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

Medical Package ID: HMO03655
Certificate ID: HMO03655-PHA01573-0117

Please see your Health Insurance Benefit Summary (HIBS) document for your contract Effective Date.

This Schedule of Benefits and the Member Certificate and any riders **together with the employer Group Master Policy, applications, amendments and any other coverage documents** constitute the contract of insurance. These documents describe the essential features of your coverage and what rules you must follow to obtain covered services.

The employer Group Master Policy **may or may not include** expanded eligibility provisions, beyond those discussed in your Member Certificate. For example, the employer Group Master Policy indicates certain limits regarding dependent coverage. Please contact your employer's group administrator for details.

If necessary, the Schedule of Benefits and the Member Certificate and any riders are replaced on your group's renewal and supersede those which were previously issued. **Keep this Schedule of Benefits with your Member Certificate and any riders and refer to these documents when determining covered services.** Benefits will be administered in accordance with the coverage which was in effect at the time services were rendered. Services must always be Medically Necessary as determined by Us.

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

Policy Deductible per Contract Period:	
Single	**$0**
Family	**$0**
Policy Coinsurance after Deductible:	
Paid by Plan	**100%**
Paid by You	**0%**
Deductible and Coinsurance Limit per Contract Period:	
Single	**$0**
Family	**$0**
Out-of-Pocket Expense Maximum per Contract Period:	
Single	**$1000**
Family	**$2000**

- **All references to "Deductible" are referring to your Deductible, as defined in your group Member Certificate.**
- **Copay amounts do not apply to the Deductible and Coinsurance Limit.**
- **Copay amounts do apply to the maximum out-of-pocket expense.**

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

Qualified Dependent Children: Qualified Dependent Children who live outside the Service Area may see certain providers outside the Service Area and still have claims paid at an in-network rate. To locate these providers or for more details call Our Customer Care Center.

Please note: Some services/procedures require Prior Authorization; please see your Member Certificate for more details or call the Customer Care Center at (800) 279-1301 or TTY 711.

The Member is responsible for all costs that exceed the benefit maximum indicated for that service.

IMPORTANT: *This Schedule of Benefits is only a summary of your benefits. A complete description of the benefits and applicable exclusions and limitations are included in your Certificate. Benefits on this Schedule are provided only when services are received according to the terms set forth in the Certificate. You may view your Certificate any time at deancare.com.*

We cover services only when We find them to be Medically Necessary and consistent with the rules explained in your Policy documents. If a particular service, procedure or item is not specifically referenced in your Policy documents, coverage will be based on these rules. Generally, if not specifically referenced, the service, procedure or item will be subject to your Deductible and Policy Coinsurance amounts. Please contact the Customer Care Center if you have questions regarding whether and how a particular service, procedure or item is covered.

Your plan may have benefits in additional riders not described in the schedule of benefits, please see any attached benefit rider for more information about these benefits.

Benefits	You Pay
A. General Medical	
Office Visit (Primary Care Provider & Optometry)	$0 copay
Chiropractic Services	$0 copay
Specialty Office Visits	$0 copay
Diabetic Education	$0 copay
Preventive Services ***1 exam per Contract Period***	$0 copay

B. Medical Supplies/Durable Medical Equipment	
Medical Supplies and Durable Medical Equipment	20% coinsurance after deductible
Diabetic Supplies	20% coinsurance after deductible

C. Diagnostic Services	
X-Rays and Labs, including readings	0% coinsurance after deductible
Other Diagnostic Services	0% coinsurance after deductible

Benefits	You Pay
C. Diagnostic Services (continued)	
MRI/MRA ***Maximum of 3 copays per Member per Contract Period***	$50 copay
CAT Scans ***Maximum of 3 copays per Member per Contract Period***	$50 copay
PET Scans ***Maximum of 3 copays per Member per Contract Period***	$50 copay
Readings for: MRI/MRA, CAT Scans, and PET Scans	0% coinsurance after deductible
D. Hearing & Vision Services	
Hearing Services	0% coinsurance after deductible
Diagnostic Hearing Services	0% coinsurance after deductible
Hearing Aids – Adults ***Limited to one aid per ear every 36 months.***	0% coinsurance after deductible
Hearing Aids – Children through age 18 ***Limited to one aid per ear every 36 months.***	0% coinsurance after deductible
Cochlear Implants	0% coinsurance after deductible
Routine Vision Exam	$0 copay per visit
Non-Routine Vision Exam	$0 copay per visit
Vision Services	0% coinsurance after deductible
Diagnostic Vision Services	0% coinsurance after deductible
Eyeglasses – Children through age 18	Not Covered
E. Hospital & Surgical Services	
Inpatient Hospital ***Maximum copay expense per Contract Period is Unlimited single / Unlimited family***	0% coinsurance after deductible
Inpatient Rehabilitative Confinement ***Maximum copay expense per Contract Period is Unlimited single / Unlimited family*** ***Limited to 90 days per Member per Contract Period***	0% coinsurance after deductible
Detoxification Services ***Maximum copay expense per Contract Period is Unlimited single / Unlimited family***	0% coinsurance after deductible

Benefits	You Pay
E. Hospital & Surgical Services (continued)	
Outpatient Hospital ***Maximum copay expense per Contract Period is Unlimited single / Unlimited family***	0% coinsurance after deductible
Ambulatory Surgical Center ***Maximum copay expense per Contract Period is Unlimited single / Unlimited family***	0% coinsurance after deductible

F. Skilled Nursing Care Services	
Licensed Skilled Nursing (Excludes Custodial Care and Other Non-Covered Expenses) ***Maximum copay expense per Contract Period is Unlimited single / Unlimited family*** ***Limited to 30 days per Confinement***	0% coinsurance after deductible
Home Health Care ***Limited to 60 visits per Contract Period***	0% coinsurance after deductible
Hospice Care	0% coinsurance after deductible

G. Emergency & Urgent Care Services	
Ambulance Services	$0 copay
Emergency Room Services ***You may be responsible for other charges in addition to the facility Copay/Deductible/Coinsurance**** ***Copay is waived if admitted for Observation or Inpatient.***	$50 copay and/or 0% coinsurance after deductible
Urgent Care Services ***You may be responsible for other charges in addition to the visit Copay/Deductible/Coinsurance****	$0 copay and/or 0% coinsurance after deductible
* Other charges will result from services rendered by other providers who treated you during your urgent care or emergency room visit. These charges include, but are not limited to, physician visits, diagnostic services, procedures/treatments and various medical supplies. The amount charged for these services received from an Out-of-Network Provider may exceed the Maximum Allowable Fee in which case you will be responsible for paying the difference between the amount charged and the Maximum Allowable Fee.	

Benefits	You Pay
H. Section Intentionally Omitted	
I. Therapies & Rehabilitation Services	
Autism – Intensive – Physician and Facility Charge ***The Member is eligible for 4 cumulative years of intensive-level services***	$0 copay per therapy type per day
Autism – Intensive – Related Services ***The Member is eligible for 4 cumulative years of intensive-level services***	0% coinsurance after deductible
Autism – Non-Intensive – Physician and Facility Charge	$0 copay per therapy type per day
Autism – Non-Intensive – Related Services	0% coinsurance after deductible
Outpatient Physical, Speech and Occupational Therapy ***Limited to 60 visits per Contract Period (All therapies combined)***	$0 copay per therapy type per day
Habilitative Services ***Limited to 60 visits per Contract Period (All habilitative therapies combined)***	$0 copay per therapy type per day
Phase II Cardiac Rehabilitation	0% coinsurance after deductible
Pulmonary Rehabilitation	0% coinsurance after deductible
Radiation Therapy	0% coinsurance after deductible

J. Dental Services	
Trauma/Accidental Injury to Teeth	0% coinsurance after deductible
Oral Surgery Consult	$0 copay per visit
Oral Surgical Services	0% coinsurance after deductible
TMD Surgical Services	0% coinsurance after deductible
TMD Office Consult	$0 copay per visit
TMD DME	20% coinsurance after deductible

Benefits	You Pay
K. Behavioral Health & Addiction Services	
Inpatient/Residential Care – Behavioral Health & Addiction Services ***Maximum copay expense per Contract Period is Unlimited single / Unlimited family***	0% coinsurance after deductible
Outpatient Behavioral Health & Addiction Services	$0 copay
Intensive Outpatient/Day Treatment/Partial Hospitalization	0% coinsurance after deductible
L. Transplants & Kidney Disease Services	
Transplant Services ***Maximum copay expense per Contract Period is Unlimited single / Unlimited family***	0% coinsurance after deductible
Kidney Disease Treatment	0% coinsurance after deductible
M. Other Services	
Acupuncture ***Limited to 10 visits per Contract Period***	$0 copay
Anesthesia Services	0% coinsurance after deductible
Allergy Injections	0% coinsurance after deductible
Infertility Services ***$2,000 lifetime benefit maximum***	50% of $4,000
Maternity Services – Physician Services	0% coinsurance after deductible
Surgical Services	0% coinsurance after deductible

Dean Health Plan, Inc.
SCHEDULE OF BENEFITS
Prescription Drug Benefits

Pharmacy Package ID: PHA01573

Benefits	You Pay
Rider – Prescription Drugs	**Tier Option**
TIER 1 Outpatient Prescription Drugs Brand and Generic ***30-day supply***	$10 copay**
TIER 2 Outpatient Prescription Drugs Brand and Generic ***30-day supply***	$20 copay**
TIER 3 Outpatient Prescription Drugs Brand and Generic ***30-day supply***	Not Covered
Mail Order	90-day supply (Tiers 1 & 2) for 2 copays
Outpatient Prescription Drugs – Infertility	50% coinsurance

**Regardless of the tier your oral chemotherapy falls into you will never pay more than $100 for a 30 day supply, in compliance with the Wisconsin law governing coverage of oral chemotherapy drugs.

Prescription Drug Rider
For Group Member Certificate

Dean Health Plan, Inc.,
1277 Deming Way, Madison, WI 53717
(800) 279-1301 or TTY 711

DeanHealthPlan
A member of SSM Health

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

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

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

Frank Lucia- President & Chief Executive Officer

Prescription Drug Coverage

IMPORTANT

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

- For the purposes of this section, the phrase cost-sharing amount refers to your plan-specific Copay, Deductible and/or Coinsurance. Please refer to the Schedule of Benefits for plan-specific prescription drug cost–sharing amounts.
- You are responsible for reviewing and complying with the formulary guidelines associated with this plan. A drug's formulary status is subject to change and your Policy documents indicate which formulary to review. To obtain a copy of the current formulary or a list of drugs requiring Prior Authorization, visit Our web site at deancare.com, log into your DeanConnect portal, or contact Our Customer Care Center at (800) 279-1301 or TTY 711.
- A formulary is a list of prescribed drugs, medications, supplies and other agents which are approved for use and covered under this Policy. Unless you obtain an exception through Our Non-Formulary Exception Request process, we do not cover any drugs not listed on the formulary.
- Our formulary is organized by tiers, and how much you pay for a certain drug depends upon its tier placement. To find out if a drug is on the formulary and/or under what tier a drug is placed, please visit Our website at deancare.com or contact Our Customer Care Center.
- Updates to the formulary may be obtained by visiting deancare.com or by contacting Our Customer Care Center. We reserve the right to change the formulary at any time without notice. Our website maintains a current version of the formulary at deancare.com.
- We maintain the formulary as a guide for physicians or other prescribers of self-administered medications. Our Pharmacy and Therapeutics Committee, which is made up of physicians and pharmacists, reviews and approves the agents listed based on efficacy, comparative studies, safety, drug interactions, side effects, pharmacokinetics and cost-effectiveness.
- We use evidence-based medical management processes when making coverage decisions, including but not limited to step therapy. A Health Care Provider, Member, or authorized representative may present medical evidence to obtain an individual patient exception for coverage of a prescription drug or device not routinely covered under the Policy.
- Drugs may be removed from the formulary at any time when a therapeutically equivalent alternative drug(s) becomes available and covered under this Policy. New drugs are excluded but may be added to the formulary after the therapeutic advantages of the drug and its medically appropriate application are determined. Certain drug products may be excluded when comparable generic or therapeutic alternatives are available.
- Certain prescription drugs included on the formulary require Prior Authorization. Please refer to the formulary on deancare.com or by contacting Our Customer Care Center. **If Prior Authorization is not obtained when required, no benefits are available.** The drug Prior Authorization process may be initiated by your treating Health Care Provider by filling out a Drug Prior Authorization Request form. This form can be found on deancare.com. When We receive your request form, We will mail Our response to you and your prescribing Health Care Provider. You may contact your Health Care Provider for information about a particular drug, or you can contact Our Customer Care Center.

- Certain drugs have quantity limits. Please refer to the formulary for these limits.
- Certain drugs on Our formulary are only covered under Our Partial Fill Program. Our Partial Fill Program requires you to fill certain prescriptions for a shorter-than-usual time period. It works as follows:
    - Your first fill will be for up to 16 days of the first month, and you will only pay half of the monthly cost-sharing amount.
    - Your second fill will complete the first month (the next 12-14 days) and you will pay the other half of the monthly cost-sharing amount.
    - You will follow this schedule for the first three (3) months. After you complete the first three (3) months, a complete one-month supply will be available with cost-sharing amount indicated in your Policy documents. See the formulary for additional information.
- We assign drugs to the specialty drug category based upon the need to provide exceptional management such as: Prior Authorization; clinical oversight and monitoring; special handling; cost; and disease management and/or case management. All specialty drugs require Prior Authorization. Specialty drugs must be obtained from Our specialty Network pharmacies. Certain specialty drugs may be subject to the Partial Fill Program. Medications classified as specialty drugs are identified on the formulary.
- All prescription drugs over $2,000 will be reviewed for medical management and/or therapeutic interchange. All compounded medications over $200 will be reviewed to determine whether they meet Our compound Prior Authorization criteria.
- Outpatient prescription drugs purchased in connection with emergency or urgent care services will be paid according to in-Network pharmacy benefits, as follows:
    - When you purchase formulary drugs in connection with urgent or emergent medical care services, you are not required to use a Network pharmacy if one is not easily accessible. We will cover your purchase as if you went to a Network pharmacy.
    - For Us to cover your prescription, an Out-of-Network Provider must not be under sanction or banned from prescribing by the Centers for Medicare and Medicaid Services (CMS).
    - To obtain reimbursement for drugs purchased from an Out-of-Network pharmacy in an urgent or emergent situation, please submit your receipts along with a prescription manual claim reimbursement form found on Our website at deancare.com.
- Any drug that is covered under this subsection is also covered when provided in connection with a Clinical Trial if Prior Authorization is obtained.
- Even if you or your prescribing Health Care Provider specifically request a brand drug, if a pharmacy fills a prescription for a brand drug when a generic equivalent is available and on the formulary, We will not cover the brand drug. You, the Member, will be responsible for 100% of the cost of the prescription.

Outpatient Prescription Drugs

Covered Expenses:

- **Formulary Drugs.** We cover drugs, medications and other agents and supplies listed on the formulary. Coverage is subject to any limitations listed on the formulary or as discussed above.
- **Clinical Trials.** We cover routine patient care for Members in an approved clinical trial. Members are subject to the terms, conditions, and restrictions that apply to other coverage under the Policy. For more information, see Section II Glossary of Terms – Clinical Trials or request our New Technology Assessment Guideline.

- **Oral Chemotherapy Drugs.** We cover orally-administered chemotherapy. Member cost-sharing amounts are limited to $100 for a 30-day supply, consistent with Wis. Stat. § 632.867.
- **HIV (Human Immunodeficiency Virus).** We cover prescription drugs for treatment of HIV infection as required by Wis. Stat. § 632.895(9).
- **Diabetes Care.** We cover the following drugs and supplies related to diabetes care:
    - Insulin, disposable supplies and any prescription medication used to treat diabetes. Disposable supplies include: blood or urine glucose strips, control solutions for blood glucose monitors, alcohol swabs, cotton swabs, finger stick devices, lancets and syringes. Single-packaged items such as blood glucose testing strips are limited to two items per cost-sharing amount.
    - Blood glucose monitors.
    - Insulin pens and formulary insulin vials listed on the formulary.
    - Infusion pumps and related equipment and supplies are covered under the medical benefit as required by Wis. Stat. § 632.895(6). Non-formulary test strips may be obtained through the medical benefit by Members with an insulin pump. Test strips and supplies listed on your formulary are covered under the pharmacy benefit.
    - Continuous glucose monitoring equipment and related supplies are covered under the medical benefit.
- **Oral Inhalants.** We cover certain oral inhalants. Coverage is limited to one item for up to three cost-sharing amounts, depending on how many days the product will last based on the drug's instructions.
- **Home Health Care.** We cover drugs dispensed in connection with mandated Home Health Care as listed in the Policy.
- Cost-sharing amounts are calculated for each 30-day supply or course of treatment. For each course of treatment or 30-day supply, you are required to pay one (1) cost-sharing amount. If a prescription is for greater than a 30-day supply, but less than a 60-day supply you are required to pay two (2) cost-sharing amounts, and if a prescription is for greater than a 60-day supply but less than or equal to a 90-day supply you will be required to pay three (3) cost-sharing amounts.
- Unless otherwise specified, prescription drugs will be dispensed in maximum quantities as follows:
    - If a retail provider fills prescriptions for more than a 30-day supply, cost-sharing amounts will apply for each 30-day supply obtained.
    - If a retail provider fills prescriptions with more than a 30-day supply, cost sharing amounts will apply for each 30-day supply obtained.
- Mail order is available for certain maintenance medications, as defined by Us.
- Single-packaged items are limited to two items or a one-month supply, whichever is less.
    - A single-packaged item includes, but is not limited to: inhalers, blood glucose sticks, eye drops and ear drops.
- If a single-packaged item will last 30 days or longer, you are limited to one single package per cost-sharing amount. If the single-packaged item lasts less than 30 days, you are limited to two single packages per cost-sharing amount. Ointments, creams, gels, solutions and other topical medications are dispensed in the smallest tube or package sizes that will last 30 days.
- Please refer to your Schedule of Benefits for Out-of-Network pharmacy coverage, if applicable to your plan.
- Infertility drugs are covered as a separate benefit. Please refer to your Schedule of Benefits for cost sharing amount.

Some of the diabetic supplies listed above and equipment are also covered under your medical supplies/durable medical equipment benefit. If you choose to purchase such supplies and equipment through a non-pharmacy provider, your cost-sharing amount will be determined by your medical supplies/durable medical equipment benefit.

Non-Covered Expenses:

- Medication for the treatment of sexual dysfunction and sexual transformation, unless mandated by law or covered under Our medical policy.
- Erectile dysfunction drugs.
- Anorexic agents or any medications prescribed for weight loss.
- Smoking cessation products not listed on the formulary. A Member must be enrolled in the Quit for Life Program.
- Charges for prescription drugs that require Prior Authorization, if Prior Authorization is not obtained from Our Quality and Care Management division.
- Charges for medications used for cosmetic purposes.
- Added dispensing fees for unit dose medications. A unit dose medication is an individually wrapped and labeled drug typically used in hospitals and nursing homes.
- Lost, stolen, or replacement prescription drugs.
- A drug that must be infused or injected by a Health Care Provider, or certain injections medically required to be administered in a Health Care Provider's office. These injections are not considered a prescription drug benefit and are governed by the medical coverage requirements as listed elsewhere in this Policy.
- Experimental, investigational or unproven services and medications; medications used for experimental indications; and/or dosage regimens determined by Us to be experimental, investigational or unproven.
- Compound drugs that are available as a similar commercially-available prescription drug or do not meet Our compound Prior Authorization criteria.
- Prescriptions written by a licensed Health Care Provider for use by the Health Care Provider or by his or her immediate family members.
- Medications obtained from a pharmacy or other establishment located outside the United States for use inside or outside the United States.
- Prescription drugs required for international travel or work in excess of the supply limitations set forth in this Certificate, the formulary, or other Policy documents.
- Medical food or vitamins, either with or without a prescription, unless the agent has been approved by Us and is listed on the formulary.
- Neutri-ceuticals, alternative drugs, natural remedies, homeopathic therapies, and any other chemical, drug, medication, agent, or therapy which has not been reviewed and approved by the Federal Food and Drug Administration for use in humans, unless approved by Us.
- Medications not medically indicated or not appropriate for the treatment of an illness or injury as determined by Us, except for specified drugs for the treatment of HIV infection as required by Wis. Stat. § 632.895(9).
- Charges for injectable medications administered in a nursing home when the nursing home stay is not covered by Us.
- Dispensing charges for unit dose medications, convenience packaging, blister packs, repackagers, costs related to the administration of a covered drug by injection or other means, and medications provided in connection with intermediate nursing care, custodial or Maintenance Care, or respite or rest care.
- All compounded estrogen, progesterone or testosterone products; oral progesterone

products unless specifically included in Our formulary; anabolic steroids except for replacement therapy; and drugs intended to modify stature except as approved by Us.

- Over-the-counter drugs, devices, durable medical equipment, supportive garments, or tobacco cessation products unless Prior Authorized by Us or coverage is required by state or federal law.
- Any medication or portion of medication that is wasted or not used.
- Medications covered by workers compensation insurance, or furnished by the U.S. Veterans Administration or any other local, state or federal agency or Medicare.
- Non-prescription enteral nutritional products that are taken by mouth or delivered through a temporary naso-enteric tube unless it has been Prior Authorized by Us.
- Shipping, handling, or delivery charges.
- Food, diet supplements, or medications prescribed for body-building or similar purposes.
- If your plan does not offer Out-of-Network coverage, prescription drugs, including covered drugs, dispensed by an Out-of-Network pharmacy except in the case of emergency services or urgently needed services as defined by Us.
  Prescription drugs dispensed prior to the Member's Effective Date of coverage or after the Member's termination date of coverage under the Policy.

eVisit Rider
For Group Member Certificate

Dean Health Plan, Inc.,
1277 Deming Way, Madison, WI 53717
(800) 279-1301 or TTY 711

DeanHealthPlan
A member of SSM Health

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

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

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

Frank Lucia - President & Chief Executive Officer

eVisits

IMPORTANT

HERE ARE SOME IMPORTANT THINGS TO REMEMBER ABOUT THESE BENEFITS:

- An eVisit is an electronically mediated process that facilitates non-face-to-face and non-real-time communication between a patient and a health care provider and occurs through Our contracted eVisit program.
- An eVisit is distinct from the process that allows you to send an electronic message to your doctor's office.
- Services are limited to basic care services, and this does not include chronic condition care.

IMPORTANT

Covered Expenses

Services are covered if all of the following apply:

1. Services are received through a non-face-to-face and non-real-time communication;
2. Services are provided by a Primary Care Provider, nurse practitioner, physician assistant, MD, or other qualified practitioner who is also Our eVisit contracted provider;
3. Services are associated with Our Medical Policy or covered conditions as listed in the certificate and on the list of available eVisit medical services;
4. Services are not otherwise excluded under the Policy. Not all conditions may be accepted for treatment by the eVisit provider, and you may be referred to another more appropriate care setting, in which case you will not be charged; and
5. The Member initiates the eVisit request from a non-clinical setting.

You Pay:
$0 copay

Non-Covered Expenses/Exclusions

1. eVisits with a provider that is not contracted with Us to perform eVisits will **not** be covered as an eVisit.
2. Conditions that are not associated to Our Medical Policy or covered conditions as listed in the certificate and on the list of available eVisit medical services will **not** be covered.
3. Real-time video or telephone (synchronous) visits will **not** be covered as an eVisit under the terms of this rider.

Sex Transformation Surgery Rider

For Group Member Certificate

Dean Health Plan, Inc.,
1277 Deming Way, Madison, WI 53717
(800) 279-1301 or TTY 711

DeanHealthPlan.
A member of SSM Health

This Sex transformation Surgery Rider is part of your Group Member Certificate issued by Dean Health Plan, Inc. (Dean). **Please keep this Rider with your Certificate and other important insurance papers.**

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

In witness whereof, Dean Health Plan, Inc. has executed this Sex Transformation Surgery Rider.

Frank Lucia - President & Chief Executive Officer

Sex Transformation Surgery

IMPORTANT

HERE ARE SOME IMPORTANT THINGS TO REMEMBER ABOUT THESE BENEFITS:

- You must receive a written Prior Authorization from Our Quality and Care Management division. Benefits will not be paid under this rider without such an authorization. Authorization may only be granted if the member is an active participant in a recognized treatment program.
- Covered benefits under this rider include sex transformation surgeries such as; genital reconstruction, genital construction, breast augmentation, and breast reduction for the treatment of gender dysphoria, even if excluded elsewhere in the Policy, subject to the lifetime maximum benefit identified in the Schedule of Benefits (provided, however, that instances of sex transformation surgery shall not be subject to such lifetime maximum benefit to the extent said surgery is considered a Covered Expense elsewhere in this Policy).
- Please contact Our Customer Care Center for additional information.

IMPORTANT

Covered Expenses:

After you receive Prior Authorization the following services are covered for the treatment of sex transformation surgery:

- Sex transformation surgery including: Genital Reconstruction, Genital Construction, Breast augmentation and reduction.

For Covered Expenses You Pay: 0% Coinsurance after Deductible Unlimited.

- Coinsurance amounts are applied toward the Deductible and Coinsurance Limit, and will apply toward the Out-of-Pocket Expense Maximum under your Certificate.

Non-Covered Expenses/Exclusions:

You pay 100% for the following non-covered services/excluded items:

1. Treatments, services or procedures that are not Medically Necessary.
2. Services or treatments that are not authorized by Our Quality and Care Management division and complications of unauthorized services or treatment.
3. Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics is not covered.
4. The following feminization and masculinization procedures including but not limited to:
   - Abdominoplasty
   - Blepharoplasty
   - Brow lift
   - Calf implants
   - Cheek/malar implants
   - Chin/nose implants
   - Face lift
   - Facial bone reduction
   - Hair removal
   - Hair transplantation
   - Liposuction of the waist (body contouring)
   - Lip reduction/enhancement
   - Liposuction
   - Mastopexy
   - Neck tightening
   - Pectoral implants

- Reduction thyroid chondroplasty
- Removal of redundant skin
- Rhinoplasty
- Voice modification surgery (laryngoplasty or shortening of the vocal cords)
- Skin resurfacing

Dean Health Plan, Inc.

Group Member Certificate
HMO Plan

Dean Health Plan, Inc.
1277 Deming Way, Madison, WI 53717
(800) 279-1301 or TTY 711

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

deancare.com

IMPORTANT INFORMATION

GROUP HMO MEMBER CERTIFICATE

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

IMPORTANT NOTICE CONCERNING STATEMENTS IN YOUR EMPLOYEE APPLICATION ENROLLMENT FORM

Please read the copy of your employee application provided to you by your employer/Policyholder or Us. Omissions or misstatements in your employee application could cause an otherwise valid claim to be denied. Carefully check the information provided when you apply for coverage and write to Us within 10 days if any of the information is incorrect or incomplete (such as an incomplete medical history). This insurance coverage was issued on the basis that the answers to all questions and any other material information shown on the employee application are correct and complete. If you have any questions, please contact Our Customer Care Center at the address and telephone numbers shown on the cover of this Certificate.

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

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

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

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

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

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

I. POLICY PROVISIONS

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

Access to Care

Because the provider network can change, you should confirm our Network Providers before you seek care. You can do this by viewing Our provider directory on deancare.com or calling Our Customer Care Center at (800) 279-1301 or TTY 711.

We have many Network Providers who can care for you. If you're not sure you need to see a doctor, or you're wondering if you have a problem, call Our free 24-hour nurse line. It's called Dean On Call and can be reached at (800) 576-8773. Dean On Call nurses do not provide medical care or treatment. They base their advice solely on the information you give them when you call. Due to licensing laws, Dean On Call services are only available to Wisconsin residents.

When you enroll as a Member you will choose a Primary Care Provider (PCP) to manage your health care. Your PCP evaluates your total health needs and provides personal medical care in one or more medical fields. You can choose either a clinic or a physician to be your PCP. If you choose a clinic rather than a physician, you may see any PCP in that clinic. Your PCP is also in charge of coordinating services with other Health Care Providers. When medically needed, your PCP preserves the continuity of your care.

We generally require the designation of a Primary Care Provider. You have the right to designate any Primary Care Provider who participates in Our network and who is available to accept you or your family members. Until you make this designation, We will designate one for you. For information on how to select a Primary Care Provider, and for a list of the participating Primary Care Providers, contact Us at (800) 279-1301 or TTY 711 (or reference Our website at deancare.com. For children, you may designate a pediatrician as the Primary Care Provider. You do not need Prior Authorization from Us or from any other person (including a Primary Care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in Our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Us at (800) 279-1301 or TTY 711.

Network Providers

Network Providers are Health Care Providers who sign an agreement with Us to provide medical services to Our Members. Network Providers include, but are not limited to, physicians (MD), podiatrists (DPM), optometrists (OD), chiropractors (DC), hospitals, doctors of osteopathy (DO), pharmacies, and nurse practitioners.

If you use Our Network Providers, covered charges will be paid based on the agreement between Us and the Network Provider. If there is a difference between the amount the Network Provider agreed to charge and the amount it actually bills, you will not have to pay the difference.

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

Please note, Our contracts with Network Providers will not affect or interfere with your relationship with your Health Care Provider. Your Health Care Provider is still responsible for making all medical decisions regarding your care. This includes deciding which treatments are appropriate for you. However, any treatment plan chosen by your Health Care Provider must meet this Policy's benefit requirements to be covered.

Out-of-Network Providers

Out-of-Network Providers are Health Care Providers who have not signed an agreement to provide medical services to Our Members. They are not listed in the most current edition of Our Provider Directory. We are not responsible or liable for the quality of care provided by an Out-of-Network Provider.

We generally do not cover care provided by Out-of-Network Providers. However, there are a few exceptions:

- We will cover emergency or urgent care you receive from an Out-of-Network Provider if you cannot reasonably reach a Network Provider.
    - You do not need to ask for Prior Authorization.
    - If you need further care after you are medically stable, we may ask that you transfer to a Network Provider. If you refuse transfer, we may not continue to cover your care.
    - You still need to pay any applicable Deductible, Coinsurance, or Copay amounts.
    - We will pay charges up to Our Maximum Allowable Fee. If there is a difference between the Maximum Allowable Fee and what the Out-of-Network Provider bills, you may have to pay the difference. Please call the Customer Care Center if you have questions about the Maximum Allowable Fee.
- We may cover care you receive from an Out-of-Network Provider if a Network Provider cannot provide that care.
    - You must ask for Prior Authorization before you see an Out-of-Network Provider, and we must approve your request. We will decide based on the following:
        i. Whether a Network Provider can provide the care you seek; and
        ii. Whether the care you are seeking is medically appropriate for you.
    - If your request is approved, we will pay based on what the Out-of-Network Provider charges, not based on Our Maximum Allowable Fee.
    - You still need to pay any applicable Deductible, Coinsurance, or Copay amounts.

Please see the Glossary of Terms and Benefits section for more information.

Prior Authorization

Your Health Care Provider must get Prior Authorization from Us before we will cover certain procedures or services. Examples of procedures and services that need Prior Authorization are listed below. This is NOT an all-inclusive list. You should contact the Customer Care Center at (800) 279-1301 or TTY 711 to verify whether a procedure or service needs Prior Authorization.

Examples of Procedures/Services Requiring Prior Authorization:

- All Out-of-Network Provider services.
- Certain medical injectables.
- Certain radiology services.
- Clinical trials.
- Communication devices.
- Non-emergent ambulance transport.
- Habilitative Services.
- Services provided in a home setting.
- Dental services required to treat accidental injury to teeth.
- Durable medical equipment (DME) greater than $500, unless otherwise stated in Our medical policies.
- Therapies (physical therapy, occupational therapy, speech therapy).
- Pain management.
- New technologies not commonly accepted as standard of care.
- Hospice.
- Transplants (except cornea).
- Elective inpatient services.
- Select diagnostic testing (e.g. genetic testing).
- Skilled nursing facility/swing beds (SNF).
- Surgical procedures related to obesity.
- Certain outpatient surgical procedures.

The Process for Obtaining Prior Authorization:

If your Health Care Provider recommends that you have a service or procedure that needs Prior Authorization, your Health Care Provider should submit a Prior Authorization request form to Our Quality and Care Management division. It is your, the Member's responsibility to make sure that your Health Care Provider requests Prior Authorization. We must receive the Prior Authorization request at least 15 business days before the date of your service or procedure. We must approve elective inpatient admission to a facility before you receive elective services.

Please note that a verbal request for Prior Authorization does not guarantee approval. Our Quality and Care Management division will notify you in writing of Our decision regarding Prior Authorization of elective outpatient services.

Your Health Care Provider may decide that it is Medically Necessary for you to receive care beyond the services or the length of time We originally authorized. If this happens, your Health Care Provider must contact Our Quality and Care Management division to request an extension of the original authorization. You and your Health Care Provider will be notified of whether we approve or deny your extension request.

Prior Authorization does not guarantee coverage and/or payment if you have already reached a benefit maximum or your coverage has been terminated.

Failure to Get Prior Authorization
If you fail to get Prior Authorization for any Medically Necessary covered service which requires an authorization, you, the Member, will be responsible for paying 100% of the total cost. You, the Member, must ensure that your Health Care Provider has gotten Prior Authorization for all services, including facility Confinements and/or surgery.

Urgent/Emergent Care:
In some situations Members may need medical attention before the written Prior Authorization process can take place. Examples of urgent or emergent care services include, but are not limited to: broken bones, sprains, minor cuts and burns, drug reactions, and non-severe bleeding. When circumstances such as these occur, and you require an admission to a facility you must call the Customer Care Center, by the next business day, at (800) 279-1301 or TTY 711.

If you need inpatient services after seeking urgent or emergent care, those inpatient services may be reviewed for Medical Necessity. If you receive urgent or emergent care from an Out-of-Network Provider and need further care, We may ask that you transfer to a Network Provider after you are medically stable. If you refuse transfer, we may not continue to cover your care.

Concurrent Review for Out-of-Network Providers:
Our Quality and Care Management division will continue to review facility Confinements and certain outpatient services after you have gotten an initial Prior Authorization. These services are reviewed concurrently by Our Quality and Care Management division to decide if they continue to be Medically Necessary. If your Health Care Provider decides that additional care beyond the length of time originally authorized is Medically Necessary, your Health Care Provider must contact Our Quality and Care Management division to request an extension. Our Quality and Care Management division will notify the Health Care Provider of our decision to approve or deny the request. If a Health Care Provider fails to provide Us the information We need to make a decision, We will deny those services. Any amount(s) denied for this reason will not apply toward satisfaction of the Out-of-Pocket Expense Maximum.

End of Section I

II. GLOSSARY OF TERMS

The terms below have special meanings in this Certificate.

Active at Work/Active Status:
Means performing your job on a regular, full-time basis, as defined in the Employer Group Application and referenced in the Employer Group Master Policy. Each day of a regular paid vacation and any regular nonworking holiday shall be deemed Active Status if you were in an Active Status on your last regular working day. You are still considered active if you are absent from work due to disability, illness, or leave of absence as determined by your employer. Unless coverage is continued as allowed under the law, a Subscriber who leaves employment due to active military service of longer than 30 days will cease to be considered active under the Policy. This definition does not apply when coordinating benefits with Medicare. Please refer to Section VII, Coordination of Benefits (COB), Coordinating Benefits with Medicare, for more information about how We coordinate benefits with Medicare.

Benefit Period:
A fixed time period determined by Us during which coverage is provided according to the Policy documents. During the Benefit Period, any Deductible, Copay or Coinsurance amounts the Member pays accumulate toward the applicable Out-of-Pocket Expense Maximum, and any visits subject to a visit limit accumulate toward that visit limit. These accumulated amounts reset at the beginning of each new Benefit Period.

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

Clinical Trial:
A Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is a type of trial that meets one or more of the following criteria:

1. The study or investigation is approved or funded by one or more of the following:
   a. The National Institutes of Health;
   b. The Centers for Disease Control and Prevention;
   c. The Agency for Health Care Research and Quality;
   d. The Centers for Medicare & Medicaid Services;
   e. A cooperative group or center of any of the entities described in clauses a) through d) or the Department of Defense or the Department of Veterans Affairs;
   f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or,
   g. Any of the following, if the conditions for departments described below are met:
      i. The Department of Veterans Affairs;
      ii. The Department of Defense; or,
      iii. The Department of Energy;
2. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; or,
3. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

The conditions for departments are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines: a) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and b) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

A life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

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.

For skilled nursing facilities (SNF), an inpatient stay begins on the day of admission into a skilled nursing facility. The 30 day SNF benefit renews when you haven't received any inpatient hospital care or skilled care in a skilled nursing facility for the same or a similar diagnosis for 60 days in a row. If you go into a hospital or a skilled nursing facility after one SNF benefit period has ended, a new benefit period begins. There is no limit to the number of SNF inpatient benefit periods. However, an additional 30 days is not available until skilled care has not been required for at least 60 consecutive days.

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

Coinsurance:
A specified percentage of Covered Expenses that a Member is required to pay each time covered services are provided, subject to any maximums specified in this Policy. Coinsurance amounts are applied to Our contracted fee or Maximum Allowable Fee. If a Covered Expense is subject to Coinsurance, the percentage amount can be located in the Schedule of Benefits.

Copay:
A specified dollar amount that a Member is required to pay each time covered services are provided, subject to any maximums specified in this Policy. Copay amounts are applied to Our contracted fee or Maximum Allowable Fee and apply at the benefit level. Copay amounts are applied toward the Out-of-Pocket Expense Maximum. If a Covered Expense is subject to a Copay, the Copay amount can be located in the Schedule of Benefits.

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

Deductible:
The amount of Covered Expenses that the Member is required to pay each Contract Period before We will pay for Covered Expenses. The Deductible is applied to Our contracted fee or to the Maximum Allowable Fee. If your coverage is subject to a Deductible, the Deductible amount can be located in the Schedule of Benefits.

Deductible and Coinsurance Limit:
Includes Deductible and Coinsurance amounts for certain medical expenses that a Member is required to pay when a covered service is provided. Pharmacy expenses and certain medical expenses are not included in the Deductible and Coinsurance Limit. These Deductible and Coinsurance amounts also apply toward the Out-of-Pocket Expense Maximum. No other out-of-pocket expenses apply toward the Deductible and Coinsurance Limit.

Effective Date:
The effective date of the Group Master Policy or the date the Eligible Employee qualifies for and enrolls in health care coverage with Us. An Eligible Employee must be Active at Work/Active Status for coverage to be effectuated. An Eligible Employee may be Active at Work/Active Status on a non-working day or while absent from work due to disability, illness, or leave of absence. For further explanation of Active at Work/Active Status, see Section II, "Glossary of Terms".

Eligible Employee:
An employee qualified under the terms of the Group Master Policy between Us and the employer.

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

Experimental or Investigational Procedures, Treatments, Supplies, Devices or Drugs:
Surgical procedures or medical procedures, treatments, supplies, devices, or drugs which at the time provided, or sought to be provided, are in the judgment of Our Medical Directors not currently recognized as accepted medical practice and/or one of the following applies:

1. The technology does not have final approval from the appropriate governmental regulatory bodies.
2. The scientific evidence does not permit conclusions concerning the effect of the technology on health outcomes.
3. The technology does not improve the net health outcome.
4. The technology is not as beneficial as any established alternatives.

5. The improvement is not attainable outside the investigational settings.

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

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

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

Please refer to Qualified Dependent definition in this section.

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

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

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

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

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

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

Long-Term Therapy:
Therapy that is determined by Our Quality and Care Management 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 Quality and Care Management division after reviewing an individual's case history or treatment plan submitted by a Health Care Provider. Any service that meets the criteria to be a covered Habilitative Service will not be considered Maintenance Therapy for the purpose of this Policy.

Maximum Allowable Fee:
Maximum Allowable Fee is the maximum amount We allow for a given service/procedure with an Out-of-Network Provider. This amount may be based on one or more of the following:

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

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

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/Medical Necessity:
The treatment, 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 Quality and Care Management division, are: a) consistent with the Member's illness or injury; b) in accordance with generally accepted standards of medical practice; c) not solely for the convenience of a Member, hospital, or other provider; and d) the most appropriate supply or level of service that can be safely provided to the Member in the most cost effective manner.

The fact that a physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular illness or injury does not mean that it is Medically Necessary, as defined in this Certificate. The definition of Medically Necessary used in this Certificate relates only to this Policy and may differ from the way a physician engaged in the practice of medicine defines medically necessary.

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 Qualified Dependent.

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

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

Out-of-Pocket Expense Maximum:
Any Covered Expenses for medical or pharmacy services the Member or family is required to pay, except for certain services specifically outlined in your Schedule of Benefits or benefit rider as not included. The Out-of-Pocket Expense Maximum includes the Deductible, Coinsurance and Copay amounts applied to Covered Expenses. Premiums, non-covered services, benefit reduction amounts, and services provided by Out-of-Network Providers that have not been Prior Authorized are not included in the Out-of-Pocket Expense Maximum.

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

Premiums:
The monthly fees established by Us and charged to the Group Policyholder to cover the provision of benefits to Members.

Primary Care Provider (PCP):
A Network Provider who evaluates the Member's total health needs and provides personal medical care in one or more medical fields. Typically a Primary Care Provider is a pediatrician, family practitioner, OB/GYN or an internist. You can choose either a clinic or a physician to be your PCP. If you choose a clinic rather than a physician, you may see any PCP in that clinic.

Prior Authorization/Prior Authorized:
A Prior Authorization is a written request that is completed by a network PCP and/or network specialist provider requesting authorization of a specific service(s) with a Network Provider or, in some cases, an Out-of-Network Provider. Certain services may require Prior Authorization before benefit coverage and claims payment can be provided. If a service is not urgent, the Prior Authorization request must be submitted and decided by Our Quality and Care Management division **before** the Member receives this service. A Prior Authorization denial for requested services will always be provided to the Member in writing. The Member and the provider make the final decision regarding whether the Member will receive any services. If a Member receives services without an approved Prior Authorization request, the claim may be denied if it is not found eligible for coverage. A verbal request for

treatment does not constitute a Prior Authorization request. Payment of services is subject to any Policy and benefit limitations. A Prior Authorization request does not guarantee payment of services received.

Qualified Dependent:
A Qualified Dependent is:

- The legally married spouse of the Subscriber;
- The Subscriber's married or unmarried biological child, step child, adopted child, legal ward, and any child placed for adoption (by court order, a licensed county agency, a Wisconsin child welfare agency, or a child welfare agency licensed by another State) until the child turns 26 years of age as determined by your employer. All placements and adoptions must follow Wisconsin's placement and adoptions laws. Please contact the Customer Care Center if you have any questions;
- The Subscriber's biological child, step child, or adopted child who was called to active duty prior to reaching the age of 27 and is a Full-Time Student. The child has up to 12 months after completing active duty to apply for Full-Time Student status at an institution of higher education. If the child has been called to active duty more than once in four years since the first call to active duty, eligibility will be determined based on the child's age at the time of the first call to active duty; A biological child of a Subscriber's dependent until the Subscriber's dependent reaches the age of 18;or
- The Subscriber's biological child, step child, child of a Domestic Partner, adopted child, legal ward, and any child placed for adoption who is required to be covered under the Subscriber's Plan in accordance with a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN).

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

- Age 26 or above.
- On active military duty, including National Guard or reserves, except for military duty shorter than 31 days.

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

A dependent child who is over the age of 26 may remain insured as a Qualified Dependent under this Certificate if he/she meets certain requirements, provided family coverage remains in force under this Certificate. The child must:

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

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

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

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

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

Service Area:
The geographic area from which We accept Members that has been approved by the appropriate regulatory agency. Please visit deancare.com or contact the Customer Care Center for more information about the geographic area We serve. The Service Area may change from time to time.

Social Security Number:
An identifying number assigned to an individual by the United States Social Security Administration.

Special Enrollment Period:
A time outside of the Open Enrollment period during which individuals and their Qualified Dependents are able to sign up for health coverage. Individuals and/or Qualified Dependents are only eligible for a Special Enrollment Period if they experience certain specified events. Please see Section V., Coverage Information, for more information about Special Enrollment Periods.

Subscriber:
The Eligible Employee enrolled in the Policy.

Totally Disabled/Total Disability:
A Member is unable, due to illness or injury, to perform any duties of his/her occupation or engage in another one for pay or profit, as determined by Us. If the Member does not have a regular occupation, this means the Member's inability, due to illness or injury, to engage in the normal activities of a person of the same age and gender. The Totally Disabled Member must be under the regular care of a Network Provider. We have the right to require an examination of such person, as often as We reasonably require, to confirm the Total Disability.

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

We, Us, Our:
Dean Health Plan, Inc. (Dean).

End of Section II

III. BENEFITS

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

A. GENERAL MEDICAL

- All services must be arranged and/or provided by a Network Provider, unless otherwise stated in this subsection.
  - Please contact Our Customer Care Center about services that require Prior Authorization.
- One second opinion per injury or illness by a Network Provider is covered as long as there are benefits available and a written Prior Authorization is obtained if needed. Prior Authorization from Our Quality and Care Management division is required if an out-of-network second opinion is requested.
- To receive maximum coverage you must receive Medically Necessary Covered Expenses from your Primary Care Provider (PCP) or from a network specialty provider.
- Any service that is covered under this subsection is also covered when provided in connection with a Clinical Trial, if Prior Authorization is obtained.
- Please also see General Exclusions and Limitations and your Schedule of Benefits for any coverage limitations.

Office Visits

Covered Expenses:

- Office calls and consults in the office. For behavioral health, maternity or infertility office visits, please see the corresponding subsection within this Certificate.

Chiropractic Services

Covered Expenses (Not an All-Inclusive List):

- Chiropractic services for treatment of those conditions that, in the judgment of the attending Health Care Provider, are expected to yield significant patient improvement, as determined by Our Quality and Care Management division, and are not considered Maintenance or Long-Term Therapy.

Non-Covered Chiropractic Expenses:

- Maintenance or Long-Term Therapy.
- Cervical pillows.
- Spinal decompression devices.
- Chiropractic services performed by an Out-of-Network Provider.

Diabetic Education

Covered Expenses:

- Diabetic education.
- Diabetic self-management training classes.

Non-Covered Diabetic Education Expenses:

- Educational services, except for diabetic education.

Preventive Services

Preventive services are defined as health care services that might include screenings, check-ups, and patient counseling to **prevent** illnesses, disease, or other health problems. The Affordable Care Act (ACA) of 2010 outlined a specific listing of preventive services which health plans cannot apply typical plan cost sharing to the Member.

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

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

More information about the preventive services coverage required under the ACA can be found at httphttps://www.healthcare.gov/coverage/preventive-care-benefits/.

Covered Expenses:

- Physical health examinations (adult and well-child care through age 18).
- Appropriate screenings and counseling as recommended by the following guidelines. The categories below address a broad range of preventive services including, but not limited to, colorectal cancer screenings, cervical cancer screenings (e.g. Pap tests), preventive mammograms, and screening lipid tests.
    - Evidence-based items or services that have a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF);
    - Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention;
    - For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); or
    - Evidence-informed preventive care and screenings for women provided for in current HRSA-approved guidelines. This includes, but is not limited to:
        - FDA-approved contraceptives (drugs and devices) prescribed by a Health Care Provider;
        - Outpatient consultations, examinations, procedures, and medical services that are necessary to prescribe, administer, maintain, or remove a contraceptive;
        - Sterilization procedures for women; and,
        - Patient education and counseling related to contraception for all women with reproductive capacity.
        - Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for breastfeeding equipment.
        - Screening and counseling for interpersonal and domestic violence.

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

Please refer to the "Diagnostic Services" subsection for non-preventive services. You may be responsible for paying out-of-pocket costs for any services We do not deem preventive.

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

B. MEDICAL SUPPLIES/DURABLE MEDICAL EQUIPMENT

- Supplies or equipment may require a Prior Authorization from Our Quality and Care Management division.
  - Please contact Our Customer Care Center about services that require Prior Authorization.
- Supplies or equipment shall either be purchased or rented as determined by Our Quality and Care Management division. Supplies or equipment cannot be rented if the cost to rent exceeds the cost to purchase the item.
- The cost sharing amounts as listed on your Schedule of Benefits apply per purchase or rental.
- Supplies or equipment must be prescribed for treatment of a diagnosed illness or injury and must be medically appropriate and cost effective for such an illness or injury.
- Supplies or equipment must be arranged and/or provided by, or purchased from, a network medical equipment provider.
- Any item that is covered under this subsection is also covered when provided in connection with a Clinical Trial, if Prior Authorization is obtained.
- Please also see General Exclusions and Limitations and your Schedule of Benefits for any coverage limitations.

<u>Medical Supplies and Durable Medical Equipment</u>

Covered Expenses:

- Medical supplies and durable medical equipment.
  - Examples include, but are not limited to:
    - Wheelchairs.
    - Tube feeding nutrition supplies.
    - Hospital beds.
    - Infusion therapy.
    - Oxygen and respiratory equipment.
    - Walking aids, e.g. walkers, crutches and canes.
    - Orthopedic products, e.g. braces and splints.
    - Urological and ostomy supplies.
    - Orthotics and prosthetics as Prior Authorized by Our Quality and Care Management division.

- Diabetic durable equipment and insulin infusion pumps. Insulin infusion pumps are limited to one pump per Contract Period, and the Member must use the pump for 30 days before purchasing.
- Other Medical Supplies as determined by Our Quality and Care Management division.

Diabetic Supplies

Covered Expenses:

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

If you have a Prescription Drug Rider, some of these diabetic supplies and equipment are also covered under that Rider. If you choose to purchase such supplies and equipment through a pharmacy, your cost-sharing will be determined by your Rider.

Non-Covered Supplies and Durable Medical Equipment Expenses:

- Medical supplies and durable medical equipment for comfort, personal hygiene and convenience, regardless of the Medical Necessity of such items. Examples include, but are not limited to: air conditioners, air cleaners, humidifiers, physical fitness equipment, physician's equipment, disposable supplies, and self-help devices not medical in nature.
- Home testing and monitoring supplies and related equipment, except those used in connection with the treatment of diabetes.
- 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 Quality and Care Management division.
- Non-prescription elastic support or anti-embolism stockings.
- Shoes or foot orthotics not custom-made and purchased over the counter.
- Any durable medical equipment or supplies used for work, athletic, or job enhancement purposes.
- Cranial bands (e.g. dynamic orthotic cranioplasty/DOC bands).
- Back-up equipment (a second piece).
- Replacement of durable medical equipment more frequently than every three years.
- Replacement of an item if the item is lost, stolen, or unusable/nonfunctioning because of misuse, abuse, or neglect.
- Items that can be purchased over the counter, unless coverage is required by state or federal law.
- Oral Nutrition: Oral nutrition is not considered a medical item. We do not cover nutritional support that is taken orally (i.e., by mouth), unless mandated by state law or covered under Our medical policy for a specific condition. Examples include, but are not limited to, over-the-counter nutritional supplements, infant formula, and donor breast milk.

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

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

C. DIAGNOSTIC SERVICES

- Certain Covered Expenses require Prior Authorization from Our Quality and Care Management division.
  - Please contact Our Customer Care Center about services that require Prior Authorization.
- All services must be arranged and/or provided by a Network Provider, unless otherwise stated in this subsection.
- One second opinion per injury or illness by a Network Provider is covered as long as there are benefits available and a written Prior Authorization is obtained, if needed. Prior Authorization from Our Quality and Care Management division is required if an out-of-network second opinion is requested.
- To receive maximum coverage, you must receive Medically Necessary Covered Expenses from your Primary Care Provider (PCP) or from a network specialty provider.
- Any service that is covered under this subsection is also covered when provided in connection with a Clinical Trial, if Prior Authorization is obtained.
- Please also see General Exclusions and Limitations and your Schedule of Benefits for any coverage limitations.

Labs & X-rays

Covered Expenses:

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

Other Diagnostic Services

Covered Expenses:

- Electrocardiogram (EKG).
- Endoscopy.
- Duplex scan.
- Pulmonary stress test.
- Sleep Study.
- Nerve conduction studies.
- Neuropsychological testing.
- Swallow study.

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

D. HEARING & VISION SERVICES

- Supplies or equipment may require Prior Authorization from Our Quality and Care Management division.
  - Please contact Our Customer Care Center about services that require Prior Authorization.
- Please also see General Exclusions and Limitations and your Schedule of Benefits for any coverage limitations.

Hearing Services

Covered Expenses:

- Hearing exams to determine if correction is needed.
- One hearing aid per ear or one set of bilateral (both ears) hearing aids, ear molds, including dispensing fees with Prior Authorization. Benefits are available per Benefit Period. The Benefit Period is 36 consecutive months from the date the benefit is first used.
- Repairs as Medically Necessary.
- The hearing aid must be repaired by/purchased from Dean Clinic, S.C., or other authorized providers. Please contact the Customer Care Center with questions regarding authorized hearing aid providers, or reference Our website at deancare.com.
- Cochlear implants, for children and adults, including procedures for implantation and post-cochlear implant aural therapy, with Prior Authorization by Our Quality and Care Management division. For therapy benefits please refer to Section I. "Therapies, Rehabilitation & Habilitative Services" subsection.
- Bone-anchored hearing aids with Prior Authorization by Our Quality and Care Management division.

Non-Covered Hearing Expenses:

- Batteries for hearing aids.
- Hearing aids that can be bought without a prescription and the following:
  - A fully implantable middle ear hearing aid.
  - Non-implantable, intraoral bone conduction hearing aid.

Vision Services

Covered Expenses:

- An initial lens (eyeglass lens or contact lens) per surgical eye required as a direct result of cataract surgery.
- Routine vision exams/services.
- Medically Necessary vision exams/services. One evaluation visit per year to a low vision clinic is considered Medically Necessary when the Member has a moderate to total visual impairment that can no longer be corrected by prescription optometrics.

Non-Covered Vision Expenses:

- Refractive eye surgery and radial keratotomy.
- Eyeglasses, including frames.
- Contact lenses (except as a part of cataract surgery or therapeutic contact lenses as defined by Our medical policy).
  - Refractive exams related to contact lenses.
  - Any fitting of contact lenses (except for fitting of therapeutic contact lenses as defined by Our medical policy).
- Any replacement lenses for contacts or eyeglasses.
- Orthoptics (e.g. eye exercise training).
- Refraction aids for low vision and instruction in their use.

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

E. HOSPITAL & SURGICAL SERVICES

- Certain services require Prior Authorization from Our Quality and Care Management division.
  - Please contact Our Customer Care Center about services that require Prior Authorization.
- All services must be arranged and/or provided by a Network Provider, unless otherwise stated in this subsection.
- Inpatient and outpatient hospital services are covered when they are necessary for the admission, diagnosis, and treatment of a patient as determined by Our Quality and Care Management division.
- Follow-up care with an Out-of-Network Provider to treat the same injury requires a written Prior Authorization, initiated by your Network Provider and approved by Our Quality and Care Management division, in order to be covered.
- Please also see General Exclusions and Limitations and your Schedule of Benefits for any coverage limitations.

Inpatient Hospital

A hospital is an institution that:

- Is licensed and run according to applicable state laws that apply to hospitals;
- Maintains, at its location, all the facilities needed to provide diagnosis of, and medical and surgical care for, injury and illness;
- Provides this care for fees;
- Provides such care on an inpatient basis;
- Provides continuous 24-hour nursing services by registered graduate nurses;
- Qualifies as a psychiatric or tuberculosis hospital;
- Is a Medicare provider;
- And is credentialed by Us or accredited as a hospital by the Joint Commission on Accreditation of Hospitals. The term hospital does not mean an institution that is chiefly a place for treatment of chemical dependency, a skilled nursing facility, or a federal hospital. We reserve the right to apply this definition to services provided by Out-of-Network Providers.

Hospital admission or being admitted in a hospital, means being registered as a patient in a hospital on the advice of a Network Provider or receiving emergency care in a hospital for an illness or injury.

Hospital swing-bed Confinement is considered the same as Confinement in a skilled nursing facility. Please refer to the "Skilled Nursing Care Services" subsection of this Certificate.

For coverage of inpatient services pertaining to dental care, please refer to the Benefits, "Dental Services" section of this Certificate.

Covered Expenses:

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

Non-Covered Expenses for Inpatient Hospital:

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

Inpatient Rehabilitation

Inpatient rehabilitation is an admission to a specialized facility that is able to deliver the intensity of services required to rehabilitate someone from a serious illness or injury, including but not limited to, stroke, cranial bleed, head injury or spinal cord injury. Inpatient rehabilitation services must be deemed Medically Necessary by Our Quality and Care Management division.

Covered Expenses:

- Inpatient rehabilitative medical Confinement when Prior Authorized as Medically Necessary.

Non-Covered Expenses for Inpatient Rehabilitation:

- Take home drugs and supplies dispensed by the hospital, unless a written prescription is obtained and filled at a network pharmacy.
- Inpatient rehabilitation stays that are extended for reasons other than Medical Necessity (e.g. lack of transportation, lack of caregiver or inclement weather).
- A continued inpatient rehabilitation 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).
- Separate charges for personal comfort or convenience items.

Detoxification Services

Covered Expenses:

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

You or the provider must notify Us if you are receiving detoxification services. These services are not applied to the Behavioral Health & Addiction benefit.

Outpatient Hospital or Ambulatory Surgical Services

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

Covered Expenses:

- Outpatient Hospital or Ambulatory surgical services, including but not limited to:
  - Diagnostic services.
  - Observation stays.
  - Medical services in an outpatient setting, e.g. IV infusions, chemotherapy or radiation therapy.
- Surgical procedures provided in a physician's office.

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

Also refer to subsections above for Inpatient or Outpatient Hospital and/or Diagnostic coverage details.

F. SKILLED NURSING CARE SERVICES

- Please contact Our Customer Care Center about services that require Prior Authorization.
- Please also see General Exclusions and Limitations and your Schedule of Benefits for any coverage limitations.

Skilled Nursing Facility

- All skilled nursing facility services require Prior Authorization from Our Quality and Care Management division.
- Skilled nursing facility services are covered when they are necessary for the admission, diagnosis, and treatment of a patient as determined by Our Quality and Care Management division.

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

A skilled nursing facility is an institution that is licensed by the State of Wisconsin as a skilled nursing facility. Admission to a swing bed setting in a hospital is considered the same as a skilled nursing facility Confinement. A written Prior Authorization may be required if services are provided by someone other than the Primary Care Provider (PCP). Rehabilitation services must be deemed Medically Necessary by Our Quality and Care Management division.

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

Covered Expenses:

- Skilled care services.

Non-Covered Expenses for Skilled Nursing:

- Respite and residential care.
- Any nursing facility services other than skilled nursing services, including intermediate care facilities and community re-entry programs.
- Custodial or domiciliary care.
  - Custodial care is the type of care given when the basic goal is to help a person in the activities of daily life, including, but not limited to, help in:
    - Bathing;
    - Dressing;
    - Eating;
    - Taking medicines properly;
    - Getting in and out of bed;
    - Using the toilet;
    - Preparing special diets;
    - Walking; or
    - 24-hour supervision for potentially unsafe behavior.
- Examples of custodial (or non-skilled) care provided by "non-skilled" persons include: range of motion exercises, strengthening exercises, wound care, ostomy care, tube and gastrostomy feedings, administration of medications, and maintenance of urinary catheters. This is also referred to as Activities of Daily Living (ADL). Daily care such as assistance with getting out of bed, bathing, dressing, eating, maintenance of bowel and bladder function, preparing special diets, and assisting patients with taking their medicines, or 24-hour supervision for potentially unsafe behavior, do not require "skilled care" and are considered to be custodial.
- Charges for injectable medications administered in a nursing home when We do not cover the nursing home stay. (These charges may be covered if you have the prescription drug benefit available through your Policy.)
- Tracheostomy care (if not skilled care).
- Parenteral feeding or tube feeding care.

Home Health Care

Covered Expenses:

- Home care. The attending physician must certify that a) hospital Confinement, or Confinement in a skilled nursing facility, would be needed if home care was not provided; b) the Member's Immediate Family, or others living with the Member, cannot provide the needed care and treatment without undue hardship; and c) a state licensed or Medicare certified home health agency or certified rehabilitation agency will provide or coordinate the home care.
- Physical, respiratory, occupational, and speech therapy when Medically Necessary.
- Medical supplies, drugs, and medicines prescribed by a 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.
- Nutritional counseling as Medically Necessary as part of the home care plan and a registered or certified dietitian must give or supervise these services.
- The assessment of the need for a home care plan and its development. A registered nurse, physician's assistant or medical social worker must do this assessment and the attending physician must request or approve this service. Individual visits from a qualified professional who provides skilled services under a home care plan, if We pre-approve them.
- Medications administered in connection with home health care.

Non-Covered Expenses for Home Health Care:

- Residential care.
- Private duty nursing.
  - Defined as the provision of individual and continuous care (in contrast to part-time or intermittent care) of 4 or more hours provided according to an individual plan of care, including shift care, by a registered or licensed practical nurse or a certified nursing assistant.
- Home care services provided by a family member or someone who resides with the Member.
- Home health aide services for assistance with activities of daily living or any service which is not required to be provided by a skilled/licensed provider.

Hospice Care

- Hospice care requires Prior Authorization from Our Quality and Care Management division.
  - Please contact the Customer Care Center for a current list of services that require Prior Authorization.

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

Hospice care is an agency or organization that:

- Has hospice care available 24 hours a day, seven days a week.
- Is certified by Medicare as a hospice program, and, if required, is licensed as such by the jurisdiction in which it is located.

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

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

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

Non-Covered Expenses for Hospice Care:
- Residential care.
- Services provided by volunteers.
- Housekeeping or homemaking services.

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

G. EMERGENCY & URGENT CARE SERVICES

- Certain services require Prior Authorization from Our Quality and Care Management division.

- Please contact Our Customer Care Center about services that require Prior Authorization.
- All services must be arranged and/or provided by a Network Provider, whenever possible, when you are in the Service Area.
- If you need inpatient services after seeking urgent/emergent care, those inpatient services are subject to review for Medical Necessity. If you receive urgent/emergent care at an out-of-network facility and need further care, We may request that you be transferred to a network hospital after you are medically stable. If you do not wish to be transferred to a network facility, continued coverage may not be available.
- Claim payments for urgent and emergency care services provided by an Out-of-Network Provider 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 for Wisconsin residents, Dean On Call, (800) 576-8773.
- Our phone numbers and instructions on when to call are on the back of your Identification (ID) card. You should carry your ID card with you at all times.
- Please also see General Exclusions and Limitations and your Schedule of Benefits for any coverage limitations.

Ambulance Services

- Ambulance transport (ground or air) must be provided by an established state-licensed ambulance service and comply with all local and federal laws.

Covered Expenses:

Ground Ambulance Transportation

- Ambulance ground transportation is covered to or from a hospital when the transportation is emergent or urgent in nature and medical attention is required en route. Coverage of non-urgent/non-emergent ground ambulance transportation will be based on the following criteria:
  - The patient's condition contraindicates the use of any other method of transportation.
  - The services are not available in the hospital to which the patient has been admitted (e.g., the patient was transported to another facility for cardiac catheterization, then returned to the admitting hospital).
  - The facility furnishing the services is the nearest one with the appropriate facilities.
  - Or as requested by Our Quality and Care Management division.

Air Ambulance Transportation

- An air ambulance transport to transfer a Member from one hospital to another hospital is covered if all of the following requirements are satisfied:
  - Transportation is emergent in nature and medical attention is required en route;
  - The Member’s condition contraindicates the use of any other method of transportation and a ground ambulance transport would endanger the Member’s health;
  - For hospital to hospital transfers, the transferring hospital does not have the needed hospital or skilled nursing care for the Member’s illness or injury; and

- The facility which receives the transported Member is the nearest one with appropriate facilities.

Non-Covered Ambulance Expenses:

- Ambulance service that is not an emergency transportation, including but not limited to, non-emergency air transportation, unless Prior Authorized by Our Quality and Care Management division.
- Charges for, or in connection with, any other form of travel, unless otherwise stated in this Section.
- Member's condition does not meet medical criteria for ambulance transportation.
- Ambulance initiated by the Member for convenience or non-medical reasons.
- Charges for basic life support or advanced life support when the Member is not transported by the ambulance supplier.

Emergency Care Services

What is Emergency Care?

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

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

What to do in case of emergency:

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 the Customer Care Center as soon as possible when you receive emergency care from an Out-of-Network Provider.

EMERGENCIES WITHIN OUR SERVICE AREA: Most of the time, you will be able to receive emergency care from a Network Provider. However, if you are unable to reach a Network Provider, you should go to the nearest medical facility for assistance. If you seek emergency or urgent care from an Out-of-Network Provider, call the Customer Care Center as soon as possible and tell Us where you are receiving emergency care.

If any emergency care results in a hospital admission to an out-of-network hospital, you or the hospital must call Us by the next business day following the admission. Failure to notify Us when notification is reasonably possible, could result in you being financially responsible for all, or part, of the services. If notification was not reasonably possible by the next business day following admission, your claim will not be prejudiced.

Covered Expenses:

- Emergency room services. Please note that emergency room services provided by an Out-of-Network Provider will be paid based on the Maximum Allowable Fee. You will be responsible for any fees that exceed the Maximum Allowable Fee.
  - Out-of-pocket responsibility, as defined in your Schedule of Benefits, may apply to any services beyond the emergency room facility charges, including but not limited to supplies, prescriptions, diagnostic testing, and imaging services.
- ER Copay is waived if admitted for observation or inpatient directly from the emergency visit.

Urgent Care Services

What is Urgent Care?
Urgent care is care that you need sooner than a regular physician's visit. Some examples of conditions that may require urgent care are broken bones, sprains, minor cuts and burns, drug reactions, and non-severe bleeding. If you are outside the Service Area, go to the nearest appropriate medical facility, unless you can safely return to the Service Area to receive care from a Network Provider.

Follow-up care is not considered urgent care, unless such care is necessary to prevent your health from getting significantly worse before you can reach your Primary Care Provider or another Network Provider. Urgent care does not include care that can be postponed until you can safely travel to the Service Area to receive care from a Network Provider.

What to do if you need Urgent Care:
Urgent care should be received at the nearest appropriate medical facility, unless you can safely return to the Service Area or see your Primary Care Provider. Please call the Customer Care Center as soon as possible after seeing an Out-of-Network Provider. The claim for the services may be reviewed by Our Quality and Care Management division to determine if the diagnosis or symptoms were urgent.

Covered Expenses:

- Urgent care services. Please note that urgent care services provided by an Out-of-Network Provider will be paid based on Our Maximum Allowable Fee. You will be responsible for any fees that exceed the Maximum Allowable Fee.
  - Out-of-pocket responsibility, as defined in your Schedule of Benefits, may apply to any services beyond the urgent care physician charges, including but not limited to supplies, prescriptions, diagnostic testing, and imaging services.

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

If you have a question regarding when to seek emergency or urgent care, you can call Our 24-hour nurse access line at (800) 576-8773.

H. OUT-OF-AREA CARE

- Please contact Our Customer Care Center about services that require Prior Authorization.

- Please also see General Exclusions and Limitations and your Schedule of Benefits for any coverage limitations.
- Out-of-area care means services you receive outside of Our Service Area.
- When you are outside of Our Service Area look at the back of your ID card to help you determine where you can seek care or call our call Our Customer Care Center at (800) 279-1301 or TTY 711 for assistance.
- Network providers are determined based on the networks listed on the back of your ID card.
- Outpatient behavioral health and addiction services for Full-Time Students attending school in Wisconsin but outside the Service Area:
    - We will provide benefits for a clinical assessment by an Out-of-Network Provider We designate. Please see the "Behavioral Health & Addiction Services" provision, under subsection "Behavioral Health and Addiction Services," for information.

Out-of-Area Care for Qualified Dependents--Excluding Spouses

- The following Covered Expenses are available to all Qualified Dependents that are not the Subscriber's spouse.
- To ensure your claims are properly processed under this provision, call Our Customer Care Center at (800) 279-1301 or TTY 711 and notify them that you are a Qualified Dependent living outside of the Service Area.
- Prior Authorization is required when you receive care out of Our Service Area.
- This coverage may be subject to Copays, Deductibles, and/or Coinsurance amounts.

Covered Expenses:

- All Covered Expenses listed within this Policy.

Non-Covered Expenses:

- Services or supplies that are not Medically Necessary, and any services or supplies listed as non-covered within this Policy.

Out-of-Area Care for Subscribers and Subscribers' Spouses

- The following Covered Expenses are available to you if you are temporarily outside of the Service Area; they are not available if you are permanently outside of the Service Area.
    - A member is permanently outside the Service Area if he/she resides continuously outside the Service Area for more than 90 days, unless the Member is a Full-Time Student.
    - A Full-Time Student is permanently outside the Service Area if he/she resides continuously outside the Service Area for more than 6 months.
- This coverage is subject to Maximum Allowable Fees, as defined in the Glossary of Terms, and to any applicable Copays, Deductibles, and/or Coinsurance amounts.

Covered Expenses:

- Initial emergency services.
    - Emergency room Copay is waived if admitted for observation or inpatient services.
- Urgent care services.
- Follow-up care following emergency or urgent care services, if Prior Authorization is obtained, for a maximum of three follow-up physician visits within 30 days of the

initial emergency room/urgent care visit. No coverage is available for follow-up care without Prior Authorization.
    - Follow-up care is care that is received after the initial emergency or urgent condition has been stabilized and that relates to the emergency room/urgent care visit.

Non-Covered Expenses:

- Services for a Member who is permanently outside the Service Area.
- Follow-up care provided more than 30 days after the related emergency room/urgent care visit, or in excess of three follow-up physician visits.
- Follow-up care in excess of three provider visits.
- Follow-up care without Prior Authorization.
- Services or supplies that are not Medically Necessary, and any services or supplies listed as non-covered within this Policy.

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

I. THERAPIES, REHABILITATION & HABILITATIVE SERVICES

- Please contact Our Customer Care Center about services that require Prior Authorization.
- Please also see General Exclusions and Limitations and your Schedule of Benefits for any coverage limitations.

<u>Autism</u>

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

Covered Expenses:

- Services specifically related to a primary verified diagnosis of autism spectrum disorder, which includes autism disorder, Asperger's syndrome and pervasive development disorder not otherwise specified. Verified diagnosis must be conducted by a provider skilled in testing and in the use of empirically validated tools specific for autism spectrum disorders. For the diagnosis to be valid, the evidence must meet the criteria for autism spectrum disorder in the most recent Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. These services include:
    - **Diagnostic testing**, if testing tool is appropriate to the age of the Member and determined through the use of empirically validated tools specific for autism spectrum disorders. We reserve the right to require a second opinion with a provider mutually agreeable to the Member and Us.
    - **Intensive-level services**. The Member is eligible for 4 years of intensive-level services. Any previous intensive-level services received by the Member will be counted against this requirement under this Policy, regardless of payor.
    - **Intensive-level services** must be consistent with the following:
        - Evidence-based.
        - Provided by a qualified provider as defined by state law.

- Based on a treatment plan developed by a qualified provider or professional as defined by state law that includes an average of 20 or more hours per week over a six-month period of time with specific cognitive, social, communicative, self-care or behavioral goals that are clearly defined, directly observed and continually measured. Treatment plans shall require that the Member be present and engaged in the intervention.
- Provided in an environment most conducive to achieving the goals of the Member's treatment plan.
- Includes training and consultation, participation in team meetings and active involvement of the Member's family and treatment team for implementation of the therapeutic goals developed by the team.
- Commences after an insured is 2 years of age and before the insured is 9 years of age.
- Services must be assessed and documented throughout the course of treatment.
- The Member must be directly observed by the qualified provider at least once every two months.

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

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

Non-Covered Autism Expenses:
- Animal-based therapy including hippotherapy.
- Auditory integration training.
- Chelation therapy.
- Child care fees.

- Cost for the facility or location when treatment, therapy or services are provided outside a Member's home.
- Cranial sacral therapy.
- Custodial or respite care.
- Hyperbaric oxygen therapy.
- Provider travel expenses.
- Special diets and supplements.
- Therapy, treatment or services to a Member residing in a residential treatment center, inpatient treatment or day treatment facility.
- Prescription drugs and durable medical equipment*.

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

Outpatient Physical, Speech, and Occupational Therapy

Covered Expenses:

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

Non-Covered Outpatient Physical, Speech and Occupational Therapy Expenses:

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

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 Quality and Care Management division. Therapists must be licensed and must not live in the patient's home or be a family member.

Habilitative Services

- Certain services require Prior Authorization from Our Quality and Care Management division.
  - Please contact the Customer Care Center for a current list of services that require Prior Authorization.
- Habilitative services and devices are those services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.
- Coverage for habilitative devices, like all other medical devices, is subject to the limitations in Our "Medical Supplies/Durable Medical Equipment" subsection.

Covered Expenses:

- Physical therapy, occupational therapy and speech therapy.
- Counseling.
- Behavioral health services.
- Services for developmental delay.

Non-Covered Expenses for Habilitative Services:

- Custodial care.
- Daycare.
- Recreational care.
- Respite care.
- Vocational training.

Phase II Cardiac Rehabilitation

Covered Expenses:

- Medically appropriate rehabilitation services for myocardial infarction, coronary bypass surgery or stable angina pectoris.

Pulmonary Rehabilitation

Covered Expenses:

- Medically appropriate rehabilitation services for chronic obstructive and restrictive lung disease, as deemed as Medically Necessary by Our Quality and Care Management division.

Radiation Therapy

Covered Expenses:

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

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

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

J. DENTAL SERVICES

- Certain services require Prior Authorization from Our Quality and Care Management division.
  - Please contact Our Customer Care Center about services that require Prior Authorization.
- There is a limited set of dental, trauma/accidental injury to teeth, oral surgery and temporomandibular disorder (TMD) related services provided under this Certificate. We do not cover other dental or dental-related services except as described in this subsection.
- All services must be arranged and/or provided by Network Providers, including oral surgeons, dentists or TMD providers, unless otherwise stated in this subsection.
- Please also see General Exclusions and Limitations and your Schedule of Benefits for any coverage limitations.

Trauma/Accidental Injury to Teeth

These benefits are intended for dental treatment needed to remove, repair, replace, restore and/or reposition sound, natural teeth damaged, lost, or removed due to an injury.

A "sound, natural tooth" is a tooth that is fully erupted, has no restoration or minor restoration that does not compromise the strength and integrity of the tooth structure, and has no evidence of periodontal disease that would predispose the tooth to injury.

To be eligible for coverage, the services must be Medically Necessary while you are enrolled under this Policy. In addition:

- The tooth must meet the definition of "sound, natural tooth".
- The evaluation of the injured tooth must occur within 72 hours of the injury.
- The repair of the injured tooth must be initiated within 120 days of the injury.
- The treatment must be completed within 24 months of the injury.

Covered Expenses:

- Tooth extractions, initial repair and/or replacement with artificial teeth, because of an accidental injury.

The term "injured" does not include conditions resulting from eating, chewing or biting.

Non-Covered Expenses for Trauma/Accidental Injury to Teeth:

- All dental services, except those listed as covered in this "Dental Services" subsection.
- Surgery performed to correct functional deformities of the mandible or maxilla.
- Correction of malocclusion.
- Orthognathic surgery.
- Orthodontic care, periodontic care, or general dental care.
- Restoration. Crowns and root canals are covered only if such treatments are the only clinically acceptable treatments for the trauma/accidental injury.
- Tooth damage due to eating, chewing or biting.

Oral Surgery

Covered Expenses:

- Surgery consult and/or evaluation.
- Surgical procedures as follows:
  - Removal of impacted teeth.
  - Removal of tumors and cysts that are not related to non-bony impacted teeth.
  - Treatment for accidental injuries of the jaw, cheeks, lips, tongue, roof, and floor of mouth.
  - Apicoectomy.
  - Removal of exostoses of the jaw and hard palate when not performed to facilitate denture placement.
  - Treatment of fractured facial bones.
  - External/ internal incision and drainage of facial abscess of soft tissues.
  - Cutting of accessory sinuses, salivary glands or ducts.
  - Reducing dislocations; alveoloplasty.
  - Lingual frenectomy.
  - Vestibuloplasty.
  - Residual root removal.

Non-Covered Expenses for Oral Surgery:

- All dental services, except those listed as covered in this "Dental Services" subsection.
- Surgery performed to correct functional deformities of the mandible or maxilla.
- Correction of malocclusion.
- Oral surgery consult and/or evaluation for a procedure not listed in this subsection.
- Orthognathic surgery.
- Orthodontic care, periodontic care, or general dental care.
- Restoration. Examples include but are not limited to crowns and root canals.
- Tooth damage due to eating, chewing or biting.
- Dental implants.

Medically Necessary Hospitalization for Dental Procedures

Covered Expenses:

- All Medically Necessary hospital or ambulatory surgery center charges incurred, and anesthetics provided in connection with dental care that is provided to a Member in a hospital or ambulatory surgery center, if Prior Authorized by Our Quality and Care Management division.

Non-Covered Expenses for Hospitalization for Dental Procedures:

- Hospitalization costs for services not listed in this Section, except those listed in the "Hospital & Surgical Services" subsection, for which Prior Authorization is required.

Temporomandibular Disorders (TMD)

Covered Expenses:

Coverage is limited to diagnostic procedures and Medically Necessary surgical or non-surgical treatment for the correction of temporomandibular disorders (TMD), if the following apply:

- Under the accepted standards of the profession of the Health Care Provider rendering the service, the procedure or device is reasonable and appropriate for the diagnosis or treatment of this condition.
- The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.
- Orthognathic surgery only for the treatment of TMD, when Prior Authorized by Our Quality and Care Management division.

Non-Covered Expenses for Temporomandibular Disorders (TMD):

- All dental services, except those listed as covered in this TMD subsection.

Non-surgical services with a TMD diagnosis code and a network TMD provider will be subject to the TMD benefit listed in your Schedule of Benefits. Surgical Services will be covered as indicated within the "Hospital & Surgical Services" subsection of this Certificate.

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

K. BEHAVIORAL HEALTH & ADDICTION SERVICES

- Certain services require Prior Authorization from Our Quality and Care Management division.
  - Please contact Our Customer Care Center about services that require Prior Authorization.
- Behavioral health services are for those conditions classified as a behavioral health disorder by the International Classification of Diseases published by the American Medical Association and/or the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association.
- Court-ordered services may not be covered if those services are NOT performed by a Network Provider, unless the services are a result of an Emergency Detention or received on an emergency basis and you or your provider notifies Us within 72 hours after the initial services.
- All services must be arranged and/or provided by a Network Provider, unless otherwise stated in this subsection.
- Related diagnostic services and prescription drugs are not subject to these behavioral health and addiction benefits. For benefit information, please see the "Diagnostic Services" subsection; "Medical Supplies/Durable Medical Equipment" subsection; and your Group Prescription Drug Benefit Rider, if applicable.
- Coverage is in accordance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.
- Please also see General Exclusions and Limitations and your Schedule of Benefits for any coverage limitations.

Inpatient Behavioral Health and Addiction Services

Inpatient behavioral health services means medically oriented treatment, psychotherapy and other behavioral health services provided by a licensed professional in a state licensed or certified hospital or behavioral health residential facility on a 24 hour per day basis to enable

a person with a behavioral health disorder or a behavioral health disorder in combination with other impairments to function successfully.

Covered Expenses:

- Medically Necessary services provided at an in-network inpatient, behavioral health inpatient/residential facility.
- Medically Necessary services in a residential/inpatient addiction treatment program provided by a licensed professional in a state licensed or certified facility.
- Medically Necessary inpatient detoxification services are considered medical and, therefore, are NOT applied to this benefit. Please see the "Detoxification Services" provision under the "Hospital & Surgical Services" subsection for more information on this coverage.

Outpatient and Other Behavioral Health and Addiction Services

Partial hospitalization or day treatment programs are more intensive than outpatient services and less intensive than inpatient services. The services must be in a licensed behavioral health or addiction treatment partial hospitalization or day treatment facility with services provided by a licensed behavioral health or addiction treatment provider.

Covered Expenses:

- Medically Necessary outpatient services, including group, family and individual therapy in an office or clinic setting with a behavioral health or addiction treatment Network Provider.
- For Full-Time Students attending school in Wisconsin, but outside the Service Area:
  - A clinical assessment by an Out-of-Network Provider and 5 visits for outpatient behavioral health or addiction treatment with an approved Prior Authorization. We retain the right to choose the provider. Further treatment may be approved upon review of Our Quality and Care Management division.

Medically Necessary and Prior Authorized services for the following treatments and programs:

- Behavioral health or addiction treatment services for adults, adolescents, and children in a partial hospitalization or day treatment program.
- Services for persons with chronic behavioral health disorders provided through a community program. These programs provide services to people with chronic behavioral illnesses that, due to history or prognosis, require repeated acute treatment or prolonged periods of inpatient care. Benefits are payable only for charges directly related to treatment of behavioral health disorders.
- Intensive outpatient programs for the treatment of drug and alcohol use disorders. Treatment must be provided by specialists in addiction medicine.
- Intensive outpatient programs for the treatment of behavioral health disorders.
- Coordinated emergency behavioral health services for persons who are experiencing a behavioral health crisis or who are in a situation likely to turn into a behavioral health crisis if support is not provided. Services are provided by a program certified for the period of time the person is experiencing a behavioral health crisis until the person is stabilized or referred to other providers for stabilization. Certified emergency behavioral health service plans shall provide timely notice to Us to facilitate

coordination of services for persons who are experiencing, or are in a situation likely to turn into, a behavioral health crisis.

To qualify for coverage under behavioral health and addiction care, the care must be Medically Necessary and Prior Authorized by Our Quality and Care Management division:

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

Non-Covered Behavioral Health and Addiction Expenses:

- Biofeedback.
- Family counseling for non-medical reasons.
- Gambling addiction.
- Wilderness and camp programs, boarding school, academy-vocational programs and group homes.
- Halfway houses.
- Hypnotherapy.
- Long-Term or Maintenance Therapy.
- Marriage counseling.
- Phototherapy.
- In-home behavioral health therapy services.

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

L. TRANSPLANTS & KIDNEY DISEASE SERVICES

- Except for corneal transplants, all transplant services, including transplant work ups require Prior Authorization and must be provided at Our approved facility.
- The appropriateness of all transplants is reviewed by Our Quality and Care Management division. Our definition of appropriateness is based upon individual patient considerations and medical literature supportive of the value of this technology.
- Coverage for organ-procurement costs is limited to costs directly related to the procurement of an organ from a cadaver or compatible living donor. Organ-procurement costs include the following: organ transportation, compatibility testing, hospitalization, and surgery (when a live donor is involved).

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

Transplant Services

Covered Expenses:

- Organ and tissue transplants when ordered by a physician. Benefits are currently available for transplants when the transplant meets the definition of a Covered Expense and is not Experimental or Investigational. **All transplants (except corneal transplants) require Prior Authorization.**
- Examples of transplants for which benefits may be available include bone marrow, stem cell, heart, heart/lung, lung, pancreas, liver, and cornea.
- Donor costs that are directly related to organ procurement for an approved organ transplant are Covered Expenses for which benefits are payable through the organ recipient's coverage under the Policy.

Non-Covered Transplant Expenses:

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

Kidney Disease Treatment

Covered Expenses:

- Inpatient and outpatient kidney disease treatment is limited to all services and supplies directly related to kidney disease, including but not limited to: dialysis, transplantation, donor-related charges, and related physician charges.
- Benefits for donor-related charges are only payable if the recipient of the kidney is Our Member. The covered donor-related charges (including compatibility testing charges) are those charges related to the person actually donating the kidney. We are not required to duplicate coverage available to the Member under Medicare or under any other insurance coverage the Member may have.

Non-Covered Expenses for Transplant Services and Kidney Disease Treatment:

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

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

M. OTHER SERVICES

- Please contact Our Customer Care Center about services that require Prior Authorization.
- Please also see General Exclusions and Limitations and your Schedule of Benefits for any coverage limitations.

Alternative Care

Covered Expenses:
- Acupuncture.

Non-Covered Alternative Care Expenses:
- Holistic medicine and any other form of alternative medicine.

Anesthesia Services

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

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

Bariatric Surgery

You must receive a written Prior Authorization from Our Medical Affairs Division to enter the Program. Benefits will not be paid without such an authorization. Prior Authorization may only be granted after you have consulted with a Dean Comprehensive Weight Management Program provider. Only certain Dean providers qualify as Program providers. Any bariatric surgeries require Prior Authorization from Our Medical Affairs Division. Any surgery must be performed at St. Mary's Hospital in Madison, Wisconsin or the Dean & St. Mary's Outpatient Surgery Center in Madison, Wisconsin.
Except as otherwise noted, services are covered according to the terms outlined in your Member Certificate. Please contact the Customer Care Center for further eligibility information.

Covered Expenses:
- After you receive Prior Authorization to participate in the Dean Comprehensive Weight Management Program, the following services are covered:
  - Medical services involving weight management received through the Program.
  - Bariatric surgeries for the treatment of morbid obesity, as considered medically appropriate in patients that meet the criteria established by Our Medical Affairs Division.
  - Follow-up care services determined to be Medically Necessary by Our Medical Affairs Division.

Members must meet certain medical policy criteria, as documented by Our medical staff, for entry into the Program. Please contact Our Customer Care Center at (800) 279-1301 or TTY 711 for medical criteria.

Non-Covered Bariatric Surgery Expenses:

- Treatments, services or procedures that are not Medically Necessary.
- Services or treatments that are not authorized by Our Medical Affairs division and complications of unauthorized services or treatment. (E.g., this does not cover removal or other surgical services related to a laparoscopic gastric adjustable band if Our Medical Affairs Division did not authorize the placement of the laparoscopic gastric adjustable band.)
- Diet supplements, low-calorie foods and beverages, Program and general weight loss books and materials.
- Subsequent bariatric surgery (only one bariatric surgery paid by Us per Member per lifetime).
- Body sculpting procedures related to weight loss.

Infertility Services

Covered Expenses:

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

Benefit maximum may apply. Please refer to your Schedule of Benefits. Please see your Prescription Drug Benefit Rider, if applicable, for self-administered infertility drug benefits.

Non-Covered Infertility Expenses:

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

Maternity Services and Coverage for Newborns

Covered Expenses:

- Medically Necessary physician services (you do not need a Prior Authorization from your network PCP to see an OB/GYN).
- Prenatal and postpartum care, including services directly related to deliveries, ectopic pregnancies, Cesarean sections, and miscarriages.
- Hospital services are covered under the "Hospital & Surgical Services" subsection.
- Maternity benefits are also available for a Qualified Dependent daughter who is covered as a Member.

New Members under this Certificate who are in their third trimester as of their Effective Date and are seeing an Out-of-Network Provider are allowed to continue receiving care with their Out-of-Network Provider for the duration of their

pregnancy and until their first postpartum checkup. Services provided by an Out-of-Network Provider require Prior Authorization.

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

Under federal law, health insurers such as Us 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 Health Care 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, We will only provide benefits for the shorter stay. We may not require you to obtain Prior Authorization for stays that are not in excess of 48 hours (or 96 hours).

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

Non-Covered Maternity Expenses:

- Amniocentesis, CVS (Chorionic Villi Sampling), or non-invasive pre-natal testing when performed exclusively for sex determination.
- Birthing classes (e.g. Lamaze).
- Elective abortions.
- Services, drugs, or supplies related to abortions, except when: 1) a woman suffers from a physical disorder, physical injury, or physical illness that would place the woman in danger of death unless an abortion is performed; 2) the pregnancy is the result of an act of rape or incest; 3) there is established significant fetal abnormality; or 4) selective fetal reduction in multiple pregnancy is recommended by a high-risk obstetrical specialist or neonatologist.
- Home or intentional out of hospital deliveries (e.g. free standing birthing centers).
- Maternity services received outside the Service Area during the last 30 days of the pregnancy, except for emergency and urgent care services. For an explanation of these services see "What is Emergency Care?" and "What is Urgent Care?" under the Emergency & Urgent Care Services subsection.
- Treatment, services or supplies for a non-Member Traditional Surrogate or Gestational Carrier.

Coverage of Newborns:

Congenital defects and birth abnormalities are considered an injury or illness under the terms of this Policy. Coverage will apply to the functional repair or restoration of any body part when necessary to achieve normal body functioning for the newborn infant. This does not include cosmetic surgery performed solely for appearance improvement.

All other services for your newborn will be covered as otherwise described in this Certificate.

Surgical Services

Covered Expenses:

- Surgical procedures required to treat an illness or accidental injury.

- Covered Expenses include: preoperative and postoperative care, necessary assistant and consultant services, and elective sterilization, unless otherwise specified.
- If a Member is receiving benefits in connection with a mastectomy, and elects to have breast reconstruction surgery in connection with that mastectomy, We will provide coverage for:
  - Reconstruction of the breast on which the mastectomy has been performed;
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  - Prostheses and physical complications of all stages of mastectomy, including lymphedema.
- Prosthetics are subject to the benefits provided in the "Medical Supplies/ Durable Medical Equipment" subsection.
- Coverage for lymphedema is subject to the benefits provided under the "Outpatient Physical, Speech and Occupational Therapy" provision of this subsection.

Non-Covered Surgical Expenses:

- Plastic surgery, unless representing a medical/surgical necessity. This limitation does not affect coverage provided for breast reconstruction in connection with a mastectomy.

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

End of Section III

IV. GENERAL EXCLUSIONS & LIMITATIONS

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

The categories listed below are for organizational purposes only. They are not meant to restrict or otherwise limit these exclusions and limitations in any way.

General Exclusions and Limitations: Medical

Diagnosis and Testing

- Cytotoxic testing and sublingual antigens in conjunction with allergy testing.
- Hair analysis (unless lead or arsenic poisoning is suspected).
- Preimplantation genetic testing of embryos and gametes.

Prescription Drugs and Other Devices or Items

- Convenience items for a Member or a Member's family, unless otherwise specified in this Policy.
- Outpatient prescription drugs, except those prescriptions otherwise covered under this Policy.
- Oral Nutrition: Oral nutrition is not considered a medical item. We do not cover nutritional support that is taken orally (i.e., by mouth), unless mandated by state law or covered under Our medical policy for a specific condition. Examples include, but are not limited to, over-the-counter nutritional supplements, infant formula, and donor breast milk.
- Replacement of an item if the item is lost, stolen, or unusable/nonfunctioning because of misuse, abuse, or neglect.
- Sexual dysfunction supplies, including but not limited to medications and injections.

Services and Procedures

- Autopsy.
- Charges or costs relating to donor sperm.
- Consultation for, or procedures in connection with, in vitro fertilization, embryo transplantation, and/or any other assistive reproductive technique (e.g. GIFT, ZIFT).
- Cosmetic services, including cosmetic surgery.
- Experimental or Investigational services, Treatments, or Procedures, and any related complications as determined by Our Quality and Care Management division, unless coverage is required by state or federal law.
- Infertility-related services or procedures not otherwise covered by this Policy, including but not limited to the collection and storage of sperm and eggs outside the course of treatment for, and diagnosis of, infertility, including for surrogacy or Gestational Carriers.
- Items that can be purchased over the counter.
- Laser treatment for Port Wine Stain (PWS) lesions, except on the face and neck.
- Podiatry services or routine foot care rendered in the absence of localized illness, injury, or symptoms in connection with, but not limited to: a) the examination, treatment, or removal of all or part of corns, calluses, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet; b) the cutting, trimming, or other non-operative partial removal of toenails; or c) any treatment or services in connection with any of these.

- Obesity-related services, including any weight loss method, surgical treatment or hospitalization for the treatment of obesity, unless specifically covered under this Certificate.
- Reversal of voluntary sterilization and related procedures.
- Services related to surrogacy.
- Sexual dysfunction treatment and services including but not limited to surgical treatment.
- Sex transformation surgery.
- Travel immunizations.

Therapies
- Behavioral health therapy services provided in the home.
- Chelation therapy for atherosclerosis.
- Coma stimulation programs.
- Dry needling.
- Holistic medicine and any other form of alternative medicine.
- Low level light therapy.
- Massage therapy.
- Prolotherapy.
- Swim or pool therapy, unless Prior Authorization is obtained.

General Exclusions and Limitations: Non-Medical

Appointments and Other Types of Visits
- Administrative examinations such as employment, licensing, insurance, adoption, or participation in athletics.
- Court-ordered care, unless Medically Necessary and otherwise covered under this Certificate.
- Educational services, except for diabetic self-management classes.
- Internet and phone consultations, including all related charges and costs, except as defined by Our medical policy.
- Missed appointment charges.
- Telephone consultation charges by or between providers.

Charges and Expenses
- Charges or costs exceeding a benefit maximum or Maximum Allowable Fee where applicable.
- Expenses incurred before the supply or service is actually provided unless prior approved by Our Quality and Care Management division.

Services, Treatments, and/or Supplies
- Services, treatment, 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.
- Services and supplies furnished by a government plan, hospital, or institution unless by law you must pay.
- Service for hospital or medical care not listed in this Certificate.
- Services, treatment, 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. (Note that this exclusion does not apply to the treatment of injuries that result from an act of domestic violence, to the extent that such treatment would otherwise be covered.)

- Services provided by members of the Subscriber's Immediate Family or any person residing with the Subscriber.
- Services or supplies for, or in connection with: a non-covered procedure or service, including complications, regardless of when a non-covered procedure or service is or was performed; a denied Prior Authorization; or a denied admission.
- Services or supplies not Medically Necessary, not recommended or approved by a provider, or not provided within the scope of the provider's license.
- Services and supplies rendered outside the scope of the provider's license.
- Services or items required as a result of war or any act of war, insurrection, riot, terrorism, or sustained while performing military service.
- 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.

End of Section IV

V. COVERAGE INFORMATION

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

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

For a Subscriber:
1. The Effective Date of the Group Master Policy; or
2. The date the Eligible Employee qualifies for and enrolls in health care coverage with Us. An Eligible Employee must be Active at Work/Active Status for coverage to be effectuated. An Eligible Employee may be Active at Work/Active Status on a non-working day or while absent from work due to disability, illness, or leave of absence. For further explanation of Active at Work/Active Status, see Section II, "Glossary of Terms".

For Qualified Dependents:
1. For a Qualified Dependent that is enrolled with the Subscriber, the Subscriber's Effective Date.
2. For an individual (other than newborns or adopted children) who becomes eligible for coverage as a Qualified Dependent as a result of marriage or some other reason, coverage will become effective on the date the individual becomes eligible for coverage.
3. For a newborn of the Subscriber, or a newly born child of a Qualified Dependent child, coverage will be effective from the moment of birth.
4. For a child adopted by or placed for adoption with the Subscriber, coverage will become effective on the date that a court makes a final order granting adoption of the child by the Subscriber or on the date that the child is placed for adoption with the Subscriber, whichever occurs first. For a child required to be covered under the Subscriber's Plan in accordance with a QMCSO or NMSN, coverage will become effective as of the date indicated in the QMCSO or NMSN. If the QMCSO or NMSN is silent regarding the effective date, coverage will become effective according to the rules described in numbers 1-3 of this list, as appropriate.

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

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

Adding Qualified Dependents
The following procedures must be followed to add a Qualified Dependent to your coverage:

1. For dependents other than newborns or adopted children, the Subscriber must file an application within 31 days of acquiring the dependent(s) as a result of marriage or of the dependent(s) otherwise becoming eligible for coverage. If the Subscriber is required to cover the dependent through a QMCSO or NMSN, the Subscriber should provide his/her employer and Us with a copy of the QMCSO or NMSN.
2. For newborn children, the Subscriber must file an application and pay any additional Premium within 60 days of birth. If a newborn child is not enrolled within 60 days of birth, the child may still be enrolled if, within one year of the child's birth, the

Subscriber makes all past due Premium payments, including interest at the rate of 5.5% per year. If no additional Premium is required for the newborn child, the Subscriber must still file an application to cover the newborn.

3. For children adopted or placed for adoption, the Subscriber must file an application within 60 days of the dependent's placement in the home.

Coverage for Full-Time Students on Medical Leave

This provision applies to a Qualified Dependent if his/her eligibility for coverage is based on his/her Full-Time Student status (i.e. he/she was called to active duty prior to reaching the age of 27 and is a Full-Time Student). If such a Qualified Dependent must take a Medically Necessary leave of absence due to illness or injury, he/she will be eligible for coverage continuation. For coverage to continue, the Qualified Dependent, or an individual on his or her behalf, must submit documentation and certification of the Medical Necessity of the leave of absence from his/her attending physician. The coverage continuation will begin on the date the Qualified Dependent ceases to be a Full-Time Student due to the Medically Necessary leave of absence.

We will continue to provide coverage until any of the following occur:

- The Qualified Dependent notifies Us or the employer that he/she does not intend to return to school full-time;
- The Qualified Dependent becomes employed full-time;
- The Qualified Dependent obtains other health coverage;
- The Qualified Dependent marries and is eligible for coverage under his/her spouse's health coverage;
- The Subscriber's coverage under this Policy is discontinued or otherwise terminated; or
- One year has elapsed since the Qualified Dependent's coverage continuation began and the dependent has not returned to school full-time.

This provision only applies to a Qualified Dependent whose eligibility for coverage is based on his/her Full-Time Student status. It does not apply to all covered Full-Time Students, such as a Full-Time Student who is eligible for coverage under his/her parent's plan because he/she is under age 26.

Initial Enrollment Period

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

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

Persons not enrolled during the initial enrollment period will be subject to the Late Enrollee Policy Please see the "Late Enrollee Policy" provision in this section for more information.

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

Late Enrollee Policy
Late Enrollees are individuals who 1) did not enroll when initially eligible for coverage, and 2) are not eligible for a Special Enrollment Period. Late Enrollees will be subject to one of the following rules chosen by your employer:

- Late Enrollees will have a 90-day waiting period before their coverage can begin;
- Late Enrollees will need to wait for the next annual open enrollment period to enroll for coverage; or
- Late Enrollees will not be allowed to enroll for coverage.

Please contact your employer for more information about applying for coverage as a Late Enrollee.

ID Card Information
Your ID card provides useful information regarding the insured Subscriber and Qualified Dependent(s), along with important telephone numbers and billing information. The ID card is not a guarantee of coverage or payment of benefits. If your ID card is lost, stolen or otherwise needs replacement, you can request a new one.

Coverage Changes/Notice of Change
As a Member, it is your responsibility to notify your Employer of any changes that might affect your coverage so that your Employer can timely notify Us. You should report these changes to your Employer 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 termination of employment, divorce or death of the Subscriber.
4. The addition of any newly acquired Qualified Dependents.
5. Changes in Qualified Dependent status (for details see "Glossary of Terms" Section).

Failure to report these changes to your Employer on a timely basis (generally 31 days from the date the change occurs) may result in you and/or your Qualified Dependents becoming subject to the Late Enrollee Policy, claims being denied, incorrect Premiums being collected, or retroactive termination of coverage under this Policy.

When Coverage Ends
Coverage under this Policy will end on the earliest of the following dates, unless otherwise specified in this Certificate or the Group Master Policy:

1. The last day of the month in which the Subscriber no longer meets the definition of an Eligible Employee. Coverage for Qualified Dependents will end on the same date.
2. The date of Policy termination or non-renewal.
3. The date the Member is called to active duty status in the military. (Check with your employer to see if it has other requirements.)
4. The date of a Member's disenrollment, as stated in the "Disenrollment" subsection.
5. For a grandchild of the Subscriber, the date the parent who is the Subscriber's Qualified Dependent child reaches age 18 or otherwise loses eligibility or coverage.
6. For a Qualified Dependent child, coverage ends on:
   - When a dependent turns 26, as determined in the Group Master Policy.
   - The day a dependent who was called to active duty prior to age 27 loses Full-Time Student status.
7. A mentally or physically disabled child may remained insured as a Qualified Dependent beyond the maximum dependent age stated in this Certificate, as set forth in the definition of "Qualified Dependent." Coverage will terminate the last day of the month in which the disabled child no longer meets the requirements for extended coverage for disabled children.
8. For a divorced spouse or stepchildren, the last day of the month in which a divorce judgment is entered.

Extension of Coverage: Confinement
If you are Confined in the hospital on the date your coverage under this Policy ends, benefits for inpatient hospital services received during that Confinement will continue until the earliest date in which:

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

This provision only applies if your coverage ends, but your employer's Policy with Us remains in force.

Extension of Coverage: Total Disability
If you are Totally Disabled on the date your coverage under this Policy ends benefits related to your disabling condition will continue until the earliest date in which:

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

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

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

Federal Group Health Continuation Rights under COBRA
The Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, requires most group health plans to provide a temporary continuation of coverage that might otherwise be terminated.

If you elect continuation coverage, you may be responsible for all or part of the Premium payments (as determined by the employer). You do not have to provide proof of good health to elect COBRA continuation coverage. This provision generally explains when COBRA continuation coverage is available and what you need to do to exercise your right to receive COBRA continuation coverage.

Qualifying Events Under COBRA
COBRA continuation coverage is available to "qualified beneficiaries" who have experienced a "qualifying event." You, your spouse, and your dependent children could become qualified beneficiaries.

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

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

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

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

1. The death of the Subscriber.
2. The termination of the Subscriber's employment (for reasons other than gross misconduct) or reduction in hours of employment.
3. Parent's divorce or legal separation.
4. The Subscriber becomes entitled to Medicare.
5. The dependent child ceases to be a Qualified Dependent.

6. The Subscriber has retiree coverage and the employer files for bankruptcy (Chapter 11 Reorganization).

Obligation to Report Qualifying Events
The Subscriber, spouse or Qualified Dependent is responsible for informing the Policy administrator/employer of any of the following qualifying events within 60 days of their occurrence:

- Divorce;
- Legal separation; or
- Child losing dependent status under the plan.

The employer (if the employer is not the Policy administrator) is responsible for notifying the Policy administrator of any of the following qualifying events within 30 days of their occurrence:

- Subscriber's death;
- Termination or reduction in hours of the Subscriber's employment;
- Subscriber's entitlement to Medicare, or
- Commencement of the employer's bankruptcy proceedings.

Within 14 days of receiving notice of your qualifying event, the Policy administrator will notify you of your right to elect COBRA continuation coverage.

Electing COBRA Continuation Coverage
Each qualified Member has an independent right to elect COBRA continuation coverage. Additionally, Subscribers may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. If you wish to elect COBRA continuation coverage, you must do so within 60 days of receiving notice of your right to elect COBRA continuation coverage or losing coverage, whichever is later. If you do not elect continuation coverage, your coverage under this Policy will terminate.

Benefits Under COBRA Continuation Coverage
If you elect continuation coverage, the employer is required to give you coverage that (as of the time coverage is being provided) is identical to the coverage provided under the Policy to other Members. You will be afforded the opportunity to maintain continuation coverage for up to 3 years from the date of your qualifying event, unless your qualifying event was termination of employment or reduction in hours.

If your qualifying event is the termination or reduction of hours of the Subscriber's employment, qualified beneficiaries are entitled to a maximum of 18 months of continuation coverage. However, an 18-month maximum period can be extended:

1. If any of the qualified beneficiaries in your family is disabled and meets certain requirements, all of the qualified beneficiaries receiving continuation coverage due to a single qualifying event are entitled to an 11-month extension of coverage, for a total maximum period of 29 months. To qualify, you must notify the plan of the disability within 60 days after the latest of: a) the date of the SSA disability determination; b) the date on which the qualifying event occurs; c) the date on which the qualified beneficiary loses (or would lose) coverage; or d) the date on which the qualified beneficiary is informed of the obligation to provide disability notice. If you choose to

extend your COBRA coverage, you must elect it before the end of the 18-month period by giving written notice of your election to extend COBRA coverage.

2. If a qualified beneficiary experiences a second qualifying event while receiving COBRA coverage, he or she is entitled to an 18-month extension of coverage, for a total maximum period of 36 months. The following are considered a second qualifying event as long it would have caused the qualified beneficiary to lose coverage under the plan in the absence of the first qualifying event: the death of the Subscriber, the Subscriber becomes entitled to Medicare, the divorce or legal separation of the Subscriber and spouse, or a loss of dependent child status under the plan. You must notify the employer/Policy administrator of all of these events within 60 days of: a) the date on which the qualifying event occurs; b) the date on which you lose (or would lose) coverage; or c) the date on which you are informed of the obligation to provide such notification.

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

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

At the end of the COBRA coverage period, you have the right to enroll in an individual policy with Us if you apply and We receive your application within 31 days after your continuation coverage ends. Please contact the Customer Care Center if you wish to enroll in Our individual policy.

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

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

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

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

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

Your employer must notify you of your right to continuation coverage within 5 days of receiving your notice to terminate coverage. You must then apply for coverage within 31 days of receiving notice of your right to continuation coverage.

If you choose continuation coverage, your employer is required to give you coverage that is identical to the coverage provided to the other Members under the Policy. You will be responsible for paying the entire Premium due for your coverage.

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

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

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

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

1. The required Premiums are not paid by the end of the grace period. The grace period ends 31 days from the last unpaid Premium due date.
2. The Member performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in connection with the coverage.
3. The Member no longer resides, lives or works in the Service Area, or in the area for which We are authorized to do business.

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

End of Section V

VI. GENERAL PROVISIONS

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

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

Circumstances Beyond Our Control
If the rendition or provision of services and other covered benefits is delayed or rendered impractical 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 We and Network Providers will use Our best efforts to provide services and other covered benefits. However, neither We nor any Network Provider shall have any other liability or obligation on account of such delay or such failure to provide services or other benefits.

Confidentiality
We respect 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 new Member information or view on Our website at deancare.com/about-dean/privacy-policy/.

Conformity with Federal and State Laws
We comply with all applicable federal and states laws. This Certificate will conform to the minimum requirements of applicable laws if any provision conflicts with the laws of the state in which We issue this Policy.

Limit on Assignability of Benefits
This is your personal Certificate. You cannot assign any benefit to anyone other than a physician, hospital or other provider entitled to receive a specific benefit for you.

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

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

Major Disaster or Epidemic
If a major disaster or epidemic occurs, Network Providers and hospitals will render medical services (and arrange extended care services and home health service), insofar as practical, according to their best medical judgment, and within the limitation of available facilities and personnel. If the disaster or epidemic causes unavailability of facilities or personnel, We and Network Providers have no liability, or obligation for delay or failure to provide or arrange for

such services. In this case, Members may receive Covered Expenses from Out-of-Network Providers.

Fraud and Intentional Misrepresentation: Right of Rescission
Intentional misrepresentations made when applying for coverage could cause an otherwise valid claim to be denied, or your coverage to be rescinded. Carefully check the information provided when you apply for coverage and write to Us within 10 days if any of the information is incorrect or incomplete (such as an incomplete medical history). This Certificate was issued on the basis that the statements, representations, and warranties made when you and any dependents applied for coverage are correct and complete.

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

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

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

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

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

Physician and Hospital Reports
Physicians and hospitals, from time to time, must give Us reports to help Us determine Member benefits. By accepting coverage under the Policy, you have agreed to authorize providers to release any necessary records to Us. This is a condition of Our issuing this contract and paying benefits. Please Note: Expenses for patient-requested records are not covered by Us.

For more information about authorizing release of records, refer to Right to Collect Needed Information below.

Physical Examination
We have the right to request a Member to receive a physical examination to determine eligibility for benefits. We will pay for this expense if We request such an examination. By accepting coverage under the Policy, you have agreed to consent to any required

examination. Please call the Customer Care Center for a listing of doctors who can provide required examinations.

Proof of Claim
As a Member, it is your responsibility to show your health insurance ID card each time you receive services. Failure to notify a Provider of your membership may result in claims not being filed on a timely basis. This delay may cause your claim to be denied and you to be billed for the charges involved.

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

Right to Collect Needed Information
Members must cooperate with Us when We investigate a claim or require information necessary to administer the Policy. Cooperation includes, but is not limited to, the following assistance:

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

Your failure to assist Us may result in Our denial of claims.

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

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

Subrogation
If you are entitled to special damages for an illness or injury caused by a third party or for which any party is liable, you agree that We have 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, the insurance company of the third party, a company that provides medical payment coverage, Workers Compensation coverage, or uninsured or underinsured motorist protection for you.

You agree to honor Our subrogation rights, to cooperate with Us in the enforcement of Our subrogation rights, and to take no action which would prejudice Our subrogation rights and interests without first obtaining Our prior consent, so We may protect such 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 Our subrogation claim. We will not pay for any fees or costs associated with a claim or lawsuit, unless We give prior, express written approval. If We erroneously pay for or provide 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 Us to the extent of the value of such services.

Timely Submission of Claims
If you receive services from a Health Care Provider that requires you to submit the claim to Us for reimbursement, you must obtain an itemized bill and submit it to:

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

Claims must be submitted within 60 days of the date of service, or as soon as possible. If We are the primary payor and We do not receive the claim within 12 months after the date of service, We will deny coverage of the claim. If you do not notify a provider that you have coverage with Us, and this failure results in a claim not being filed in a timely manner, We may deny coverage of the claim. If We are the secondary payor, the time limit for timely submission begins with the date of notice of payment or rejection by the primary payor.

End of Section VI

VII. COORDINATION OF BENEFITS (COB)

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

Coordination of Benefits Provision
This Coordination of Benefits (COB) provision applies when a Member has coverage through more than one health plan or through an out-of-network pharmacy policy. Please note that We coordinate benefits following Wisconsin's requirements.

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

Allowable Expense is the necessary, reasonable, and customary item of expense for health care, when the expense is covered in whole, or in part, by one or more Plans covering the Member for whom the claim is made. For example, the cost difference between a private and semi-private hospital room is not an Allowable Expense, unless it is determined that the person's stay in a private hospital room is Medically Necessary.

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

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

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

Primary Plan will pay benefits for Covered Expenses as if no other coverage were involved.

Secondary Plan will determine payment for Covered Expenses based on the benefits paid by the Primary Plan.

This Plan means the Certificate We have issued to you as a Member.

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

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

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

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

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

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

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

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

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

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

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

5. Active/Inactive Employee

The Plan that covers a Member as an employee, or a dependent of an employee, that is neither laid off nor retired is primary over the Plan that covers a Member as an employee, or a dependent of an employee, that is either laid off or retired. If the other Plan does not have this rule and as a result the Plans do not agree on the order of benefits, this rule is ignored.

6. Continuation Coverage

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

7. Longer/Shorter Length of Coverage

If none of the above rules apply, the Plan that has covered the person for a longer period of time is primary.

Calculating Benefits When This Plan 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.

The benefits under this Plan may be reduced so that Our benefits and the benefits payable under the other Plans do not equal more than the total Allowable Expenses. When the benefits of this Policy are reduced as described, each benefit is reduced in proportion and it is then applied to any applicable benefit limit of this Policy.

Coordinating Benefits with Medicare

We will coordinate benefits with Medicare when a Member becomes eligible for Medicare benefits. In doing so, We will follow all applicable state and federal laws (including, but not limited to, statutes, regulations, and sub-regulatory guidance). In no case will Our payment and Medicare's payment be more than the total Allowable Expenses. All Plan Copays, Coinsurance, Deductibles, maximums, limitations, and exclusions apply to all benefits paid under This Plan.

If a Member is eligible for Medicare and Medicare would be the Primary Plan for that Member, We strongly suggest that the Member enroll in both Medicare Part A and Part B. Failure to enroll in Medicare Part A and B will result in the Member paying out-of-pocket expenses for services that Medicare might have covered, because We will process the Member's claims as if the Member is enrolled in Medicare. For more information, please see the "Payment of Claims" subsection in this section, or contact the Customer Care Center.

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

1. Reaching Age 65

A Member who reaches age 65 may become eligible for Medicare Parts A and B. We strongly suggest that you contact the employer through which This Plan was obtained and the Social Security office in your area for information regarding enrollment into Medicare before your 65th birthday. You may also contact Our Medicare COB Analyst, through Our Customer Care Center, for additional assistance.

Once you reach age 65 and are eligible for Medicare benefits, We will coordinate benefits as follows:

a. Subscriber has "current employment status" as defined by Medicare regulations:

i. If the Subscriber's employer has 19 or fewer employees, as defined by Medicare regulations, We will pay secondary to Medicare.

ii. If the Subscriber's employer has 20 or more employees, as defined by Medicare regulations, We will pay primary to Medicare.

b. Subscriber does not have "current employment status" as defined by Medicare regulations:

i. If the Subscriber has accepted a severance package, is retired, is on group continuation, is on long-term disability, or otherwise does not have "current employment status" as defined by Medicare, We will pay secondary to Medicare.

Benefits will be coordinated as described in the "Payment of Claims" subsection.

2. Medicare Disability

If the Member is under age 65, is considered Medicare Disabled, and is eligible for Medicare Parts A and B, We will coordinate benefits as follows:

a. Subscriber has "current employment status" as defined by Medicare regulations:

i. If the Subscriber's employer has 99 or fewer employees, as defined by Medicare regulations, We will pay secondary to Medicare.

ii. If the Subscriber's employer has 100 or more employees, as defined by Medicare regulations, We will pay primary to Medicare.

b. Subscriber does not have "current employment status" as defined by Medicare regulations:

i. If the Subscriber has accepted a severance package, is retired, is on group continuation, is on long term disability, or otherwise does not have "current employment status" as defined by Medicare regulations, We will pay secondary to Medicare.

Benefits will be coordinated as described in the "Payment of Claims" subsection.

3. End Stage Renal Disease

If the Member is diagnosed with End Stage Renal Disease (ESRD), This Plan will be primary to Medicare for 30 months from the initial month of Medicare eligibility, as determined by the Social Security Administration.

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

Please contact Our Medicare COB Analyst or the Customer Care Center when you receive information from Medicare or Social Security about changes to End Stage Renal Disease coverage.

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

Payment of Claims

1. When We coordinate benefits as the Secondary Plan, We will coordinate after Medicare has processed the claim. If the Member is eligible for Medicare Parts A and B, but did not enroll in Medicare, We will coordinate benefits as if the Member was enrolled in Medicare. The Member will be responsible for all services that would have been covered by Medicare. All Plan Copays, Deductibles, maximums, limitations, and exclusions will still apply to benefits coordinated with Medicare.

2. When We coordinate benefits as the Primary Plan, We will process the claims without consideration of what Medicare may cover. All Plan Copays, Deductibles, maximums, limitations, and exclusions will apply. If, at any time, We become the Secondary Plan (e.g. due to retirement or change in employer), We will then coordinate benefits as the Secondary Plan. In the event We pay claims as primary, but determine at a later time, whether during or after the termination of This Plan, that Medicare should have paid the claims as primary, We will recover such payments. The recovery date of these claims will go back one year, to the first day of the month in which the error is discovered. (For example, if an error is found on October 15, 2015, the recovery will go back to October 1, 2014).

End of Section VII

VIII. GRIEVANCES AND APPEALS

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

Grievances and Appeals

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. We take all Member complaints seriously and are committed to responding to them in an appropriate and timely manner.

If you have a complaint, please contact Our Customer Care Center. We will document and investigate your complaint and notify you of the outcome of your complaint. If your complaint is not resolved to your satisfaction you have the right to file a grievance. Any written expression of dissatisfaction will automatically be addressed as a grievance. (See "B. Grievance")

B. Grievance

A grievance is any dissatisfaction with Us, including Our provision of services, determination to reform or rescind a policy, or claims practices, that is expressed in writing to Us by, or on behalf of, a Member. This process does not apply to non-formulary exception requests. Please see the non-formulary exception request section below. To file a grievance, you or your authorized representative must submit it to Us in writing at:

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

Upon receipt of the grievance, the Grievance and Appeal Department will send an acknowledgement letter within 5 business days. Our acknowledgment letter will advise you of:

- Your right to submit written comments, documents or other information regarding your grievance;
- Your right to be assisted or represented by another person of your choosing;
- Your right to appear before the Grievance and Appeal Committee; and
- The date and time of the next scheduled meeting, which will not be less than 7 calendar days from the date of the acknowledgment and within 30 calendar days of receiving the grievance.

If you choose to meet with the Committee you may do so either in person or via teleconference. You must call (as indicated in the acknowledgement letter) and schedule a meeting time.

Your grievance will be documented and investigated. We will provide the following information automatically so that you will have time to respond prior to Our grievance determination: 1) any new or additional evidence considered, relied upon, or generated by

Us in the course of the grievance process, or 2) any new or additional rationale on which the determination will be based. If you wish to receive a free copy of any other documents relevant to the outcome of your grievance, send a written request to the address listed above. All grievances will be resolved within 30 calendar days of receipt.

C. Expedited Grievance

If the grievance is determined to be urgent in nature, according to Our criteria, which is based on the expedited grievance provisions of applicable law, the grievance will be resolved within 72 hours of receipt. We will automatically treat your grievance as expedited:

1. If your concerns are related to an admission or concurrent review of a continued stay;
2. If Our Medical Director determines your life, health, or ability to regain maximum function could be jeopardized by the standard review timeframe,
3. If your physician notifies Us that you would be subject to severe pain that cannot be adequately managed without the services that are the subject of the claim, or
4. If your physician notifies Us that he or she has determined your claim to be one involving urgent care.

You, your authorized representative or your physician may also request an expedited grievance by notifying Us orally or in writing, either separately or along with your initial request for a grievance. If your grievance meets criteria for an expedited grievance and you are eligible for external review, you are also eligible for an expedited external review concurrent with the internal expedited review of your grievance.

D. Independent External Review

You may also be entitled to an independent external review (IER) if the outcome of your grievance involves care that has been determined not to meet the Policy requirements for Medical Necessity, appropriateness, health care setting, level of care, effectiveness of care or where the requested services are considered Experimental or Investigational. Policy Rescissions are also eligible for IER.

You must exhaust Our internal review process before requesting an external review unless:

1. We fail to comply with internal claims and appeals requirements,
2. You request an expedited external review when you request an expedited internal review; or
3. We grant your request to bypass Our internal review process.

If you or your authorized representative wish to file a request for an independent review, you or your authorized representative must submit your request within four months of the date your grievance was decided.

There are two categories of external review, standard and expedited.

Standard External Review

You may request a standard external review in one of the following ways:

1. By directly submitting the request online at www.externalappeal.com;

2. By mailing the request to the independent review organization (IRO) at the following address:

   MAXIMUS Federal Services
   3750 Monroe Avenue, Suite 705
   Pittsford, NY 14534

3. By mailing the request to Us at the address listed above under the section describing the grievance process; or
4. By faxing the request to (888)-866-6190.

If you choose to mail or fax your request, you can either print off the online form, or you can provide the following information:

1. Name
2. Address
3. Phone number
4. Email address
5. Whether the request is urgent;
6. Member's signature if the person filing the appeal is not the Member; and
7. A brief description of the reason you disagree with your plan's initial decision.
8. Documents to support the claim, such as physician's letters, reports, bills, medical records, explanation of benefits (EOB) forms (optional);
9. Letters sent to your health insurance plan about the denied claim (optional); and
10. Letters received from the health insurance plan (optional).

You can get the online form at www.externalappeal.com or by calling the Customer Care Center at (800) 279-1301 or TTY 711.

The IRO will notify you and Us of its decision no later than 45 days after it receives your request for external review.

A decision made by the IRO is binding for both Us and the Member with the exception of the Rescission of a policy or certificate. You are not responsible for the costs associated with the IER.

Expedited External Review

In some cases you may ask for an expedited (faster than usual) external review. You may request an expedited external review when:

1. You have asked for an expedited grievance and want an expedited external review concurrently (at the same time) and the timeframe for an expedited grievance (72 hours) would place your life, health, or ability to regain maximum function in danger; or
2. You have completed the grievance process described above and the decision was not in your favor, and:
   a. The timeframe to do a standard external review (45 days) would place your life, health or ability to regain maximum function in danger; or

b. The decision is about admission, care availability, continued stay, or emergency health care services where the person has not been discharged from the facility.

You may request an expedited external review by following the process described above for standard external reviews, or by calling the IRO at (888) 866-6205. The 72-hour timeframe for an expedited review request begins when the phone call ends.

The IRO will notify you and Us of its decision as soon as possible, but no later than 72 hours after it receives the request for external review. The IRO may call you with its decision, but it must also mail you a written version of the decision within 48 hours of calling you.

A decision made by the IRO is binding for both Us and the Member with the exception of the Rescission of a policy or certificate. You are not responsible for the costs associated with the IER.

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 may file a complaint online or print a complaint form at:
Oci.wi.gov.

You may also request a complaint form by writing to:

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

or calling (608) 266-0103 (Madison) or toll free at 1-800-236-8517 (Statewide).

Non-Formulary Exception Request

If your prescribing Health Care Provider feels it is Medically Necessary to prescribe a clinically appropriate drug that is not on Our formulary, you can submit an exception request. To request an exception, you can either request a form from Our Customer Care Center at (800) 279-1301 or TTY 711 or obtain the form on deancare.com. You or your prescribing Health Care Provider can send the completed form via mail or fax as instructed. You must request the exception within 60 calendar days following the notification of the denial.

Your request will be processed through Our standard exception process unless there are urgent circumstances. We will notify you, your authorized representative, and your prescribing Health Care Provider of Our decision no later than 72 hours after We receive your request. If We approve the exception request, We will cover the drug until your prescription expires, including refills.

If you need the requested drug more urgently, we will process the request through Our expedited exception process. Urgent circumstances exist when you are suffering from a

health condition that may seriously jeopardize your life, health, or ability to regain function or you are undergoing a current course of treatment using a non-formulary drug. When you submit the request, you must indicate that your circumstances are urgent. We will notify you or your authorized representative and your prescribing Health Care Provider of Our decision no later than 24 hours after We receive your request. If We approve the request, We will cover the drug for as long as your circumstances remain urgent.

If We deny your non-formulary exception request, you, your authorized representative, or your prescribing Health Care Provider may request to have Our denial reviewed by the IRO. You must request this review within 60 calendar days of Our denial. For instructions on how to submit a standard external review of your exception request, see the Standard External Review section above. For instructions on how to submit an expedited external review of your exception request, see the Expedited External Review section above.

If We processed your original request through the standard exception process, the IRO will notify you and Us of its decision no later than 72 hours after receiving your request.

If We processed your original request through the expedited exception process, the IRO will notify you and Us of its decision no later than 24 hours after receiving your request.

End of Section VIII

IX. INDEX

End of Section IX
END OF DOCUMENT

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

Language Assistance – General Taglines

Dean Health Plan is required by federal law to provide the following information.

If you, or someone you're helping, have questions about Dean Health Plan, you have the right to get help and information in your preferred language at no cost. To talk with an interpreter, call Customer Care at (800) 279-1301.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Dean Health Plan, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al Customer Care. (800) 279-1301.

Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Dean Health Plan, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau Customer Care. (800) 279-1301.

如果您，或是您正在協助的對象，有關於[插入SBM項目的名稱 Dean Health Plan 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 Customer Care. (800) 279-1301。

Falls Sie oder jemand, dem Sie helfen, Fragen zum Dean Health Plan haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer (800) 279-1301 an.

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Dean Health Plan فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ (800) 279-1301

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Dean Health Plan, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону Customer Care. (800) 279-1301.

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Dean Health Plan 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 (800) 279-1301 로 전화하십시오.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Dean Health Plan, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi Customer Care. (800) 279-1301.

Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Dean Health Plan, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du (800) 279-1301 uffrufe.

ຖ້າທ່ານ, ຫຼືຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ມີຄຳຖາມກ່ຽວກັບ Dean Health Plan, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ການໂອ້ລົມກັບນາຍພາສາ, ໃຫ້ໂທຫາ Customer Care. (800) 279-1301.

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Dean Health Plan, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez Customer Care. (800) 279-1301.

Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Dean Health Plan, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer Customer Care. (800) 279-1301

यदि आपके ,या आप द्वारा सहायता किए जा रहे किसी व्यक्ति के Dean Health Plan के बारे में प्रश्न हैं ,तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। किसी दुभाषिए से बात करने के लिए , (800) 279-1301 पर कॉल करें।

Nëse ju, ose dikush që po ndihmoni, ka pyetje për Dean Health Plan, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin Customer Care. (800) 279-1301.

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Dean Health Plan, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa Customer Care. (800) 279-1301.

Non-Discrimination Statement: Dean Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Dean Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Dean Health Plan provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Dean Health Plan provides free language services to people whose primary language is not English such as: qualified interpreters and information written in other languages. If you need these services, contact the Dean Health Plan Customer Care Center at (800) 279-1301. If you believe that Dean Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance. If you need help filing a grievance, Megan Simpson, Civil Rights Coordinator for Dean Health Plan is available to help you. You can file a grievance in person or by mail, fax, or email:

Megan Simpson, Civil Rights Coordinator
1277 Deming Way
Madison, Wisconsin 53717
Phone: (608) 828-2216
Email: civilrightscoordinator@deancare.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-868-1019, 800-537-7697 (TDD)