits, as described in this Subsection, during your covered inpatient care or at the time you are discharged from covered inpatient care.	**[$0]**
Non-Covered Services for Outpatient, Inpatient Mental	**You Pay**

Health and AODA and Follow-up Outpatient Services:	
1. Biofeedback, except when prior authorized by The Medical Affairs Division 2. Family counseling for non-medical reasons 3. Gambling addiction 4. Halfway houses 5. Hypnotherapy 6. All charges or costs exceeding a benefit maximum 7. Long-term or maintenance therapy 8. Marriage counseling 9. Phototherapy 10. Residential care 11. Unauthorized post discharge follow-up	**[100%]**

Transplants and Kidney Disease Services		
IMPORTANT	**HERE ARE SOME IMPORTANT THINGS TO REMEMBER ABOUT THESE BENEFITS:** ► Please see the "You Pay" column to determine what benefits are available, if any, for each transplant. ► Except for corneal transplants, all transplant services, including transplant work ups, must be prior authorized by our Medical Affairs Division, and provided at a Dean approved facility. ► 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 this Policy. ► 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.	**IMPORTANT**
Transplant Services		**You Pay**
Covered Services: <u>All transplant coverage is based upon the below disease-specific medical conditions. Unless otherwise specified in this Policy, the following transplants are covered</u>: **Allogeneic (donor to self) and Autologous (self to self) bone marrow transplantations, including stem cell support/rescue:** Example conditions include, but are not limited to, the treatment of: aplastic anemia, acute leukemia, severe combined immunodeficiency (adenosine deaminase deficiency and idiopathic deficiencies), Wiskott-Aldrich syndrome, infantile malignant osteopetrosis (Albers-Schoenberg disease or marble bone disease), Hodgkins and non-Hodgkins lymphoma, combined immunodeficiency, chronic myelogenous leukemia, pediatric tumors (based		**"Nothing after deductible is met"**

upon individual consideration), neuroblastoma, multiple myeloma or myelodysplastic syndrome. **Corneal:** For treatment of corneal diseases causing significant visual impairment, pain or risk of loss of vision due to infection or impending perforation. Example conditions include, but are not limited to: Fuchs' corneal dystrophy, aphakic/pseudophakic corneal edema, keratoconus, post-infectious or post-traumatic scarring, and conditions causing an irregular refractive surface which is either not correctable with a contact lens or the member cannot wear a contact lens. **Heart:** Example conditions include, but are not limited to, the treatment of: congestive cardiomyopathy, end-stage ischemic heart disease, hypertrophic cardiomyopathy, terminal valvular disease, congenital heart disease (based upon individual consideration), cardiac tumors (based upon individual consideration), myocarditis, coronary embolization or post-traumatic aneurysm. **Heart-Lung:** Example conditions include, but are not limited to, the treatment of: end-stage cardiac and pulmonary disease unresponsive to medical management (primary pulmonary hypertension, Eisenmenger's syndrome, cystic fibrosis, left or right ventricular disease associated with an elevated pulmonary vascular resistance or severely impaired pulmonary function). **Liver:** For children with biliary atresia. Example conditions include, but are not limited to, the treatment of: extrahepatic biliary atresia, inborn error of metabolism (alpha-1-antitrypsin deficiency, Wilson's disease, glycogen-storage disease, tyrosinemia, hemochromatosis), primary biliary cirrhosis, hepatic vein thrombosis, sclerosing cholangitis, post-necrotic cirrhosis or chronic active hepatitis (HBe Ag negative), or alcoholic cirrhosis (if patient has abstained from alcohol consumption for 6 or more months), epithelioid hemangioepithelioma, poisoning, polycystic disease, or primary hyperoxaluria. **Lung:** Example conditions include, but are not limited to, the treatment of: select end-stage pulmonary disease unresponsive to medical management with good cardiac function (idiopathic fibrosis, toxic exposure, fibrosing alveolitis, sarcoidosis, primary pulmonary hypertension, alpha-1 antitrypsin deficiency, and emphysema).	
Kidney Disease Treatment	**You Pay**
Covered Services: 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 you under Medicare or under any other insurance coverage you may have.	**"Nothing after deductible is met" [No Annual or Lifetime Limit]**
Non-Covered Services for Transplant Services and Kidney Disease Treatment	**You Pay**
1. All charges or costs exceeding a benefit maximum	**[100%]**

2. Any transplants, and all related expenses, not outlined as covered in this subsection. 3. Services and supplies in connection with covered transplants that are not prior authorized by our Medical Affairs Division. 4. Any experimental or investigational transplant or any other transplant-like technology not listed. 5. Any resulting complications from these and any services and supplies related to such experimental or investigational transplantation or complications, including, but not limited to: high dose chemotherapy, radiation therapy, or immunosuppressive drugs. 6. Transplants involving non-human or artificial organs.	

General Exclusions and Limitations	You Pay 100 %
1. Acupuncture, dry needling and prolotherapy. 2. Autopsy. 3. Chelation therapy for atherosclerosis, except as prior authorized by our Medical Affairs Division. 4. Coma Stimulation programs. 5. Court ordered care, unless medically necessary and otherwise covered under this Plan. 6. Cytotoxic testing and sublingual antigens in conjunction with allergy testing. 7. Services required for employment, licensing, insurance, adoption, participation in athletics. 8. 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. 9. Services provided by members of the subscriber's immediate family or any person residing with the subscriber. 10. Holistic medicine and any other form of alternative medicine. 11. Lyme disease vaccination. 12. Massage therapy. 13. Swim or pool therapy. 14. Services and supplies furnished by a government plan, hospital, or institution unless by law you must pay. 15. Items or services required as a result of war or any act of war, insurrection, riot, terrorism or sustained while performing military service. 16. 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; (c) the treatment of flexible flat feet; or (d) for any treatment or services in connection with any of these. 17. 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. 18. 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. 19. 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.	

20. Hair analysis (unless lead or arsenic poisoning is suspected).
21. Obesity-related services, including any weight loss method, unless specifically covered under this Policy.
22. 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.
23. Any hospital service or medical care not listed in this Policy.
24. Outpatient prescription drugs, except those prescriptions otherwise covered under this Policy.
25. Services and supplies rendered outside the scope of the provider's license, not recommended or approved by a provider, or services and supplies not medically necessary.
26. An expense incurred before the supply or service is actually provided unless prior authorized by the Medical Affairs Division.
27. 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.
28. Services provided in conjunction with the diagnosis and treatment of infertility.
29. Maternity services and prenatal and postpartum care, including services directly related to deliveries, Cesarean sections, medically necessary abortions and miscarriages. (This does not include complications of pregnancy as required by Wisconsin law.)
30. Treatment, services or supplies for a non-member traditional surrogate or gestational carrier.
31. All charges or costs exceeding a benefit maximum.
32. Collection and storage of sperm and eggs outside the course of treatment for, and diagnosis of, infertility.
33. 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.
34. All charges or costs related to internet and phone consultations.
[35.] [Travel immunizations.]

End of Section III.

IV. Coverage Information

*Certain terms used in this Section are defined in the **Glossary of Terms** Section*

Effective Date of Coverage

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

For a Subscriber:
The first day of the month following approval by Dean Health Plan, Inc. (Dean). Premium for the first month of coverage must be received prior to the effective date of coverage.

For Qualified Dependents:

1. The first day of the month following approval by Dean of proof of good health for all dependents (other than newborns and adopted children). For a newly acquired spouse and stepchildren, coverage will be effective on the date of marriage if application is made within 31 days of the date of marriage and proof of good health is approved by Dean. A qualified dependent will not become effective unless, and until, coverage for the subscriber is in effect.

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 Dean receives the application after 60 days of birth or placement in the home, coverage will be subject to underwriting approval. 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.

"**Qualified Dependent**" is defined in the **Benefit Provisions** Section.

(Medical expenses incurred prior to your effective date of coverage are excluded.)

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 us immediately. These changes include, but are not limited to:
1. Eligibility for Medicare.
2. Coverage under other health insurance.
3. Loss of eligibility for coverage due to divorce or death of the subscriber.
4. The addition of newly acquired qualified dependents.
5. For qualified dependents, reaching the maximum dependent age.
6. A change of dependent eligibility to include termination of parental rights.

Failure to report these changes to us on a timely basis (31 days from the date the change occurs) may result in having to provide proof of health, claims being denied or incorrect premiums being collected.

When Coverage Ends

Coverage under this Policy will end on the earliest of the following dates, unless otherwise specified in this Policy:
1. The last day of the month, if you request in writing a termination of coverage prior to the end of that month. (If you intended to end your coverage, but did not provide us with your written request before the last day of the month, at your request, we will retroactively end your coverage to the last

day of the previous month. We will not retroactively end your coverage if you incurred any claims during this time period.)
2. The date of Policy termination or non-renewal.
3. The date the member is called to active duty status in the military.
4. The date of a member's disenrollment, as stated in the Dean Disenrollment subsection.
5. For grandchildren of the subscriber, the date the Subscriber's qualified parent dependent child reaches age 18 or otherwise loses eligibility or coverage.
6. The last day of your grace period, if the entire monthly premium due is not paid to us during the grace period.
7. For qualified dependents, the last day of the month following the subscriber's death.
8. 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.

9. 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 maximum dependent 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.

A mentally or physically disabled child may continue coverage under your family coverage beyond the maximum dependent age stated in this Policy, as set forth in the definition of "**Qualified Dependent**" (in the **Benefit Provisions** Section). 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.

Your Policy coverage can also be termed if Dean elects to discontinue this type of Policy in Wisconsin. If we do elect to do so, we will notify you 90 days prior to the discontinuance date and will offer you the option of purchasing any other type of Individual Health Policy that we offer. If Dean discontinues offering all types of Individual Health Plans in Wisconsin, we will notify you 180 days prior to the discontinuance date.

Dean Disenrollment

A member may be disenrolled for any of the following reasons:
1. The member has failed to pay required premiums by the end of the grace period.
2. The member has committed acts of physical or verbal abuse which pose a threat to providers or other members of the organization.

3. The member has allowed a non-member to use their 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 no longer lives in 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 PCP, 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, coverage will terminate on the anniversary date of this Policy.

Your Right to Other Coverage

In some cases, if your coverage under this Policy ends, you will be eligible for other coverage from or through Dean. Upon completion of an application within 30 days of losing eligibility for coverage, the following member(s) may become a subscriber of his/her own Individual Conversion Policy:
1. The former spouse and dependents of the subscriber upon divorce or annulment.
2. A qualified dependent child if his/her coverage ends for any reason described in "When Coverage Ends."
We must receive notice that your coverage may end due to one of these causes. When we do, we will inform you in writing of your right to obtain an Individual Conversion Policy according to the law. You can then apply for an Individual Conversion Policy without proof of good health. If you apply and pay the appropriate premium within 30 days of the date you notify us that your coverage may end due to one of these causes, your coverage will be continuous from the date your coverage ended.

To obtain your own Individual Policy rather than the Individual Conversion Policy coverage, proof of good health must be received and approved by Dean.

End of Section IV.

V. Policy, Renewal, and Premium Payment Terms

*Certain terms used in this Section are defined in the **Glossary of Terms** Section*

Your Policy cannot be canceled because you have used benefits or overused benefits. However, we can change your Policy if we change all Dean Policies in this class of business.

We will renew this Policy until you turn age 65 AND are eligible for Medicare Parts A and B, unless we discontinue offering this type of Policy in Wisconsin. If we elect to discontinue this type of Policy we will notify you 90 days prior to the discontinuance date. We will offer you the option of purchasing any other type of Individual Health Policy that we offer. If we discontinue offering all types of Individual Health Plans in Wisconsin, we will notify you 180 days prior to the discontinuance date.

You can cancel your Dean Policy effective on the last day of any month, or as described in section **Coverage Information**, under subsection "**When Coverage Ends**". We will need written notification prior to the end of the month. If you end your Policy, it will not affect any outstanding claims incurred during the time that your Policy was in effect. We will not issue retroactive premium refunds.

Changes in Premium

We will not change your premium unless we change the premium of every member that we have issued this type of Policy to. The premium will increase if the subscriber or member changes age brackets. If there is a premium change, it will occur on the Policy Renewal Date. In the event of misrepresentation, Dean reserves the right to retroactively adjust premiums.

Premium Rates

The premium rates for this Policy were determined before your Application was accepted by us. We will notify you of a premium change at least 30 days before any renewal period. We will provide a 60-day notice of any premium increase of 25% or more.

Premium Notices

We will only bill you once when your premium is due.

Premium Due Date

This Policy will become effective as of the date stated in our letter of acceptance and if we have accepted your prepaid premium payment. After that, this Policy will be in force and will renew for future periods of coverage, as long as you pay your premiums on time. Premium payments are due by the 15th of the month before each renewal period.

Grace Period

Your grace period for paying premiums is 31 days from the first day of the month. Your Policy will remain in force during the grace period. Any claims for covered services incurred during the grace period will be deducted from, and applied to, the premium due for the grace period. If a premium payment is not received by the end of the grace period, your coverage under this Policy will terminate.

Reinstatement (after Policy cancellation for nonpayment of premium)

We will only allow you to reinstate this Policy one time. If we accept your premium payment without reservation and within one year after your Policy has been canceled, your Policy will be reinstated as of the date of our acceptance of that premium. This is called acceptance without reservation.

If we accept with reservation, it means that we deliver or mail a written statement of reservations to you within 45 days after we receive your premium payment. If your Policy is reinstated under the terms of this provision, or if we reinstate your Policy within one year after the date of termination, any claims for services between the date of termination and the effective date of reinstatement of this Policy will not be covered. No premium is payable for that period except to the extent that the premium is applied to a reserve for future losses.

In all other respects, this Policy shall be treated as an uninterrupted contract.

End of Section V.

VI. General Provisions

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

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 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 plan providers will use their best efforts to provide services and other covered benefits. However, neither Dean nor any plan 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 State Laws

Any provision that conflicts with the laws of the state in which we issue this Policy will conform to the minimum requirements of such laws.

Limit on Assignability of Benefits

This is your personal Policy. 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 ever cause prejudice against you. No action can be brought more than 3 years after the time we required written proof of loss.

Major Disaster or Epidemic

If a major disaster or epidemic occurs, plan 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 plan 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 non-plan 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. The Policy of Insurance 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 which indicates a fraudulent or intentional misrepresentation was made by you, or anyone acting on your behalf, when you applied for insurance, and the person knew, or should have known, that the representation was false and either:

1. We relied on the misrepresentation which was material; the misrepresentation 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 fraudulent or intentional 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 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 Policy; or be used in the prosecution or defense of a claim under this Plan.

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 one. By accepting coverage under the Policy, you have agreed to consent to any required examination.

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 plan,

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

Claims can be denied in whole, or in part, in the event of misrepresentation or fraud by you or your representative. Members must cooperate with us when we are investigating a claim. The member will be asked to assist us by:

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; and
3. Providing information about other insurance coverage and benefits.

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 plan 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, plan 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 Plan. All members have a right to access their medical records.

Severability

If any part of this Policy is ever prohibited by law, it will no longer apply. The rest of this 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 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 Plan, 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.

Time Limit on Certain Defenses

After 2 years from your original effective date, no misstatement on your Application or proof of good health form will be used to void this Policy, or to deny a claim beginning after the 2-year period expires. This does not apply to fraudulent misstatements made in the application or proof of good health form.

Timely Submission of Claims

If you receive services from a health care provider that requires that you 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, resulting 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

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

This Coordination of Benefits (COB) Section applies when a member has coverage through more than one health plan, such as a group-type or government plan, as described below. Please note that Dean coordinates benefits following all applicable federal and state laws.

Definitions: For the purpose of this COB Section, the following terms are defined:

Allowable Expense is a health care service or expense covered in whole, or in part, by a health plan. 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.

Group-Type or Government Plan is an insurance policy, benefit program or other arrangement that provides benefits or services for medical care. This includes:

Group: insurance contracts 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.

Governmental: Plan 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.

If we are the **Primary Plan**, we will pay benefits for covered services as if no other coverage were involved.

If we are the **Secondary Plan**, we will determine our payment based on the benefits paid by the Primary Plan.

Coordinating Benefits

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. Failure to provide the requested information could result in a delay in the processing of your medical claims. We may also provide necessary information to another organization or person in order to coordinate benefits. Medical records remain confidential as provided by state law.

Calculating Benefits When This Policy Is Secondary

When one or more group-type or government health plans are primary, the benefits of this Policy may be reduced under this Section.

As the secondary payer, 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 Policy are reduced as described, each benefit is reduced in proportion. It is then applied to any applicable benefit limit of this Policy.

When this Policy is the primary payer, we will pay the benefits described in this Policy.

Payment of Claims as Secondary Plan with:

Group type - When we coordinate benefits as the Secondary Plan, we will coordinate after the group-type plan has processed the claim. All Policy copays, deductibles, maximums, limitations, and exclusions will still apply to benefits coordinated with other plans.

Medicare - The Individual Plan sold by Dean Health Insurance will always be "secondary payer" to Medicare and we will coordinate after Medicare has processed the claim. This applies if the member is under age 65 and is enrolled in Medicare Part A and/or Part B due to a disability. Coordinating Medicare benefits does not apply to members over age 65 who are not eligible for Medicare Parts A and B.

If Dean Health Insurance discovers that it has paid any medical claims incorrectly, due to Medicare coverage, we have the right to recover all incorrectly paid medical claim amounts. All Policy copays, deductibles, maximums, limitations, and exclusions will still apply to benefits coordinated with Medicare.

End of Section VII.

VIII. Complaint, Grievance and Independent External Review Procedure

*Certain terms used in this Section are defined in the **Glossary of Terms** Section.*

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 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 our 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 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. If Dean is unable to resolve the grievance within 30 days, we may extend the time period by an additional 30 calendar days, upon our written notification to you. Our notification will include our reason for the extension and when we expect to resolve the grievance.

C. Independent External Review

You may be entitled to an independent external review of a final Coverage Denial Determination involving care which has been determined not to meet the Plans' requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness of care or where the requested services have been found to be experimental 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 [$296].
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 our 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 preexisting condition exclusion denial determination or a rescission, which are not binding on you (the insured). Requests for benefits beyond those in your benefit package are not eligible for independent external review.

D. Urgent Grievance

If the grievance involves the need for urgent care, we will resolve that grievance within 72 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.

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.

IX. Index

End of Section IX.

END OF DOCUMENT