Dean Health Plan, Inc.

Individual Member Policy and Benefit Summary

Dean Health Plan, Inc
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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 until you turn age 65 AND are eligible for Medicare Parts A and B, 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 Service Department.

HEALTH SAVINGS ACCOUNT

NOTE: If you obtain a Health Savings Account (HSA) after your initial enrollment in this Individual Policy, please contact our Customer Service Department for further information about how this Policy works with HSAs. You may call 1-800-279-1301 or (608) 828-1301.

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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 23 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. 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, Kenosha, Lafayette, Marquette, Racine, Richland, Rock, Sauk, Walworth, Washington, 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, pharmacies, and nurse practitioners.

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.

Non-emergency or non-urgent care will be covered at 50% of the maximum allowable fee if the care is medically necessary and prior authorized by our Medical Affairs Division. Dean has no responsibility for 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.

Any Policy limitations, such as deductibles, coinsurance, and copays, will apply. Please call our Customer Service Department for additional information on maximum allowable fees.

End of Section I.

II. Benefit Provisions

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

If this Policy has a deductible or coinsurance amount it will be indicated below.

Policy Deductible: * This is a specified dollar amount that the member or family is required to 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 contract year is the 12-month period following the Renewal Date of the Policy. The deductible is applied to either the Dean contracted fee or to the maximum allowable fee.	$1,000 single $2,000 family
Policy Coinsurance: This is a specified percentage 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. The contract year is the 12-month period following the Renewal Date of the Policy. The coinsurance amount is subject to any maximums specified in this Policy. The coinsurance amount is applied to the Dean contracted fee or maximum allowable fee. Coinsurance amounts are applied toward the Policy maximum out-of-pocket expense.	20%
***** 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.	
Out-of-Pocket Expense Maximum: This includes any Eligible Expenses the member is required to pay. The out-of-pocket expense maximum includes the deductible and plan coinsurance amounts applied to covered services. Copays, non-covered services, and benefit reduction amounts are not included in the out-of-pocket expense maximum.	$2,000 single $4,000 family
Pre-Existing Condition Exclusion: *(Applies only if the box to the right is marked. Not applicable to newborn or adopted children.)* Any health condition not disclosed on your application or during the initial health underwriting period that manifested itself through medical diagnosis or treatment during the 6-month period prior to the enrollment date will be subject to a pre-existing condition limitation. Pre-existing conditions will be covered for 12 months after the enrollment date.	[X]
Policy Lifetime Maximum:	$3,000,000

Maximum Allowable Fees:

Maximum allowable fee 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 Service Department 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. If you are unsure on whether a service is covered, please call our Customer Service Department prior to having the service performed.

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 Service Department.

Coverage of Newborn Infants:

Coverage is provided under this policy for newly born children of the insured from the moment of birth. The insured must follow the enrollment requirements for dependent children as outlined in Section III (Coverage Information) of this document. 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:

1. the legally married spouse of the subscriber;
2. the legal ward of the subscriber if the legal ward is unmarried, resides with the subscriber in a permanent parent-child relationship, and is dependent on the subscriber for at least 50% of his/her support and maintenance, to the age described in this Policy;
3. a biological child of an unmarried dependent child until the dependent child is 18 years of age; and
4. the subscriber's unmarried biological child, step child, adopted child, 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), to the age described in this Policy. All placements and adoptions must follow Wisconsin's placement and adoptions laws. Please contact our Customer Service Department if you have any questions.

A person is not a qualified dependent if he/she is:

1. eligible for coverage under the Policy as a subscriber;
2. on active duty with the military service, including national guard or reserves, other than for military duty of less than 31 days; or
3. in the case of a child, if such child provides 50% or more of his/her own support. 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 he is named on the birth certificate as the legal father.

A dependent child who is over the limiting age, as described in this Policy, may remain insured as a qualified dependent under this Policy if he/she meets certain requirements, provided family coverage remains in force under this Policy. The child must:

1. be unable to support himself/herself with a job because of a mental or physical disability;
2. have become disabled before he/she reached the limiting age; and
3. 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 Policy.

Qualified dependents are covered to the maximum age described below, unless otherwise specified in this Policy ("**Qualified Dependent**" is defined above.):

1. To the end of the calendar year in which age 19 is attained.
2. For an unmarried child who is a full-time student between the ages of 19 and 23, to the end of the calendar year in which full-time student status ceases.
3. To the end of the calendar year in which age 23 is attained for an unmarried child who is a full-time student (as determined by the standards of the school being attended) at an accredited school.

Full-time student: A qualified dependent that has attained the age stated in "1." immediately above, but has not attained the age stated in "3." immediately above. 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

Ancillary Services	**You pay**
Ancillary services may include, but are not limited to, the following services provided in addition to an office visit, urgent care visit, or emergency room visit: 1. Labs 2. x-rays 3. Anesthesia 4. Pathology 5. Radiology 6. Diagnostic Tests This Ancillary Services coverage amount is applicable to all services received in conjunction with benefits listed in the **Dental, Accidental Injury to Teeth, Oral Surgery Services and TMD** Subsection, unless specifically stated otherwise in this Subsection.	20% coinsurance after deductible is met
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. Includes 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. 3. The term "injured" does not include conditions resulting from eating, chewing or biting. 4. Treatment must begin within 90 days after the accident. *Also, see "Non-Covered Services" at the end of this subsection.*	20% coinsurance after deductible is met
Temporomandibular Disorders (TMD) **Subject to $1,250 maximum benefit**	
Covered Services: Surgical Services	20% coinsurance after deductible is met
Office Consult	20% coinsurance after deductible is met
Durable Medical Equipment	20% coinsurance after deductible is met

We will cover diagnostic procedures and medically necessary surgical or non-surgical treatment for the correction of TMD, if all of the following applies:

1. The condition is caused by congenital, developmental or acquired deformity, disease or injury; and
   The procedure or device is reasonable and appropriate for the diagnosis or treatment of this condition. The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction. This includes coverage for prescribed intraoral splint therapy devices.

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.	100%, Not Covered

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

Ancillary Services	You pay
Ancillary services may include, but are not limited to, the following services provided in addition to an office visit, urgent care visit, or emergency room visit: 1. Labs 2. X-rays 3. Anesthesia 4. Pathology 5. Radiology 6. Diagnostic Tests This Ancillary Services coverage amount is applicable to all services received in conjunction with benefits listed in the Emergency Care, Urgent Care and Out-of-Plan Care Subsection unless specifically stated otherwise in this Subsection.	20% coinsurance after deductible is met

Emergency Care	You pay
Covered Services:	
Emergency care at a Physician's Office	20% coinsurance after deductible is met
Emergency care at an Urgent Care center	20% coinsurance after deductible is met
Emergency Room (facility charge) *(copay waived when admitted to the hospital)*	20% coinsurance 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, which 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 Plan.

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 Service Department as soon as possible when you receive emergency care from a non-plan provider.

Emergency Care (continued…)

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 Service Department 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 at a Physician's office or Urgent Care Center	20% coinsurance 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 Service Department 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.	20% coinsurance after deductible is met
2. The urgent care services are covered, subject to Policy provisions. For follow-up care, please see below.	20% coinsurance 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.	20% coinsurance after deductible is met. Once the maximum out of pocket expense has been met, then 50% coinsurance applies to all remaining services. (50% coinsurance does not apply to Plan's maximum out of pocket)

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 we designate. 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 information.	Nothing up to 5 visits annually
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 Provision**s 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.	20% coinsurance after deductible is met. Once the maximum out of pocket expense has been met, then 50% coinsurance applies to all remaining services. (50% coinsurance does not apply to Plan's maximum out of pocket)

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.
- Private rooms are payable if medically necessary and approved by our Medical Affairs Division.
- 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

Ancillary Services	You pay
Ancillary services may include, but are not limited to, the following services provided in addition to an office visit, urgent care visit, or emergency room visit: 1. Labs 2. X-rays 3. Anesthesia 4. Pathology 5. Radiology 6. Diagnostic Tests This Ancillary Services coverage amount is applicable to all services received in conjunction with benefits listed in the **Facility Services (Hospital Inpatient Care, Outpatient Care and Skilled Nursing Facility), Home Health and Hospice** Subsection unless specifically stated otherwise in this Subsection.	20% coinsurance after deductible is met
Inpatient Hospital	**You pay**
Covered Services: 1. Hospitals and specialty hospital services for a semi-private room, ward or intensive care unit, and any medically necessary miscellaneous hospital expenses. 2. 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: a) The member is a child under the age of 5, b) The member has a chronic disability, or c) The member has a medical condition that requires hospitalization or general anesthesia for dental care.	20% coinsurance after deductible is met
Inpatient rehabilitative confinement. *(copay is waived if admitted from a hospital)* 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."	20% coinsurance after deductible is met (Coverage is limited to 90 days per Contract Year.)

Inpatient Hospital (continued...)	You pay
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 accredited as a hospital by the Joint Commission of 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. 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%, Not Covered
Outpatient Hospital or Ambulatory Surgical	**You pay**
Covered Services: Emergency care**:** first aid or an accident or sudden illness requiring immediate medical services	20% coinsurance after deductible is met
Surgical care at an Ambulatory Surgical Center or a physician's office	20% coinsurance 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 center must be 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. Care must meet our definition of skilled care. Confinement in a swing bed setting in a hospital is considered the same as a Skilled Nursing Facility confinement. 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.	20% coinsurance after deductible is met (Coverage is limited to 30 days per Contract Year.)

Skilled Nursing Facility (continued…)	You pay
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%, Not Covered
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.	20% coinsurance after deductible is met (Coverage is limited to 40 visits per Contract Year.)

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. They must be medically necessary as part of the home care plan and must consist solely of caring for the patient. A registered nurse or medical social worker must supervise them.
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. It must be medically necessary as part of the home care plan and a registered or certified dietitian must give or supervise these services.
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.

If a member was confined in a hospital just before care began, the home care plan must be approved, at its start, by the physician who was the primary provider of care during the hospital confinement. 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).

Home Health Care (continued...)	You pay
Non-Covered Services: 1. All charges or costs exceeding a benefit maximum. 2. Respite and Residential care. 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.	100%, Not Covered
Hospice Care	**You pay**
Covered Services: Coverage is provided for hospice care on a case by case basis. Care must be prior authorized by our Medical Affairs Division.	20% coinsurance after deductible is met
Non-Covered Services: 1. Respite and residential care.	100%, Not Covered
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.	20% coinsurance after deductible is met

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

Ancillary Services	**You pay**
Ancillary services may include, but are not limited to, the following services provided in addition to an office visit, urgent care visit, or emergency room visit: 1. Labs 2. x-rays 3. Anesthesia 4. Pathology 5. Radiology 6. Diagnostic Tests This Ancillary Services coverage amount is applicable to all services received in conjunction with benefits listed in the **General Medical and Diagnostic Services** Subsection unless specifically stated otherwise in this Subsection.	20% coinsurance after deductible is met
Ambulance Services	**You pay**
Covered Services: Established ground ambulance service. Ambulance transportation is covered to or from a hospital when the transportation is emergent/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.	20% coinsurance 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.	100%, Not Covered
Anesthesia Services	**You pay**
Covered Services: Anesthesia services provided in connection with covered services.	20% coinsurance after deductible is met
Non-Covered Services: Any anesthesia services provided for non-covered services, except in connection with dental care as listed in the **Facility Services** subsection.	100%, Not Covered

Childhood Immunizations	You pay
Covered Services: All appropriate and necessary immunizations for children through the age of 6, including, but not limited to: Diphtheria, Hemophilus Influenza B, Hepatitis B, Measles, Mumps, Rubella, Pertussis, Polio, Tetanus, and Varicella.	Nothing
Chiropractic Services	**You Pay**
Covered Services: Chiropractic services (you do not need a referral from your PCP).	20% coinsurance after deductible is met
Non-Covered Services: 1. Maintenance or long-term therapy. 2. Chiropractic services performed by a non-plan provider, unless otherwise stated above.	100%, Not Covered
Diagnostic 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. Sleep studies (diagnostic and portable) 5. Colonoscopy 6. Mammography screening 7. Pelvic examinations 8. Papanicolaou (Pap) tests *Services of a nurse practitioner are covered in connection with mammography screening, pelvic exams and papanicolaou tests.*	20% coinsurance after deductible is met
9. Outpatient Facility MRI, per visit	20% coinsurance after deductible is met
10. Outpatient Facility CAT Scan, per visit	20% coinsurance after deductible is met
Hearing Services	**You pay**
Covered Services: Hearing exams to determine if correction is needed.	20% coinsurance 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%, Not Covered
Office Visits	**You pay**
Covered Services: 1. Office calls and consults in the office or an urgent care center (other than mental health services). 2. Podiatry services for diabetics. 3. Preventive care office visits, or physical exams, for members age 18 and over, including related diagnostic and lab services.	20% coinsurance after deductible is met
4. Well child care through age 17, including related diagnostic and lab services.	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.	20% coinsurance after deductible is met (Coverage is 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.	20% coinsurance after deductible is met (Coverage is limited to 4 visits per Contract Year)
Non-Covered Services (for Outpatient Physical, Speech and Occupational Therapy and Developmental Delay)**:** 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 as provided by an approved therapist for treatment of approved conditions as determined by medical policy. 6. Services to enhance athletic training or performance. 7. All charges or costs exceeding a benefit maximum	100%, Not Covered
Phase II Cardiac Rehabilitation	**You pay**
Covered Services: Rehabilitation services for myocardial infarction, coronary by-pass surgery or stable angina pectoris.	20% coinsurance 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 Service for a list of approved providers.	20% coinsurance after deductible is met

Surgical Services	You Pay
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 lymph edemas. WHCRA 1998 • Prosthetics are subject to the benefits provided in the **Medical Supplies and Durable and Disposable Medical Equipment** subsection. • Coverage for lymph edemas is subject to the benefits provided under the "Outpatient Physical, Speech and Occupational Therapy" provision of this Subsection.	20% coinsurance 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%, Not Covered
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
Vision Care Services	**You pay**
Covered Services: An initial lens per surgical eye following cataract surgery is covered if purchased from a plan provider	20% coinsurance after deductible is met
Preventive vision exams/services	20% coinsurance after deductible is met
Medically necessary vision exams/services	20% coinsurance after deductible is met
Non-Covered Services: 1. Refractive eye surgery and radial keratotomy. 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%, Not Covered

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.
- Repairs, purchases or rentals over $200 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 aides, e.g. walkers, crutches and canes 8. Orthopedic products, e.g. braces and splints 9. Urological and ostomy supplies 10. Orthotics and prosthetics 11. Intrauterine contraceptive devices (IUD) received from a clinic or physician 12. Other medical supplies	20% coinsurance 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.	20% coinsurance after deductible is met
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 use the pump for 30 days before purchasing.	20% coinsurance after deductible is met

Medical Supplies (continued…)	You pay
Non-Covered Services: 1. Medical supplies and durable medical equipment for comfort, personal hygiene and convenience, 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. Implantable birth control devices (e.g., Norplant) 11. Cranial bands for misshapen heads (e.g., Dynamic Orthotic Cranioplasty)	100%, Not Covered

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, Transitional, 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 <u>combined</u> 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.	50% coinsurance after deductible is met (Coverage is limited to $1,000 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.	50% coinsurance after deductible is met (Coverage limited to $2,000 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.	Nothing
Non-Covered Services for Outpatient, Inpatient Mental Health and AODA and Follow-up Outpatient Services:	**You pay**
Non-Covered Services: 1. Biofeedback 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%, Not Covered

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
ALL TRANSPLANTS HAVE A COMBINED LIFETIME MAXIMUM PER MEMBER OF $1,000,000	
Covered Services: All transplant coverage is based upon the below disease-specific medical conditions. Unless otherwise specified in this Policy, the following transplants are covered: **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 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.	20% coinsurance after deductible is met
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.	20% coinsurance after deductible is met (Coverage is limited to $30,000 per Contract Year)

Transplant Services and Kidney Disease Treatment (continued…)	You pay
Non-Covered Services: 1. All charges or costs exceeding a benefit maximum 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.	100%, Not Covered

General Exclusions and Limitations	You Pay 100%
1. Acupuncture, dry needling and prolotherapy. 2. Autopsy. 3. Chelation therapy for atherosclerosis. 4. Coma Stimulation programs. 5. Court ordered care, unless medically necessary and otherwise covered under this Plan. 6. Cytotoxic testing 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 treatment rendered in connection with: (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. Services or supplies not medically necessary, not recommended or approved by a provider, or not provided within the scope of the provider's license. 23. 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. 24. Any hospital service or medical care not listed in this Policy.	You pay 100% for all listed exclusions and limitations

General Exclusions and Limitations *continued…*	You Pay 100%
25. Outpatient prescription drugs, except those prescriptions otherwise covered under this Policy. 26. Services and supplies rendered outside the scope of the provider's license. 27. An expense incurred before the supply or service is actually provided. 28. Services or supplies for, or in connection with, a non-covered procedure or service, including complications; a denied referral or prior authorization; or a denied admission. 29. Services provided in conjunction with the diagnosis and treatment of infertility. 30. 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. 31. Treatment, services or supplies for a third party or non-member traditional surrogate or gestational carrier. 32. All charges or costs exceeding a benefit maximum. 33. Collection and storage of sperm and eggs outside the course of treatment for, and diagnosis of, infertility.	You pay 100% for all listed exclusions and limitations

End of Section II.

III. 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 last day of the month in which you turn age 65 AND are eligible for Medicare Parts A and B. If you are not eligible for Medicare Parts A and B, you may retain this Policy.
4. The date the member is called to active duty status in the military.
5. The date of a member's disenrollment, as stated in the **Dean Disenrollment** subsection.
6. For grandchildren of the subscriber, the date your qualified parent dependent child reaches age 18 or otherwise loses eligibility or coverage.
7. The last day of your grace period, if the entire monthly premium due is not paid to us during the grace period.
8. For qualified dependents, the last day of the month following the subscriber's death.

9. For a qualified dependent child, on the earliest of the following:
   a. The date the child marries.
   b. When the child reaches the maximum dependent age as outlined in this Policy, while not a full-time student.
   c. The date the child becomes insured as a Dean subscriber.
   d. The date the child becomes an emancipated minor or the date the insured terminates parental rights and responsibilities for the child to another party.
10. For a divorced spouse or stepchildren, the end of the month in which a divorce judgment is entered. This will also apply in the case of an annulment.

Please 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. 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 III.

IV. Policy, Renewal, & 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 IV.

V. 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 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.

Misrepresentation/Right of Rescission

Omissions or misstatements 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 misrepresentation or a breach of affirmative warranty 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 or affirmative warranty which was material;
2. the misrepresentation was made with intent to deceive; or
3. the fact misrepresented or falsely warranted contributes to a loss under the Policy.

We will notify you within 60 days after acquiring knowledge of a misrepresentation or breach of affirmative warranty 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 a misrepresentation or breach of affirmative warranty, 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. If the services were received outside the United States, it is your responsibility to submit to us the original bill along with an itemized bill translated into English, and to indicate the appropriate exchange rate at the time the services were received.

End of Section V.

VI. 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 VI.

VII. 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 Service Department. 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 adverse 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. 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 $256.
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:
   a. The name of the certified Independent Review Organization (IRO) you have chosen.
   b. A $25 fee payable to the IRO you have chosen.

   You can obtain a list of the certified IROs by calling our Customer Service Department 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. If our decision is overturned in part or in whole, your $25 fee will be refunded to you. 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 VII.

VIII. 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, $256.

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 amount; either a dollar amount or percentage, 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.

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 other authorized person takes a child or juvenile into custody and the officer or authorized person has cause to believe that the 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 and Family 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, $256.

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.

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.

SKILLED CARE:
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.

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

SUBSCRIBER:
An individual under age 65, an individual age 65 or older who is not eligible for Medicare Parts A and B, 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 VIII.

IX. Index

End of Section VIII
END OF DOCUMENT