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Schedule of Benefits

PPO Group Plan

Medical Package ID: PPO04732
Certificate ID: PPO04732-PHA05969-0125

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:

Cost Sharing Category	In-Network Amount	Out-of-Network Amount
Policy Deductible per Contract Period:	Single: $100 Family: $200	Single: $250 Family: $500
Policy Coinsurance after Deductible:	Paid by Plan: 100% Paid by You: 0%	Paid by Plan: 80% Paid by You: 20%
Out-of-Pocket Expense Maximum per Contract Period:	Single: $4600 Family: $9200	Single: $6900 Family: $13800

- **All references to "Deductible" are referring to your Deductible, as defined in your group Member Certificate.**
- **Copay amounts do apply to the maximum out-of-pocket expense.**

Policy Deductible and Out-of-Pocket Expense Maximum amounts are separate between Network and Out-of-Network Providers.

Your plan is administered on a calendar year basis, so all references to the term "Contract Period" are referring to the calendar year.

Please note: Some services/procedures require Prior Authorization; please see your Member Certificate for more details or call Member Services at **1 (800) 279-1301** (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 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 Member Services 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.

A. General Medical

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
Office Visit (Primary Care Provider & Optometry)	$20 copay; Waived for dependents through age 18	20% coinsurance after deductible
Chiropractic Services	$20 copay; Waived for dependents through age 18	20% coinsurance after deductible
Specialty Office Visits	$20 copay; Waived for dependents through age 18	20% coinsurance after deductible
Diabetic Education	$0 copay	20% coinsurance after deductible
Telehealth *Your cost sharing may be different for services delivered via telehealth as compared to virtual care provided by a designated virtual care provider. Member cost share is based on place and type of service as defined in this Policy.*	Primary Care Provider: $20 copay; Waived for dependents through age 18 Specialty Office Visits: $20 copay; Waived for dependents through age 18	Primary Care Provider: 20% coinsurance after deductible Specialty Office Visits: 20% coinsurance after deductible
Virtual Care/Virtual Visits • SSM Health Virtual Visit • Other Virtual Visit	 $0 copay 0% coinsurance after deductible	 Not Covered
Preventive Services ***One preventive physical exam, unless additional visits are necessary to obtain all covered preventive health care.***	$0 copay	20% coinsurance after deductible

B. Durable Medical Equipment, Prosthetics and Medical Supplies

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
Medical Supplies and Durable Medical Equipment	0% coinsurance after deductible	50% coinsurance after deductible; not subject to out-of-pocket maximum
Diabetic Supplies	0% coinsurance after deductible	50% coinsurance after deductible; not subject to out-of-pocket maximum

C. Diagnostic Services

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
X-Rays and Labs, including readings	0% coinsurance after deductible	20% coinsurance after deductible
Other Diagnostic Services	0% coinsurance after deductible	20% coinsurance after deductible
MRI/MRA	0% coinsurance after deductible	20% coinsurance after deductible
CAT Scans	0% coinsurance after deductible	20% coinsurance after deductible
PET Scans	0% coinsurance after deductible	20% coinsurance after deductible
Readings for: MRI/MRA, CAT Scans, and PET Scans	0% coinsurance after deductible	20% coinsurance after deductible

D. Hearing & Vision Services

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
Hearing Services	0% coinsurance after deductible	20% coinsurance after deductible
Hearing Aids – Adults ***Limited to one aid per ear every 36 months.***	0% coinsurance after deductible	Not Covered
Hearing Aids – Children through age 18 ***Limited to one aid per ear every 36 months.***	0% coinsurance after deductible	20% coinsurance after deductible
Cochlear Implants	0% coinsurance after deductible	20% coinsurance after deductible
Routine Vision Exam	$20 copay per visit; Waived for dependents through age 18	20% coinsurance after deductible
Non-Routine Vision Exam	$20 copay per visit; Waived for dependents through age 18	20% coinsurance after deductible
Vision Services	0% coinsurance after deductible	20% coinsurance after deductible
Eyeglasses – Children through age 18	Not Covered	Not Covered

E. Hospital & Surgical Services

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
Inpatient Hospital ***Maximum IN copay expense per Contract Period is Unlimited single / Unlimited family***	0% coinsurance after deductible	20% coinsurance after deductible
Inpatient Rehabilitative Confinement ***Maximum IN copay expense per Contract Period is Unlimited single / Unlimited family*** ***Combined benefit limited to 90 days per Member per Contract Period***	0% coinsurance after deductible	20% coinsurance after deductible
Detoxification Services ***Maximum IN copay expense per Contract Period is Unlimited single / Unlimited family***	0% coinsurance after deductible	20% coinsurance after deductible
Outpatient Hospital ***Maximum IN copay expense per Contract Period is Unlimited single / Unlimited family***	0% coinsurance after deductible	20% coinsurance after deductible
Ambulatory Surgical Center ***Maximum IN copay expense per Contract Period is Unlimited single / Unlimited family***	0% coinsurance after deductible	20% coinsurance after deductible

F. Skilled Nursing Facility

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
Licensed Skilled Nursing (Excludes Custodial Care and Other Non-Covered Expenses) ***Maximum IN copay expense per Contract Period is Unlimited single / Unlimited family*** ***Limited to 30 days per Confinement***	0% coinsurance after deductible	20% coinsurance after deductible

G. Home Health Care

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
Home Health Care ***Limited to 60 visits per Contract Period***	0% coinsurance after deductible	20% coinsurance after deductible

H. Hospice Care

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
Hospice Care	0% coinsurance after deductible	20% coinsurance after deductible

I. Palliative Care

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
Palliative Care	$0 copay	20% coinsurance after deductible

J. Emergency & Urgent Care Services

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
Ambulance Services	0% coinsurance after deductible	0% coinsurance after in-network deductible
Emergency Room Services* ***You may be responsible for other charges in addition to the facility Copay/Deductible/Coinsurance.**** ***Copay is waived if admitted for Observation or Inpatient.***	$150 copay and/or 0% coinsurance after deductible	$150 copay and/or 0% coinsurance after in-network deductible
Urgent Care Facility* ***You may be responsible for other charges in addition to the visit Copay/Deductible/Coinsurance.****	$20 copay; Waived for dependents through age 18 and/or 0% coinsurance after deductible	$20 copay; Waived for dependents through age 18 and/or 0% coinsurance after in-network deductible
* Other charges will result from services rendered by other providers who treated you during your urgent care or emergency room visit. These charges include, but are not limited to, physician visits, diagnostic services, procedures/treatments and various medical supplies. The amount charged for these services, excluding emergency 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. Cost-sharing requirements for items and services provided by Out-of-Network Providers at in-network facilities will be no greater than in-network requirements.		

K. Therapies, Rehabilitation & Habilitative Services

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
Autism Spectrum Disorder – Intensive – Physician and Facility Charge	$20 copay per therapy type per day; Waived for dependents through age 18	20% coinsurance after deductible
Autism Spectrum Disorder – Intensive – Related Services	0% coinsurance after deductible	20% coinsurance after deductible
Autism Spectrum Disorder – Non-Intensive – Physician and Facility Charge	$20 copay per therapy type per day; Waived for dependents through age 18	20% coinsurance after deductible

K. Therapies, Rehabilitation & Habilitative Services (continued)

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
Autism Spectrum Disorder – Non-Intensive – Related Services	0% coinsurance after deductible	20% coinsurance after deductible
Outpatient Physical, Speech and Occupational Therapy ***Limited to 60 visits per Contract Period (All therapies combined)*** ***Please note:*** *This visit limit does not apply to services for treatment of a mental health and/or substance use disorder condition.*	$0 copay per therapy type per day	20% coinsurance after deductible
Habilitative Services ***Limited to 60 visits per Contract Period (All habilitative therapies combined)*** ***Please note:*** *This visit limit does not apply to services for treatment of a mental health and/or substance use disorder condition.*	$0 copay per therapy type per day	20% coinsurance after deductible
Phase II Cardiac Rehabilitation	0% coinsurance after deductible	20% coinsurance after deductible
Radiation Therapy	0% coinsurance after deductible	20% coinsurance after deductible

L. Dental Services

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
Trauma/Accidental Injury to Teeth	0% coinsurance after deductible	20% coinsurance after deductible
Oral Surgery Consult	$20 copay per visit; Waived for dependents through age 18	20% coinsurance after deductible
Oral Surgical Services	0% coinsurance after deductible	20% coinsurance after deductible
Treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level.	Covered at the corresponding out-of-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit out-of-network benefit level and surgical services are covered at the surgical services out-of-network benefit level.
TMJ DME	0% coinsurance after deductible	50% coinsurance after deductible; not subject to out-of-pocket maximum

M. Behavioral Health & Addiction Services

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
Inpatient/Residential Care – Behavioral Health & Addiction Services ***Maximum IN copay expense per Contract Period is Unlimited single / Unlimited family***	0% coinsurance after deductible	20% coinsurance after deductible
Outpatient Behavioral Health & Addiction Services	$20 copay; Waived for dependents through age 18	20% coinsurance after deductible
Intensive Outpatient/Day Treatment/Partial Hospitalization	0% coinsurance after deductible	20% coinsurance after deductible

N. Transplants

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
Transplant Services ***Maximum IN copay expense per Contract Period is Unlimited single / Unlimited family***	0% coinsurance after deductible	20% coinsurance after deductible

O. Kidney Disease Treatment

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
Kidney Disease Treatment	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level.	Covered at the corresponding out-of-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit out-of-network benefit level and surgical services are covered at the surgical services out-of-network benefit level.

P. Other Services

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
Acupuncture ***Combined benefit limited to 10 visits per Contract Period***	$20 copay; Waived for dependents through age 18	20% coinsurance after deductible
Anesthesia Services	0% coinsurance after deductible	20% coinsurance after deductible
Allergy Injections	0% coinsurance after deductible	20% coinsurance after deductible
Genetic Counseling	Primary Care Provider: $20 copay; Waived for dependents through age 18 Specialty Office Visits: $20 copay; Waived for dependents through age 18	Primary Care Provider: 20% coinsurance after deductible Specialty Office Visits: 20% coinsurance after deductible
Genetic Testing Services	0% coinsurance after deductible	20% coinsurance after deductible

P. Other Services (continued)

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
Home Infusion Therapy	0% coinsurance after deductible	20% coinsurance after deductible
Infertility Services ***$2,000 combined lifetime benefit maximum***	50% of $4,000	50% of $4,000
Maternity Services – Physician Services	0% coinsurance after deductible	20% coinsurance after deductible
Reconstructive and Restorative Surgery	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level.	Covered at the corresponding out-of-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit out-of-network benefit level and surgical services are covered at the surgical services out-of-network benefit level.
Surgical Services	0% coinsurance after deductible	20% coinsurance after deductible
Travel Immunizations	0% coinsurance after deductible	20% coinsurance after deductible

Rider – Prescription Drugs – Tier Option

Benefits	In-Network Amount You Pay	Out-of-Network Amount You Pay
TIER 1 Outpatient Prescription Drugs*** Brand and Generic ***30-day supply***	$6 copay**	50% coinsurance
TIER 2 Outpatient Prescription Drugs*** Brand and Generic ***30-day supply***	$15 copay**	50% coinsurance
TIER 3 Outpatient Prescription Drugs Brand and Generic ***30-day supply***	$30 copay**	Not Covered
TIER 4 Outpatient Prescription Drugs Brand and Generic ***30-day supply***	Not Covered	Not Covered
Mail Order	90-day supply (Tier 1) for 2 copays; 90-day supply (Tiers 2 & 3) for 3 copays	Not Covered
Outpatient Prescription Drugs – Infertility	50% coinsurance	Not Covered

**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.

***For certain generic maintenance drugs, as defined by Us, a retail provider must dispense a 90-day supply. This requirement will apply after you have received three consecutive 30-day supplies. A Member may request an exception to this requirement by either: 1) asking the retail pharmacy provider to contact pharmacy benefit manager, or 2) contacting Our Customer Care Center.

Prescription Drug Rider

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.



Alicia Reuter - Secretary

IMPORTANT: Information About this Rider

- 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 website at deancare.com, log into your Member Profile portal, or contact Our Member Services at **1 (800) 279-1301** (TTY: **711**).
- A formulary is a list of prescribed Drugs, medications, supplies and other agents that 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 or other items 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 Member Services.
- When you get coverage of a "non-covered" medication through Our Non-Formulary Exception Request process, you will pay the highest cost tier based on your prescription Drug benefit.
- Lowering a tier of a Drug product that is either listed on your formulary or a "non-covered" prescription Drug for which you obtained approval through Our Non-Formulary Exception Request process is not allowable.
- 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 Necessary application are determined. Certain Drug products may be excluded when comparable generic or therapeutic alternatives are available.
- Certain covered preferred and non-preferred brand name Drugs include a chemically equivalent generic Drug on the formulary. If you still choose to use a brand name prescription drug, We will pay the amount that We would have paid had you received the generic Drug. You will pay, in addition to the applicable Deductible, Copayment or Coinsurance described in the Schedule of Benefits, any remaining charges due to the pharmacy in excess of Our payment to the pharmacy. These charges are not applied to your Deductible or Out-of-Pocket Expense Maximum.
    - If your Health Care Provider requests that a preferred and non-preferred brand name Drug be dispensed as written and there is a chemically equivalent generic Drug on the formulary, a brand Drug will be covered at the brand name benefit level and a non-preferred brand Drug will be covered at the non-preferred brand benefit level.
    - Please note that receiving brand name Drugs when an equivalent generic drug is on the formulary may result in significantly more than the Out-of-Pocket Expense Maximum.
- Certain prescription Drugs included on the formulary require Prior Authorization. Please refer to the formulary on deancare.com or by contacting Our Member Services. 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 Member Services.
- 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 15-day supplies for the first three months. You will pay half of the monthly cost-share.
- 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. Some 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 U.S. Department of Health and Human Services Office of Inspector General.
    - 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.
- 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. Some specialty Drugs require Prior Authorization. Specialty Drugs must be obtained from Our Network specialty pharmacies. Certain specialty Drugs may be subject to the Partial Fill Program. Medications classified as specialty Drugs are identified on the formulary.
- If it is determined that you are receiving certain prescription drugs in a quantity or manner that may harm your health, benefits for these medications will be restricted to medications that are both prescribed by one specific network physician and dispensed by one specific network pharmacy. Failure to receive these medications in this manner will result in a denial of coverage. We will notify you regarding the specific physician and pharmacy assigned for you.
- The use of physician samples or manufacturer discount programs does not count toward historical drug utilization to guarantee drug coverage. All criteria, including Prior Authorization, Step Therapy, and any other requirements, must be met in order to obtain coverage of the drug.
- FOR BRAND/GENERIC: Brand Copays apply when there is no generic equivalent of the brand Drug.
- FOR BRAND/GENERIC: The generic Drug Copay does not apply to the brand Drug out-of-pocket maximum, if your plan has a brand name out-of-pocket maximum.

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, finger stick devices, lancets and syringes. Single-packaged items such as blood glucose testing strips are limited to two items per cost-sharing amount.
  - Infusion pumps and related equipment and supplies are covered under the medical benefit as required by Wis. Stat. § 632.895(6) from a network durable medical equipment provider.
  - Continuous glucose monitoring equipment and related supplies.
- **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 stated otherwise, 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.
- 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.

Non-Covered Expenses:

- Medication for the treatment of sexual dysfunction.
- Erectile dysfunction Drugs.
- Infertility drugs, including, but not limited to, those administered by a medical provider for the purpose of ART.
- Anorexic agents or any medications prescribed for weight loss.
- Drugs prescribed by a provider who is not acting within their scope of licensure.
- New to market Drugs. Products recently approved by the FDA and introduced into the market will not be covered until they are reviewed and considered for placement on Our Drug List.
- New to market biologics, biosimilars and professionally administered drugs. Biologics, biosimilars and professionally administered drugs recently approved by the FDA (including approval for a new indication) will not be covered until they are reviewed and approved for coverage by Us.
- If you fail to provide your prescription coverage information to the pharmacy, you will be responsible for any amount above what We would have paid for your prescription under this policy.
- Products that are duplicative to, or are in the same class and category as, products on Our Drug list.
- Drugs, supplies, biologics and biosimilars that have not been approved by the U.S. Food and Drug Administration (FDA).
- Professionally administered drugs that do not meet both of the following requirements: (a) administered in conjunction with a covered benefit and (b) administered by a physician acting within the scope of the provider's license.

- Any form, mixture or preparation of cannabis for medical or therapeutic use and any device or supplies related to its administration.
- Charges for prescription Drugs that require Prior Authorization, if Prior Authorization is not obtained from Us.
- Services or drugs used to treat conditions that are cosmetic in nature, unless otherwise determined to be reconstructive.
- 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.
- Compounded Drugs that do not contain at least one ingredient that has been approved by the FDA and requires a prescription order or refill or do not meet Our compound Prior Authorization criteria. Compounded Drugs that are available as a similar commercially available prescription Drugs.
- 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 FDA for use in humans, unless Prior Authorized 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 Prior Authorized 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.
- Any health care service, item or investigational drug that is subject of a clinical trial, unless coverage is otherwise specified in this Certificate.

- Growth hormone for the treatment of idiopathic short stature.
- Drugs applied, ingested or administered while Member is a patient or resident in a hospital, outpatient provider setting, behavioral health facility, extended-care facility, convalescent hospital, skilled nursing facility, hospice or similar institution.
- Prescription drugs, including diabetic equipment and supplies, preventive drugs and other supplies received at an out-of-network pharmacy.
- Prescription Drugs dispensed prior to the Member's Effective Date of coverage or after the Member's termination date of coverage under the Policy.

Expanded Preventive Drug List Rider

This Expanded 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.



Alicia Reuter – Secretary

IMPORTANT: Information About this Expanded Drug Rider

- 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 website at deancare.com, log into your Member Profile portal, or contact Our Member Services at **1 (800) 279-1301** (TTY: **711**).
- This plan covers certain Drugs for treatment of limited chronic conditions at no cost to you.
- For more information about covered prescriptions under this Policy, please refer to your Prescription Drug Rider.

Covered Expenses:

- $0 Copay for all preventive medications included on the Expanded Preventive Drug List.
- The most up-to-date Expanded Preventive Drug List can be found here: Dean Health Plan Drug Formularies - Dean Health Plan (deancare.com) .

Group PPO Plan

Member Certificate

Learn more about your plan or get answers to your benefit questions:

CALL

Member Services
1 (800) 279-1301 (TTY: **711**)

CLICK

deancare.com

Business Address:
Dean Health Plan, Inc.
1277 Deming Way
Madison, WI 53717

Mailing Address:
Dean Health Plan, Inc.
P.O. Box 56099
Madison, WI 53705

IMPORTANT INFORMATION

GROUP PPO MEMBER CERTIFICATE

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

IMPORTANT NOTICE CONCERNING STATEMENTS IN YOUR EMPLOYEE APPLICATION ENROLLMENT FORM

Please read the copy of your employee application provided to you by your employer/Policyholder or 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. 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 Member Services at the address and telephone numbers shown on the cover of this Certificate.

No eligibility rules or variations in premium will be imposed based on your health status, medical condition, claim experience, receipt of health care, medical history, genetic information, evidence of insurability, disability or any other health status related factor. You will not be discriminated against for coverage under this Policy on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.

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 Our Member Services 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 lower than the amount the Out-of-Network Provider bills. If there is a difference between the Maximum Allowable Fee and the amount Out-of-Network Provider bills, the Member will be responsible for paying the difference, except for Emergency Services or services at a network facility by an Out-of-Network Provider. 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 Member Services.

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 Our Member Services prior to having the service performed. Our Member Services will attempt to assist you. However, no information provided by Our Member Services shall change your coverage, obligations and responsibilities under the Policy.

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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 Member Services at **1 (800) 279-1301** (TTY: **711**).

We have many preferred provider organization (PPO) Network Providers who can care for you. Your Plan also allows you the freedom to see providers who are outside of the PPO network. You may see the physician of your choice for any covered service. This Plan does not require you to choose a Primary Care Provider or obtain a referral to see a specialist. However, some services may require Prior Authorization.

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 Network Providers who specialize in obstetrics or gynecology, contact Us at **1 (800) 279-1301** (TTY: **711**).

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 24-Hour Nurse Advice Line and can be reached at **800-57-NURSE** or/and **1 (608) 250-1393**. 24-Hour Nurse Advice Line nurses do not provide medical care or treatment. They base their advice solely on the information you provide when you call. Due to licensing laws, 24-Hour Nurse Advice Line services are only available to Wisconsin residents.

Network Providers

PPO Network Providers are Health Care Providers that sign an agreement with Us to provide medical services to Our Members. They are part of the PPO network and are listed in the most current edition of Our PPO Provider Directory (which is also located online at deancare.com.

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

Please note, Our contracts with PPO 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

You can choose to seek care from Health Care Providers that are not in Our Network. However, if you choose to seek care from an Out-of-Network Provider you will be responsible for paying higher out-of-pocket costs.

Out-of-Network Providers are those Health Care Providers who are not Network Providers, as defined above We are not responsible or liable for the quality of care provided by an Out-of-Network Provider.

For the following notice, non-participating provider means Out-of-Network Provider.

NOTICE: LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING OR OUT-OF-NETWORK PROVIDERS ARE USED. You should be aware - when you elect to utilize the services of a non-participating provider for a covered service, benefit payments to such non-participating providers are not based upon the amount billed. The basis of your benefit payment will be determined according to your Policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the Policy. YOU RISK PAYING MORE THAN THE COINSURANCE, DEDUCTIBLE AND COPAY AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating providers may bill enrollees for any amount up to the

billed charge after the plan has paid its portion of the bill. Participating providers have agreed to accept discounted payment for covered services with no additional billing to the enrollee other than Copay, Coinsurance, and Deductible amounts. You may obtain further information about the participating status of providers and information on out-of-pocket expenses by calling Member Services at 1 (800) 279-1301 (TTY: 711) or by visiting deancare.com.

Generally, if you choose to see an Out-of-Network Provider, 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 Our Member Services if you have questions about the Maximum Allowable Fee.

However, there are a few exceptions:

- We will cover Emergency Services or Urgent Care you receive from an Out-of-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.
    - You still need to pay any applicable Deductible, Coinsurance, or Copay amounts.
    - If you receive Urgent Care, 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 Our Member Services if you have questions about the Maximum Allowable Fee.

Continuity of Care:

Continuity of care is the process by which We authorize a Member, for a limited period of time, to continue accessing covered services with a treating provider who is not in Our network while still receiving in-network benefits.

To request continuity of care, or if you have questions about whether you may be eligible, call Member Services at the telephone number on your Medica ID card.

In-network benefits will continue to apply to health services you receive from a provider (1) if that provider was listed as a Network Provider in the Our provider directory at your last enrollment period or your last coverage renewal period, or (2) you are new to Us because your employer terminated its health plan, and your current treating provider is not a Network Provider, for the following periods of time:

1. For up to 90 days if you were undergoing a current course of treatment, including but not limited to, treatment for one or more of the following conditions, at the time of termination:
    a. An ongoing course of treatment for a serious acute condition;
    b. An ongoing course of treatment for a chronic condition;
    c. Undergoing a course of institutional or inpatient care from the provider or facility;
    d. Scheduled non-elective surgery, including postoperative care; and
    e. If your course of treatment is maternity care, health services may be continued to be provided by the terminated provider through the completion of postpartum care for you and your infant.
2. Authorization to continue to receive services from your current provider may extend to the remainder of your life if a physician certifies that your life expectancy is 180 days or less.
3. In addition, for health services received from a primary are physician whom you have chosen to receive services from and who is no longer a Network Provider, until the end of your current contract year as stated in your employer's Contract.

We may require medical records or other supporting documentation from your treating provider to review your continuity of care request, and will consider each continuity of care request on a case-by-case basis. If We authorize your request to continue care with your current treating provider, We will explain how continuity of care will be provided. After the time period for which continuity of care is approved, your services or treatment will need to be transitioned to a Network Provider to continue to be eligible for benefits. If your continuity of care request is denied, We will explain the criteria used to make its decision. You may appeal this decision.

Continuity of care applies only if your treating provider agrees to comply with Our Prior Authorization requirements, provides Us with all necessary medical information related to your care and accepts as payment in full the lesser of Our Network Provider reimbursement or the treating provider's customary charge for the service.

Continuity of care is not available for treating providers that are terminated for cause. If We terminate your current treating provider's contract for cause, We will inform you of the change and how your care will be transferred to another Network Provider. In-network benefits will not continue to be applied to health services you receive from a provider whose contract is terminated for misconduct on the part of the provider.

Under continuity of care, coverage will not be provided for services or treatments that are not otherwise covered under this Certificate.

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

Before you seek care from an Out-of-Network Provider, you can call Our Member Services to get information about Maximum Allowable Fees. Before you call, You will need to contact your Out-of-Network Provider to get the procedure code(s) and the amount(s) the Out-of-Network Provider intends to charge. You can give this information to Our Member Services so We can determine the Maximum Allowable Fee for the service(s) you are seeking. Within 5 business days of receiving your request, We will notify you to tell you whether the service is covered and if it is subject to the Maximum Allowable Fee or any other Policy provisions (e.g., Deductibles or Copays).

Harmful Use of Medical Services:

If We determine that you are receiving health services or prescription Drugs in a quantity or manner that may harm your health, We may restrict your benefits to services provided by or arranged through one specific network physician, one specific network pharmacy, and, in certain situations, one specific network hospital (your "coordinating Health Care Providers"). We will choose your coordinating Health Care Providers or determine if you may choose your own coordinating Health Care Providers. Your benefits are restricted to services provided by or arranged through your coordinating Health Care Providers. If you are subject to this section, We may deny claims for health services or prescription Drugs you receive from a non-coordinating Health Care Provider if such services and prescription Drugs are harmful to your health.

If you have questions about how this provision applies to you, including the specific physician, pharmacy or hospital assigned for you, call Member Services at the telephone number listed at the front of this certificate. Additionally, you have the right to appeal Our decision concerning the application of this section. See the "Grievance and Appeals" subsection for more information on your appeal rights.

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 a complete list. You should contact Our Member Services at **1 (800) 279-1301** (TTY: **711**) to verify whether a procedure or service needs Prior Authorization.

Examples of Procedures/Services Requiring Prior Authorization:

- Certain organ and blood and marrow transplant services - this Prior Authorization must be obtained before the transplant workup is initiated;
- In-network benefits for services from non-network providers, with the exception of emergency services;
- Certain Reconstructive or Restorative Surgery procedures;
- Certain Drugs, biologics and biosimilars;
- Certain home health care services;
- Certain durable medical equipment;
- Certain outpatient surgical procedures;
- Certain imaging services;
- Non-emergency licensed air ambulance transportation; and
- Skilled Nursing Facility services.

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 Us. It is 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 will notify you in writing of Our decision.

Your Health Care Provider may decide that it is Medically Necessary for you to 1) get additional services beyond what We originally authorized, or 2) receive care for longer than the length of time We originally authorized. If this happens, your Health Care Provider must contact Us 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, a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence, is applied or the service may be denied for failure to obtain an authorization. All Copays, Deductibles and Coinsurance for Covered Expenses still apply. This penalty will not count toward your Out-of-Pocket Expense Maximum. You, the Member, must ensure that your Health Care Provider has gotten Prior Authorization for all services.

Urgent Care and Emergency Services:

In urgent and emergency situations, you may need medical attention before the written Prior Authorization process can take place. You do not need to get Prior Authorization for Urgent Care or Emergency Services. However, if you need to be admitted to a facility We must be notified within 48 hours or when it is medically feasible (whichever is longer) at **1 (800) 279-1301** (TTY: **711**).

Inpatient services may be reviewed for Medical Necessity.

If you get Urgent Care or Emergency Services 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.

Concurrent Review for Out-of-Network Providers:

We will continue to review facility Confinements and certain outpatient services after you have gotten an initial Prior Authorization. We review these services concurrently 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 Us to request an extension. We 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.

Assisted Reproductive Technology (ART):

All treatments or procedures that include the handling of human eggs, sperm, and/or embryos to help a woman become pregnant. ART includes, but is not limited to, gamete intrafallopian transfer (GIFT), uterine embryo lavage, embryo transfer, artificial insemination (AI), intrauterine insemination (IUI), intracervical insemination (ICI), intravaginal insemination (IVI), in vitro fertilization (IVF), pronuclear state transfer (PROST), tubal embryo transfer (TET), zygote intrafallopian transfer (ZIFT), low tubal ovum transfer, intracytoplasmic sperm injection (ICSI), cryopreservation (e.g., egg, embryo, sperm), and other third party-assisted ART methods (e.g., sperm donation, egg donation, Traditional Surrogates and Gestational Carriers, embryo donation).

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.

A Clinical Trial must satisfy all of the following criteria:

1. Meets at least one of the following three criteria:
    a. Is approved, funded (which may include funding through in-kind contributions), sponsored and/or provided by one or more of the following:
        i. The National Institutes of Health (NIH);
        ii. The Centers for Disease Control and Prevention (CDC);
        iii. The Agency for Health Care Research and Quality (AHCRQ);
        iv. The Centers for Medicare & Medicaid Services (CMS);
        v. A cooperative group or center of any of the entities described in clauses (i) through (iv) or the Department of Defense (DOD) or the Department of Veterans Affairs (VA);
        vi. A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants;
        vii. The VA, the DOD or the Department of Energy (DOE) if the following conditions are met:
            1) The study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be:
                a) Comparable to the system of peer review of studies and investigations used by the NIH; and
                b) Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review; or

viii. A cancer center that has been designated by the National Cancer Institute (NCI) as a Clinical Cancer Center or Comprehensive Cancer Center.

b. Is conducted under an investigational new Drug application reviewed by the Food and Drug Administration (FDA); or

c. Is a Drug trial that is exempt from such an investigational new Drug application.

2. Has a written protocol that describes a scientifically sound study and has been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm the trial meets current standards for scientific merit and has the relevant IRB approvals.
3. The subject or purpose of the trial is the evaluation of an item or service that meets the definition of a Covered Expense and is not otherwise excluded under this Policy.

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 doctor 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 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, additional days are not available until skilled care has not been required for at least 60 consecutive days.

Contract Period:

Unless stated otherwise 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.

Cosmetic Surgery, Services or Procedures:

Services and procedures that improve physical appearance but do not correct or improve a physiological function and that are not Medically Necessary unless the service or procedure meets the definition of Reconstructive Surgery.

Covered Expense:

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

Custodial 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.

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.

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.

Emergency Medical Condition:

A medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, to lead a prudent layperson who possesses an average knowledge of health and medicine to reasonably conclude that a lack of immediate medical attention will likely result in any of the following:

1. Serious jeopardy to the person's health or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child.
2. Serious impairment to the person's bodily functions.
3. Serious dysfunction of one or more of the person's body organs or parts.
4. Inadequately controlled pain; or
5. With respect to a pregnant woman who is having contractions:
    a. That there is inadequate time to effect a safe transfer to another hospital before delivery; or
    b. That transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

Emergency Services:

1. A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, a licensed independent freestanding emergency department, or an Urgent Care Facility that is permitted under state law to provide emergency services and that meets the definition of an independent freestanding emergency department as defined under 42 USC §300gg–2799A-1(a)(3)(D), to evaluate such Emergency Medical Condition; and
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities at the hospital, as are required to Stabilize the patient.

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.

Habilitative Services:

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.

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.

Hospice Care:
Hospice Care is provided by an agency or organization that:

- Is available 24 hours a day, seven days a week.
- Is certified by Medicare as a hospice program and, if required, is licensed by the jurisdiction in which it is located.
- Provides core services, which include:
  - Nursing services available 24 hours a day, seven days a week.
  - Medical social worker services.
  - Dietary, spiritual and bereavement counseling.
  - Palliative and supportive medical, social and psychological services.
- Provides or arranges for other services when approved by your Health Care Provider. These services may include:
  - Health Care Provider or social worker services.
  - 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:

- Is licensed to provide Hospice Care in the area in which it is located.
- Provides services 24 hours per day, seven days per week.
- 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 providing core services.
- Maintains written or electronic records.

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

Infertility:
A term used to describe the inability to get pregnant or the inability to carry a pregnancy to term.

Inpatient Behavioral Health Services:
Medically-oriented treatment, psychotherapy and other behavioral health services to enable a person with a behavioral health disorder, or a behavioral health disorder in combination with other impairments, to function successfully. These services must be provided:

- By a licensed professional;
- In a state-licensed or certified hospital or behavioral health residential facility; and
- On a 24 hour per day basis.

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.

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 Medically Necessary.

Intensive Outpatient Behavioral Health Services:

Planned, structured behavioral health services that are more intensive than outpatient services but are less intensive than inpatient services. They include a prearranged weekly schedule of core services (e.g., individual counseling, group therapy, family psychoeducation, medication management and case management) that are provided over several sessions during the course of a week. The level of care is typically short-term intensive treatment that aims to reduce symptom disruption to the extent that intensive treatment is no longer required. Intensive outpatient services must be provided by a licensed behavioral health or addiction treatment provider.

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 Us 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 Us 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, other than Emergency Services, 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 Us, 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 doctor 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 doctor 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."

Observation:
In a hospital facility, Observation care is a set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment and reassessment. Treatment can frequently include surgical services to resolve an urgent, unforeseen condition. An Observation stay is considered an outpatient service and is paid as an outpatient benefit. It is an alternative to an inpatient hospital admission to allow reasonable and necessary time to evaluate and render Medically Necessary services to a Member and determine if they may require an inpatient stay or follow-up care in another setting.

Ongoing Course of Treatment:
The treatment of a condition or illness that requires repeated health care services pursuant to a plan of treatment by a physician because of the potential for changes in the therapeutic regimen.

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

Outpatient Hospital or Ambulatory Surgical Services:
An ambulatory surgery center is an outpatient surgical facility that provides day surgery services to persons who need care for less than 24-hours. An outpatient surgical facility is 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.

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, including Emergency Services provided by an Out-of-Network Provider. Premiums, non-covered services, benefit reduction amounts and non-emergency services

provided by Out-of-Network Providers that have not been Prior Authorized are not included in the Out-of-Pocket Expense Maximum.

Policy Deductible and Out-of-Pocket Expense Maximum amounts are separate between Network and Out-of-Network Providers.

Partial Hospitalization Behavioral Health Services:

Structured and medically supervised day, evening and/or night treatment services designed to address a mental health and/or substance-related disorder. They are more intensive than outpatient services, but less intensive than inpatient services. They include a prearranged weekly schedule of core services (e.g., individual counseling, group therapy, family psychoeducation, medication management and case management). The level of care is typically short-term intensive treatment that aims to reduce symptom disruption to the extent that intensive treatment is no longer required. Partial Hospitalization services:

- Must be provided in a licensed behavioral health or addiction treatment partial hospitalization facility; and
- Must be provided by a licensed behavioral health or addiction treatment provider.

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.

Prescription Drug Product/Drug:

A medication or product that has been approved by the U.S. Food and Drug Administration (FDA) and that can, under federal or state law, be dispensed only pursuant to a prescription order or refill. A prescription Drug includes a medication that, due to its characteristics, is appropriate for self−administration or administration by a non−skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- Inhalers (with spacers)
- Insulin
- Oral hypoglycemic agents
- The following diabetic supplies:
  - Standard insulin syringes with needles;
  - Blood−testing strips −glucose;
  - Urine−testing strips −glucose;
  - Ketone−testing strips and tablets;
  - Lancets and lancet devices; and
  - Patient self-testing blood glucose meters (except continuous insulin pumps).

Primary Care Provider (PCP):

A 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.

Prior Authorization/Prior Authorized:

A Prior Authorization is a written request that is completed by a Network Provider 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 Us 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.

Professionally Administered Drugs:

Professionally Administered Drugs must be, as determined by Us, typically administered or directly supervised by a qualified provider or a licensed/certified health professional. We generally consider Drugs that require intravenous infusion or injection, intrathecal infusion or injection, intramuscular injection or intraocular injection, as well as Drugs that, according to the manufacturer's recommendations, must typically be administered by a Health Care Provider, to be Professionally Administered Drugs.

Qualified Dependent:

A Qualified Dependent is:

- The legally married spouse of the Subscriber;
- The Subscriber's married or unmarried biological child, stepchild, adopted child, foster 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 Our Member Services if you have any questions;
- The Subscriber's biological child, stepchild, foster 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;
- The Subscriber's biological child, stepchild, 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 meet the following:

- Is an unmarried Qualified Dependent child who is incapable of self-support because of a physical or mental disability;
- Is dependent on the Subscriber for at least 50% of the child's support and maintenance;
- Have become disabled before he/she reached the limiting age. 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.

Quantity Limits (QL):

Certain covered Drugs have limits on the maximum quantity allowed per prescription over a specific time period. The medications subject to Quantity Limits are shown on Our Drug List with the abbreviation "QL." Some Quantity Limits are based on the manufacturer's packaging, FDA labeling or clinical guidelines.

Reconstructive Surgery:
Surgery to rebuild or correct a:

1. Body part when such surgery is incidental to or following surgery resulting from injury, sickness, or disease of the involved body part; or
2. Congenital disease or anomaly which has resulted in a functional defect as determined by your Health Care Provider.

In the case of mastectomy, surgery to reconstruct the breast on which the mastectomy was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance shall be considered reconstructive. Surgery that is cosmetic is not reconstructive.

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.

Restorative Surgery:
Surgery to rebuild or correct a physical defect that has a direct adverse effect on the physical health of a body part, and for which the restoration or correction is Medically Necessary.

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 Our Member Services for more information about the geographic area We serve. The Service Area may change from time to time.

Skilled Nursing Facility:
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. Rehabilitation services must be deemed Medically Necessary by Us.

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.

Stabilize:
To provide such medical treatment of an emergency medical condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or transfer of the individual between floors or departments in a single facility. For a pregnant woman having contractions, it means to deliver (including the placenta).

Step Therapy (ST):
Process that involves trying an alternative covered Drug first before moving to another covered Drug for treatment of the same medical condition. The medications subject to Step Therapy are shown on the Drug list with the abbreviation "ST." You must meet applicable Step Therapy requirements before We will cover these preferred brand or non-preferred brand drugs.

Subscriber:
The Eligible Employee enrolled in the Policy.

Telemedicine:
Refers to interactions through the use of technology, between patients and providers at different locations for the purpose of assessment, diagnosis, consultation, treatment, education, care management, and self-management.

- Telehealth; an interactive audio and/or video telecommunications system that permits real-time communication between the provider at the practice location and the Member at a different location. Telehealth refers to patient/Member-initiated remote clinical services provided to a patient/Member via an interactive audio and/or video telecommunication system that permits real-time communication between the provider at a practice location and the Member at a different location to manage a medical condition. Services must address an issue that would typically require a face-to-face visit.
- Virtual Care/Virtual Visit refers to patient/Member-initiated non-face-to-face, non-real time evaluation and treatment by a provider using technology services that do not require a scheduled appointment. Technology services may include use of a patient portal, email, or secure messaging for the exchange of text, images, or videos. Services must address an issue that would typically require a face-to-face visit.

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.

Urgent Care:
Care that you need sooner than a regular doctor'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.

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.

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

- We will cover second opinions per injury or illness as long as you have benefits available.
  - Please contact Our Member Services about services that require Prior Authorization.
- If you fail to get Prior Authorization for any Medically Necessary covered service which requires an authorization, a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence, is applied or the service may be denied for failure to obtain an authorization.
- Any service that is covered under this subsection is also covered when provided in connection with a Clinical Trial.
- Please also see General Exclusions and Limitations and your Schedule of Benefits for any coverage limitations.

Office Visits

Covered Expenses:

- Office visits and consults. 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 examination, diagnosis, adjustment, manipulation and treatment that, delivered by a licensed chiropractor are expected to yield significant patient improvement, and are not considered Maintenance or Long-Term Therapy.

Non-Covered Chiropractic Expenses:

- Maintenance or Long-Term Therapy.

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. Routine preventive services are as defined by state and federal law.

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

- Be expenses for;
  - Care to evaluate or assess health and wellbeing;
  - 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 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 (CDC) with respect to the individual involved (an ACIP recommendation is considered in effect after it has been adopted by the Director of the CDC, and a recommendation is considered to be for routine use if it is listed on the CDC's Immunization Schedules);
    - 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.

The USPSTF, ACIP, and HRSA may issue new and updated recommendations and guidelines. New or updated recommendations and guidelines from the USPSTF, ACIP, and HRSA are covered as preventive health services starting on the first day of the Contract Period begins one year after the final recommendations and guidelines are issued.

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.

Non-Covered Expenses:

- Any service, except those listed as covered in this preventive subsection.

Telemedicine Services

- This term is the umbrella term that includes a wide range of technologies that support Telehealth and Virtual Care/Virtual Visits.
- Not all conditions may be available or appropriate for treatment by a Telehealth Services provider, and you may be referred to another more appropriate care setting.

Covered Expenses:

- Telehealth; an interactive audio and/or video telecommunications system that permits real-time communication between the provider at the practice location and the Member at a different location.
  - Coverage of a service provided via Telehealth is subject to the same benefits and limitations as if the service is provided face-to-face (e.g., allowable providers, prior authorization, copay, deductible, coinsurance).
- Virtual Care/Virtual Visit; non-face-to-face and non-real-time communication-based technology services.

Non-Covered Telehealth Services Expenses:

- All other benefits not otherwise listed in the Policy.

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

B. DURABLE MEDICAL EQUIPMENT, PROSTHETICS AND MEDICAL SUPPLIES

- Supplies or equipment may require a Prior Authorization.
  - Please contact Our Member Services about services that require Prior Authorization.
- Supplies or equipment shall either be purchased or rented. We will make that decision. Supplies or equipment cannot be rented if it costs more to rent than to buy.
- 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 Necessary and cost effective for that illness or injury.
- Any item that is covered under this subsection is also covered when provided in connection with a Clinical Trial.
- Please also see General Exclusions and Limitations and your Schedule of Benefits for any coverage limitations.

Durable Medical Equipment, Prosthetics and Medical Supplies

Covered Expenses:

- Durable medical equipment, prosthetics and medical supplies.
  - Examples include, but are not limited to:
    - Wheelchairs.
    - Tube feeding nutrition supplies.
    - Hospital beds.
    - 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.
    - 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 Us.

Non-Covered Durable Medical Equipment, Prosthetics and Medical Supplies Expenses:

- Enteral feedings, unless they are the sole source of nutrition; however, enteral feedings of standard infant formulas, standard baby food and regular grocery products used in blenderized formulas are excluded regardless of whether they are the sole source of nutrition.
- 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, Health Care Provider equipment except as covered by Our medical policy, disposable supplies and self-help devices not medical in nature.
- Home testing and monitoring supplies and related equipment, except as covered by Our medical policy.
- Equipment, models or devices that have features over and above what is Medically Necessary. Coverage will be limited to the standard model as determined by Us.
- 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.
- Back-up equipment (a second piece).
- Replacement of durable medical equipment more frequently than every three years, unless defined by Our medical policy or mandated by law.
- Replacement of an item that 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 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.
- Technology devices that are not primarily and customarily used to serve a medical purpose such as desktop computers, portable multi-media players, smart phones, tablet devices and similar items are not considered Durable Medical Equipment.

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

C. DIAGNOSTIC SERVICES

- Certain Covered Expenses require Prior Authorization.
  - Please contact Our Member Services about services that require Prior Authorization.
- We will cover second opinions per injury or illness by a Provider as long as there are benefits available. Prior Authorization is required for an out-of-network second opinion.
- Any service that is covered under this subsection is also covered when provided in connection with a Clinical Trial.
- 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.
- 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.
- Diagnosis of the cause of Infertility.
- 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.
  - Please contact Our Member Services 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 hearing aids (both ears) and ear molds, including dispensing fees. 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 SSM Health Dean Medical Group, or another authorized provider. Please contact Our Member Services 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. For therapy benefits please refer to Section I. "Therapies, Rehabilitation & Habilitative Services" subsection.
- Bone-anchored hearing aids.

Non-Covered Hearing Expenses:

- Batteries and chargers for hearing aids.
- Hearing aids that are available over-the-counter.

Vision Services

Covered Expenses:

- An initial lens (eyeglass lens or contact lens) following surgical repair of the eye.
  - For the purposes of this benefit, reasons for surgical repair include treatment for cataracts or diseases of the cornea surface.
- Therapeutic contact lenses for the treatment of the following diseases of the ocular surface, when these contact lenses will result in significantly better visual and/or improved binocular function when compared to eyeglasses, such as the following conditions:
  - Keratoconus;
  - Pathological myopia;
  - Aphakia;
  - Anisometropia;
  - Aniridia;
  - Corneal disorders;
  - Post-traumatic disorder;
  - Irregular astigmatism;
  - High ametropia;
  - Bullous keratopathy.
- Routine vision exams/services.
- Medically Necessary vision exams/services.

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 above).
  - Refractive exams related to contact lenses.
  - Any fitting of contact lenses (except for fitting of therapeutic contact lenses as defined above).
- Any replacement lenses for contacts or eyeglasses.
- 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.
  - Please contact Our Member Services about services that require Prior Authorization.
- Inpatient and outpatient hospital services are covered when they are necessary for the admission, diagnosis and treatment of a patient as determined by Us.
- If you fail to get Prior Authorization for any Medically Necessary covered service which requires an authorization, a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence, is applied or the service may be denied for failure to obtain an authorization.
- Hospital admission or being admitted in a hospital, means being registered as inpatient in a hospital or receiving Emergency Services 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 Facility" subsection of this Certificate.
- For coverage of inpatient services pertaining to dental care, please refer to the Benefits, "Dental Services" section of this Certificate.
- Please also see General Exclusions and Limitations and your Schedule of Benefits for any coverage limitations.

Inpatient Hospital

Covered Expenses:

- Hospital and specialty hospital services for a semi-private room or intensive care unit.
- Where available, certain network hospitals are designated facilities for the provision of inpatient services in a Member's home through a home hospitalization program. Members who are accepted into a home hospitalization program by a designated facility have the option to receive inpatient services in the hospital or at their home through the home hospitalization program. Services covered through each such home hospitalization program are as defined by the designated facility and Us. In order to be covered, such services must be provided under the direction of a physician and received through a designated facility. Please note: not all network hospitals are designated facilities for covered home hospitalization programs. If you have a question concerning whether a particular hospital is such a designated facility, call Member Services at the number on the back of your ID card.
- 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 Health Care Provider 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

Covered Expenses:

- Inpatient Rehabilitative medical Confinement when Prior Authorized.

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 Health Care Provider 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 covered separately from the Behavioral Health & Addiction benefit.

Outpatient Hospital or Ambulatory Surgical Services

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 Health Care Provider'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 FACILITY

- Please contact Our Member Services 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.
- Skilled Nursing Facility services are covered when they are necessary for the admission, diagnosis and treatment of a patient as determined by Us.
- 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 Care.
  - 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 and maintenance of urinary catheters. 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.
- 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.

G. HOME HEALTH CARE

- All services must be Medically Necessary, Prior Authorized and part of the home care plan. They are covered to the same extent as if the Member was Confined to a hospital. Services must be provided by a hospital's licensed home health department or by a licensed home health agency.

Covered Expenses:

- Home care.
  - The attending Health Care Provider 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.
- The assessment and development of a home care plan.
  - A registered nurse, physician's assistant or medical social worker must do this assessment and the attending Health Care Provider must request or approve this service.
  - Individual visits from a qualified professional who provides skilled services under a home care plan, if We Prior Authorize them.
- Physical, respiratory, occupational, behavioral health and addiction and speech therapy.
- Medical supplies, Drugs and medicines prescribed by a Health Care Provider.
- Lab services prescribed by a Health Care Provider.
- Nutritional counseling. A registered or certified dietitian must give or supervise these services.
- Medications administered in connection with home health care.

Non-Covered Expenses for Home Health Care:

- Residential care.
- Private duty nursing.
  - Defined as individual and continuous skilled care (in contrast to part-time or intermittent care) of four or more hours; provided according to an individual plan of care, including shift care; and provided 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.
- Custodial Care or any service that is not required to be provided by a skilled/licensed provider.

H. HOSPICE CARE

- Hospice Care may require Prior Authorization.
  - Please contact Our Member Services about services that require Prior Authorization.
  - To be eligible for Hospice Care benefits, the Member must have a life expectancy of one year or less, as confirmed by the attending Health Care Provider. Covered Expenses will continue if the Member lives longer than one year.

Covered Expenses:

- Hospice Care provided in the home or at a Hospice Care facility.
  - 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.
- Respite care is a form of hospice services that gives your uncompensated primary caregivers (i.e., family members or friends) rest or relief when necessary to maintain a terminally ill Member at home.
- Respite care is limited to not more than five consecutive days.

Non-Covered Expenses for Hospice Care:

- Residential care.
- Services provided by volunteers.
- Housekeeping or homemaking services.
- Respite care for more than five consecutive days.

I. PALLIATIVE CARE

- Palliative care is specialized medical care ordered by a palliative care provider for people living with an advanced life-limiting illness, focused on providing relief from the symptoms and stress of the illness.
- Palliative care team may include providers such as doctors, nurses, or social workers.
- These services are coordinated by a palliative care provider and must be Medically Necessary.
- Prior Authorization may be required for in-home palliative care services.
- Please contact Our Member Services about services that require Prior Authorization.

Covered Expenses:

- Outpatient visits with palliative care providers.
- In-home visits with a palliative care provider or team member for member-facing issues associated with advanced life-limiting illnesses.
  - Licensed skilled nursing.
  - Licensed medical social worker.

Non-Covered Expenses for Palliative Care:

- Custodial Care or any service that is not required to be provided by a skilled/licensed provider.
- Services provided by volunteers.
- Residential Care.
- Housekeeping or homemaking services.
- Home care services provided by a family member or someone that resides with the Member.

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

J. EMERGENCY & URGENT CARE SERVICES

- Claim payments for Urgent Care may be based on Our Maximum Allowable Fee. You may be responsible for any fees that exceed this amount.
- If you have a question regarding when to seek Urgent Care or Emergency Services, you can call Our 24-hour nurse access line for Wisconsin residents, 24-Hour Nurse Advice Line, **800-57-NURSE** or/and **1 (608) 250-1393**.

- Our phone numbers, and instructions on when to call Us are on the back of your Identification (ID) card. You should carry your ID card with you at all times.
- No Prior Authorization is needed for emergency and urgent care However, if you need to be admitted to a facility We must be notified within 48 hours or when it is medically feasible (whichever is longer) at **1 (800) 279-1301** (TTY: **711**).
- Please also see General Exclusions and Limitations and your Schedule of Benefits for any coverage limitations.

Ambulance Services

- Ambulance transportation must be provided by an established state-licensed ambulance service and comply with all local and federal laws.
- Out-of-network air ambulance services are covered at the in-network level if determined to be a covered benefit.

Covered Expenses:

Ground Ambulance Services

- Ground ambulance transportation to or from a hospital in urgent or emergency situations when medical attention is required along the way.
- Non-urgent or non-emergency ground ambulance transportation situations that is arranged through an attending physician in the following circumstances:
  - The Member needs to be transported from one acute inpatient facility setting to another inpatient facility care setting.
  - The Member is transported from an acute facility to another acute care site because Medically Necessary services are not available in the hospital the Member was admitted or such transfer is required by Us.
  - The Member is a mother whose baby requires transfer to a higher level of care, and the mother requires an inpatient level of post-partum care and has been accepted for admission at the receiving facility.
  - Other non-urgent or non-emergency ground ambulance transportation involving transport between higher level of care to lower level of care or transport between lower levels of care, such as from a hospital, long term acute care hospital (LTACH), or an acute inpatient rehab (AIR) to a Skilled Nursing Facility when the Member requires medical care en route, may require Prior Authorization.
  - Please contact Our Member Services about services that require Prior Authorization.
- Ground ambulance services when transportation is not provided, in the following circumstances:
  - Transportation is unplanned;
  - Services are provided by qualified medical professionals from the ambulance provider; and
  - Services are deemed Medically Necessary to treat the injury or medical condition that prompted the call for the ambulance.

Air and Water Ambulance Transportation

- Ambulance transportation to transfer a Member to a hospital or from one hospital to another hospital is covered if all of the following requirements are met:
  - The Member needs to be transported due to an emergency situation and requires medical attention along the way;
  - Using any other method of transportation, including ground ambulance transportation, would endanger the Member's health;
  - The transferring hospital cannot provide the hospital or skilled nursing care the Member's illness or injury requires; and
  - The facility which receives the transported Member is the nearest one with appropriate facilities.

Non-Covered Ambulance Expenses:

- Non-emergency or non-urgent ground or air ambulance services or transportation, unless the transportation or service is listed as a Covered Expense under Ground Ambulance Transportation in the Section or is Prior Authorized by Us.

- 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 services or transportation.
- Any ambulance transportation or services initiated for convenience or non-medical reasons.

Emergency Services

What to do in case of emergency:

If you need Emergency Services please go to the nearest medical facility. You must notify Our Member Services as soon as possible when you receive Emergency Services from an Out-of-Network Provider.

Claims for emergency services rendered in a foreign country will require the following additional documentation:

1. Claims submitted in English with the currency exchange rate for the date health services were received.
2. Itemization of the bill or claim.
3. The related medical records (submitted in English).
4. Proof of your payment of the claim.
5. A complete copy of your passport and airline ticket.
6. Such other documentation as We may request.

For emergency services rendered in a foreign country, We will pay you directly.

We will not reimburse you for costs associated with translation of medical records, claims, fees, service charges or other costs imposed related to the exchange of currency.

If you receive Emergency Services and are admitted to a hospital, you or the hospital must call Us within 48 hours or when it is medically feasible (whichever is longer) following the admission.

Covered Expenses:

- Emergency Services provided for an Emergency Medical Condition.
  - 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.
- Post-stabilization services as required under 42 USC §300gg–2799A-1.

Urgent Care Facility

Covered Expenses:

- Urgent Care services.
  - Out-of-pocket responsibility, as defined in your Schedule of Benefits, may apply to any services beyond the Urgent Care Health Care Provider's charges, including but not limited to supplies, prescriptions, diagnostic testing and imaging 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.

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 800-57-NURSE or/and 1 (608) 250-1393.

K. THERAPIES, REHABILITATION & HABILITATIVE SERVICES

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

Autism Spectrum Disorder

Please contact Our Member Services 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 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.
    - 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 Spectrum Disorder Expenses:

- Animal-based therapy including hippotherapy.
- 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 Spectrum Disorder benefit. Please see your Prescription Drug Benefit Rider, if applicable and/or Section III, Benefits, B. "Durable Medical Equipment, Prosthetics and Medical Supplies" for more information.**

Outpatient Physical, Speech and Occupational Therapy

Covered Expenses:

- Medically Necessary services resulting from illness or injury.
- Speech and hearing screening examinations to determine the need for correction.
- Post-cochlear implant aural therapy.

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

- Vocational rehabilitation, including work hardening programs.
- Hearing therapy for communication delay, therapy for perceptual disorders, intellectual disability and related conditions and other long-term special therapy, except as specifically listed under the "Habilitative Services" or "Autism Spectrum Disorder" section.
- Therapy services such as recreational or educational therapy, physical fitness or exercise programs.
- Services to enhance athletic training or performance.
- Services or treatment received at intermediate care facilities.
- Submaximal Stress Testing except for members with cardiovascular disease.

These therapy benefits are only 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 Us. 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 Us.
  - Please contact Our Member Services about services that require Prior Authorization.
- Coverage for habilitative devices, like all other medical devices, is subject to the limitations in Our "Durable Medical Equipment, Prosthetics and Medical Supplies" subsection.

Covered Expenses:

- Medically Necessary 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 or life training.

Phase II Cardiac Rehabilitation

Covered Expenses:

- Medically Necessary rehabilitation services for cardiac disease as deemed Medically Necessary by Us.

Pulmonary Rehabilitation

Covered Expenses:

- Medically Necessary rehabilitation services for lung disease, as deemed Medically Necessary by Us.

Radiation Therapy

Covered Expenses:

- Medically Necessary therapeutic methods, such as x-rays, radium and radioactive isotopes.
  - Please contact Our Member Services 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.

L. DENTAL SERVICES

- Certain services may require Prior Authorization from Us.
  - Please contact Our Member Services about services that require Prior Authorization.
- There is a limited set of dental, trauma/accidental injury to teeth, oral surgery and temporomandibular joint disorder (TMJ) related services provided under this Certificate. We do not cover other dental or dental-related services except as described 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 and/or replace sound, natural teeth damaged, lost, or removed due to an injury. The term “injured” does not include conditions resulting from eating, chewing or biting.

To be eligible for coverage:

- The services must be Medically Necessary while you are enrolled under this Policy.
- The tooth must meet the definition of “sound, natural tooth”.
  - A “sound, natural tooth” is a tooth (including supporting structures) that is free from disease that would prevent continual function of the tooth for at least one year.
- In the case of primary (baby) teeth, the tooth must have a life expectancy of one year.

Covered Expenses:

- Emergency examination.
- Necessary diagnostic x-rays.
- Prior Authorization may be required following the initial examination for the following:

- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Simple minimal restorative procedures (fillings).

- Post-traumatic crowns if such are the only clinically acceptable treatment.

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.
- Dental implants (tooth replacement), except as described in the Dental subsection.
- Tooth extractions, except as described elsewhere in this section.
- Osteotomies and other procedures associated with the fitting of dentures or dental implants.

Oral Surgery

Covered Expenses:

- Surgery consult and/or evaluation covered under this section.
- 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 Anesthesia and Facility Charges for Dental Procedures

Covered Expenses:

Charges for medical facilities (e.g., hospital, ambulatory surgery center (ASC)) and general anesthesia services for dental care will be covered if the Member is a child under the age of five. Charges for medical facilities and general anesthesia services will also be covered in the ASC or hospital location if the Member is five years and older and if any of the following applies:

- The Member has a chronic disability that;
  - Is attributable to a behavioral or physical impairment or combination of behavioral and physical impairments;
  - Is likely to continue indefinitely; and
  - Results in substantial functional limitations in self-care, language, learning, mobility, capacity for independent living or economic self-sufficiency; or
- The Member has a medical condition requiring hospitalization or general anesthesia for dental care.

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" and "Dental Services" subsection, for which Prior Authorization is required.
- Any non-hospital or non-ambulatory surgery center facility charges.
- Any charges related to dental procedures unless listed as a Covered Expense elsewhere in this Certificate.

Temporomandibular Joint Disorders (TMJ)

Covered Expenses:

- Diagnostic procedures including diagnostic casts, diagnostic study models and bite adjustments and Medically Necessary surgical or non-surgical treatment for the correction of temporomandibular joint disorders (TMJ), if the following apply:
  - Services are provided under the accepted standards of the profession of the Health Care Provider providing 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.
  - Surgical treatment may require Prior Authorization.
- Orthognathic surgery only for the treatment of TMJ, Prior Authorization may be required.

Non-Covered Expenses for Temporomandibular Joint Disorders (TMJ):

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

Non-surgical services with a TMJ diagnosis code and a network TMJ provider will be subject to the TMJ 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.

M. BEHAVIORAL HEALTH & ADDICTION SERVICES

- Certain services require Prior Authorization from Us.
  - Please contact Our Member Services 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.
- To qualify, a treatment program must be staffed by a multi-disciplinary team, which should include registered nurses, occupational therapists, social workers, psychologists, doctors 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.

- Court-ordered services may not be covered unless the services are a result of an Emergency Detention or received on an emergency basis.
- 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; "Durable Medical Equipment, Prosthetics and Medical Supplies" 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.
- Inpatient detoxification services are considered medical services and are therefore NOT applied to this Behavioral Health & Addiction Services benefit. Please see the "Detoxification Services" provision under the "Hospital & Surgical Services" subsection for more information on this coverage.
- Please also see General Exclusions and Limitations and your Schedule of Benefits for any coverage limitations.

Inpatient Behavioral Health and Addiction Services

Covered Expenses:

- Services provided at an inpatient hospital or behavioral health inpatient/residential facility.
- Services in a residential/inpatient addiction treatment program provided by a licensed professional in a state licensed or certified facility.

Outpatient and Other Behavioral Health and Addiction Services

Covered Expenses:

- Partial Hospitalization or Intensive Outpatient/Day Treatment Programs.
- Outpatient services, including group, family and individual therapy.
  - Must be provided with a behavioral health or addiction treatment Health Care 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. We retain the right to choose the provider. Further treatment may be authorized upon review by Us.
- Services for the following treatments and programs:
  - 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.
  - 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.

Non-Covered Behavioral Health and Addiction Expenses:

- Biofeedback.
- Family counseling for non-medical reasons.
- Wilderness and camp programs, boarding school, academy-vocational programs and group homes.
- Halfway houses.
- Hypnotherapy.
- Long-Term or Maintenance Therapy.
- Marriage counseling.
- Phototherapy.

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

N. TRANSPLANTS

- Except for corneal transplants, all transplant services, including transplant work ups require Prior Authorization and must be provided at Our approved facility.
- If you fail to get Prior Authorization for any Medically Necessary covered service which requires an authorization, a penalty of 50% of the allowed amount, up to a $500 maximum per occurrence, is applied or the service may be denied for failure to obtain an authorization.
- To be covered, the transplant must not be considered Experimental or Investigational.
- The appropriateness of all transplants is reviewed by Us. Our definition of appropriateness is based upon individual patient considerations and supportive medical literature.
- Coverage for organ-procurement costs is limited to costs directly related to the procurement of an organ from a compatible cadaver, cord blood or 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:

- The following organ and tissue transplants when ordered by a Health Care Provider:
  This is not a complete list, although these are the most common:
  - Bone marrow
  - Stem cell
  - Cornea
  - Heart
  - Heart/lung
  - Kidney
  - Liver
  - Pancreas
  - Kidney/pancreas
  - Intestine
- Health services provided to a Member's organ donor which are directly related to organ procurement.

Non-Covered Transplant Expenses:

- Health services for organ and tissue transplants unless specifically covered under this Policy.
- Organ procurement costs for a Member who is donating an organ to another person.
  - Organ procurement costs may be covered by the organ recipient's health insurance policy.
- Health services for transplants involving permanent mechanical or animal organs.
- Transplant services that are not performed at an approved facility.
- Any transplants and 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.

O. KIDNEY DISEASE TREATMENT

Covered Expenses:

- We cover Health Care Provider directed treatment of kidney disease, including dialysis, as described in this Policy. Please refer to the "Transplants" subsection for information regarding coverage for kidney transplants and donor-related services. We are not required to duplicate coverage if the Member is enrolled under Medicare or under any other insurance coverage.

Non-Covered Kidney Disease Treatment Expenses:

- Other services, supplies, and associated expenses for the treatment of kidney disease, except as otherwise described in this Policy.

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

P. OTHER SERVICES

- Please contact Our Member Services 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:

- All other forms of alternative medicine, not otherwise listed in the Policy.

Anesthesia Services

Covered Expenses:

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

Non-Covered Anesthesia Expenses:

- Anesthesia services provided for non-covered expenses, unless specifically listed as a Covered Expense within this Policy.

Genetic Counseling and Testing

We cover genetic counseling, occurring in an office, clinic, or telephonically. Genetic testing services received in an office or outpatient hospital setting.

Covered Expenses:

- Genetic counseling, pre-test or post-test.
- Genetic testing.
    - When the test will directly affect treatment decisions or frequency of screening for a disease, or when results of the test will affect reproductive choices.

Non-Covered Genetic Counseling and Testing Expenses:

- Genetic counseling and testing services provided by an Out-of-Network provider.
- Genetic testing when performed in the absence of symptoms or high-risk factors for a heritable disease.
- Genetic testing when knowledge of genetic status will not affect treatment decisions, frequency of screening for the disease, or reproductive choices.
- Genetic testing that has been performed in response to direct to consumer marketing and not under the direction of your physician.

Please note: BRCA testing, if appropriate, is covered as a women's preventive health service.

Home Infusion Therapy

The intravenous or subcutaneous administration of Drugs or biologicals to an individual at home by a licensed professional or an individual who has been trained by a licensed professional to safely administer a drug or biologic. A Member is not required to be restricted to their home to qualify for home infusion services.

Covered Expenses:

- Medically Necessary drug or biological.
- Equipment and supplies required to safely administer the drug or biological.
- Prior authorized Medically Necessary services by a qualified professional to prepare the drug or biologic, administer and/or to teach and train an individual or family member to safely administer the drug or biological.

Non-Covered Home Infusion Therapy Expenses:

- A drug or biologic that is not considered Medically Necessary.
- Home infusion administered by a family member or someone who resides with a family member.

Infertility Services

Benefit maximum may apply.

To determine if you have coverage for self-administered infertility Drugs please refer to your Prescription Drug Benefit Rider.

Covered Expenses:

- Diagnosis of the cause of Infertility

Non-Covered Infertility Expenses:

- Consultation, treatment, or procedures for Assisted Reproductive Technology (ART).
- Infertility drugs, including, but not limited to, those administered by a medical provider for the purpose of ART.

Maternity Services and Coverage for Newborns

Hospital services are covered under the "Hospital & Surgical Services" subsection.
Maternity benefits are also available for a Qualified Dependent who is covered as a Member.

Covered Expenses:

- Health Care Provider services.
- Prenatal and postpartum care, including services directly related to deliveries, ectopic pregnancies, cesarean sections and miscarriages.

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 Member Services.

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).
- 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.
- Home or intentional out-of-hospital deliveries.
- Treatment, services or supplies for a non-Member Traditional Surrogate or Gestational Carrier, who is not covered under this Policy.

Congenital Defects and Birth Abnormalities:

Congenital defects and birth abnormalities are considered an injury or illness under the terms of this Policy. Coverage includes Reconstructive Surgery, functional repair or restoration of any body part when necessary to achieve normal body functioning. This does not include Cosmetic Surgery performed solely for appearance improvement.

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

Nutritional Counseling and Education Visits

Covered Expenses:

Nutritional counseling services by a registered dietitian when both of the following are true:

- Patient self-management is an important component of the treatment for a disease.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Non-Covered Nutritional Counseling and Education Visits Expenses:

- Food or medical food formulated to be consumed or administered internally under the supervision of a physician intended for specific dietary management.
- Nutritional supplements or vitamins.

Professionally Administered Drugs

Covered Expenses:

- Medically Necessary Professionally Administered Drugs that are administered, in conjunction with a covered benefit such as an office visit or home health care visit, by a physician acting within the scope of the provider's license, on an outpatient basis in a hospital, physician's office or in your home.
- Prior Authorization (approval in advance) is required before you receive certain biologics, biosimilars and professionally administered drugs. Certain biologics, biosimilars and Professionally Administered Drugs may be subject to Step Therapy. In certain cases, it is possible to get an exception to Step Therapy requirements. To obtain more information about the Step Therapy exception process call Member Services at the number on the back of your ID card.
- If you require certain Professionally Administered Drugs, We may direct you to a designated Health Care Provider with whom We have an arrangement to provide those certain Professionally Administered Drugs. Such designated Health Care Providers may include an outpatient pharmacy, specialty pharmacy, home health care agency, home infusion provider, hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy. If you or your provider administering the Professionally Administered Drugs are directed to a designated Health Care Provider and you or your provider choose not to obtain your Professionally Administered Drug from that designated Health Care Provider, benefits may not be available under this Policy for that professionally administered drug.

Non-Covered Professionally Administered Drug Expenses:

- Professionally Administered Drugs provided by an Out-of-Network Network Provider.

Surgical Services

Covered Expenses:

- Reconstructive and restorative surgical procedures required to treat an illness or accidental injury.
- Preoperative and postoperative care, necessary assistant and consultant services, and elective sterilization, unless stated otherwise in this Policy.
- 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 "Durable Medical Equipment, Prosthetics and Medical Supplies" 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:

- Non-Medically Necessary plastic surgery.
  - This limitation does not affect coverage provided for breast reconstruction in connection with a mastectomy.
- Cosmetic services and procedures, including Cosmetic Surgery.

Travel Immunizations and Medicines

- Medically Necessary travel-related preventive treatment recommended by the Centers for Disease Control Yellow Book: Health Information for International Travel.

Covered Expenses:

- Vaccinations
  - Hepatitis A & B
  - Typhoid
  - Yellow Fever
  - Meningococcal
  - Rabies
  - Japanese B Encephalitis
  - Influenza
  - Routine Immunizations
- Travel-related prescriptions for the following conditions (cost-sharing will be determined by your Outpatient Prescription Drug benefit):
  - Malaria Prophylaxis
  - Travelers' Diarrhea
  - Altitude Illness
  - Motion Sickness

Non-Covered Travel Immunizations and Medicine Expenses:

- Any travel-related prescriptions not listed above. Or on your formulary.
- Work related travel.

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:

Diagnosis and Testing

- Court-ordered drug testing unless Medically Necessary.
- Cytotoxic testing and sublingual antigens associated to 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 stated otherwise in this Policy.
- Drugs provided or administered by a physician or other provider, except those drugs that meet the definition of Professionally Administered Drugs. Coverage for Professionally Administered Drugs is as described under Professionally Administered Prescription Drugs. Coverage for prescription drugs is as described in Outpatient Prescription Drugs or otherwise described as a specific benefit in this Policy.
- Infertility drugs, including, but not limited to, those administered by a medical provider for the purpose of ART.
- 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, unusable or nonfunctioning because of misuse, abuse, or neglect.
- Sexual dysfunction devices and supplies, including but not limited to medications and injections.

Services, Procedures, Treatment and/or Supplies

- Autopsy.
- Collection, retrieval, purchase, freezing and/or storage of sperm or eggs.
- Charges directly related to a non-covered service, such as hospitalization charges, except when a complication results from the non-covered service that could not be reasonably expected and the complication requires Medically Necessary treatment. The treatment of the complication must be a covered benefit.
- Consultation, treatment, or procedures for Assisted Reproductive Technology (ART).
- Cosmetic services and procedures, including Cosmetic Surgery.
- Removal of blemishes on skin surfaces and scars (excluding scar revisions) primary for cosmetic purposes, unless otherwise covered in the Surgical Services section.
- Repair of a pierced body part and surgical repair of bald spots or loss of hair.
- Repairs to teeth, including any other dental procedures or treatment, whether the dental treatment is needed because of a primary dental problem or as a manifestation of a medical treatment or condition.
- Surgical correction of male breast enlargement primarily for cosmetic purposes.
- Hair transplants.
- Treatment for superficial veins, also referred to as telangiectasia, thread, reticular or spider veins.
- Orthognathic surgery for cosmetic purposes.
- Experimental or Investigational Services, Treatments, or Procedures and any related complications as determined by Us, unless coverage is required by state or federal law.
- Hearing aids (including internal, external or implantable hearing aids or devices) and other devices to improve hearing and their related fittings except as specifically stated in this Policy. Additionally, hearing aids that are available over-the-counter. Cochlear implants and their related fittings are covered as surgical services under office visits or hospital.
- Non-medical services provided in a Hospital or medical setting, not otherwise listed as covered in this Certificate.

- Items that can be purchased over the counter and considered to be for comfort, convenience and/or personal hygiene, examples include but are not limited to: seasonal affective disorder light units, disposable undergarments, wigs and modification to a Member's home such as ramps, grab bars, stair lifts and bench/chair lifts.
- Podiatry services or routine foot care, except as Medically Necessary for Members who are at risk for developing foot disorders secondary to systemic disease or another medical condition. Such care must be performed by a licensed provider acting within the scope of their license to be eligible for coverage.
- 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, 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 the law requires you to pay.
- Services, treatment and supplies provided in connection with any illness or injury caused by: a) a Member engaging in an illegal occupation or b) a Member committing or attempting to commit, a felony. (Note that this exclusion does not apply to the treatment of injuries that result from an act of domestic violence, if that treatment would otherwise be covered.)
- Services provided by members of the Subscriber's Immediate Family or any person living with the Subscriber.
- Services prohibited by applicable law or regulation in the jurisdiction in which the services are received.
- Services or supplies associated to a denied Prior Authorization.
- Services or supplies associated to 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 or items provided as a result of war or any act of war, insurrection, riot or terrorism.
- Services or supplies provided for an injury sustained while performing military service.
- Services or supplies for which a Member receives or is entitled to receive any benefits, settlement, award, or damages, 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.
- Sexual dysfunction treatment and services, including but not limited to surgery.
- Take home Drugs and supplies unless a written prescription is obtained and filled at a network pharmacy.
- Non-emergency services received outside of the United States.

Therapies

- Chelation therapy for atherosclerosis.
- Coma stimulation programs.
- Alternative medicine, not otherwise listed in the Policy.
- Low level light therapy.
- Massage therapy.
- Prolotherapy.
- Swim or pool therapy, unless Prior Authorization is obtained.

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 consultations, including all related charges and costs, except as defined by Our medical policy.
- Missed appointment charges.
- Telephone consultation charges 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 Authorized by Us.

End of Section IV

V. COVERAGE INFORMATION

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

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

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, coverage will begin on the Subscriber's Effective Date.
2. For an individual (other than a newborn or adopted child) who becomes eligible for coverage as a Qualified Dependent as a result of marriage or another qualifying event, coverage will begin 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 begin from the moment of birth.
4. For a child adopted by or placed for adoption with the Subscriber, coverage will begin 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 begin on the date indicated in the QMCSO or NMSN. If the QMCSO or NMSN is silent regarding the effective date, coverage will begin 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.

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 submit 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, if an additional Premium is required to add the newborn to your coverage, the Subscriber must submit an application to your employer and pay any additional Premium within 60 days of birth. If a newborn child is not enrolled within 60 days of birth, coverage will not continue, unless within one year of the child's birth, the Subscriber submits an application and makes all past due Premium payments with 5½% interest. If no additional Premium is required for the newborn child, We request that the Subscriber submit an application to your employer to add the newborn to the plan, to make sure we have accurate records and are able to cover claims.
3. For children adopted or placed for adoption, the Subscriber must submit an application within 60 days of the dependent's placement in the home.

Coverage for Full-Time Students on Medical Leave following Active Duty Service

This provision applies to Qualified Dependents who have returned to school full-time following active duty service. If such a Qualified Dependent must take a Medically Necessary leave of absence from school due to illness or injury, he or she will be eligible to remain covered under this Policy despite no longer being a Full-Time Student, as described below.

For coverage to continue, the attending Health Care Provider must certify that the leave of absence is Medically Necessary. This certification can be sent to Us by the attending Health Care Provider, or by the Qualified Dependent or an individual on his or her behalf. The continued coverage will begin on the date the Qualified Dependent stops being 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 or 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 or 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 continued coverage 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 or 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 or her parent's plan because he or she is under age 27.

Initial Enrollment Period

When an employer first begins offering Our coverage, all existing Eligible Employees and their Qualified Dependents may enroll for coverage within 31 days of their employer's Group Master Policy Effective Date of Coverage.

After the first 31 days described above, all newly Eligible Employees and their Qualified Dependents may enroll within 31 day of becoming eligible. To enroll, the Eligible Employee must either submit to Us a completed and signed application or complete an online employee application.

Eligible Employees who do not enroll during their initial enrollment period will be subject to the Late Enrollee Policy. Please see the "Late Enrollee Policy" described in this section for more information.

Special Enrollment Period

If an Eligible Employee with other health insurance (known as "creditable coverage") chose not to enroll during his or her initial enrollment period, he or she may have another opportunity to enroll. When the other creditable coverage ends, the Eligible Employee may be able to enroll him or herself and any Qualified Dependents in this Policy if he or she requests coverage within 31 days after the creditable coverage ends.

Additionally, if an Eligible Employee adds a new Qualified Dependent to his or her family through marriage, birth, adoption or placement for adoption, the Eligible Employee may be able to 1) add the new Qualified Dependent(s) to his or her existing coverage, or 2) enroll him or herself and his or her Qualified Dependents for the first time. Enrollment must be requested within 31 days of 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 does not guarantee coverage or payment of benefits. If your ID card is lost, stolen or otherwise needs replacement, you can request a new one.

Notice of Change(s) That May Affect Your Coverage

As a Member, it is your responsibility to notify your employer of any changes that might affect your coverage so that your employer can notify Us timely. 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 new Qualified Dependents to your family.
5. Changes in Qualified Dependent status (for details see "Glossary of Terms" Section).

Failure to timely report these changes to your employer (generally 31 days from the date the change occurs) may result in you and/or your Qualified Dependents:

1. Becoming subject to the Late Enrollee Policy;
2. Claims being denied;
3. Incorrect Premiums being collected, or
4. Retroactive termination of coverage under this Policy.

When Coverage Ends

Coverage under this Policy will end on the earliest of the following dates, unless stated otherwise 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 for coverage.
6. For a Qualified Dependent child, coverage ends:
   - 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 stops being a Full-Time Student.
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 end the last day of the month that the disabled child no longer meets the requirements for extended coverage of disabled children.
8. For a divorced spouse or stepchildren, the last day of the month that 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, We will continue to cover Inpatient Hospital services you receive during that Confinement until the earliest of the following:

1. Your Confinement ends;
2. You exhaust the benefits available under this Policy;
3. 90 consecutive days pass after your coverage under this Policy ends; or
4. You get similar coverage 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, coverage for services for your disabling condition will continue until the earliest of the following:

1. Your Total Disability ends;
2. The Benefit Period specified in the Group Master Policy or Certificate ends;
3. You exhaust the maximum available benefit; or
4. You get similar coverage 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 the "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 Our Member Services for information on how to enroll.

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 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 Coverage

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. You can apply 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.

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 Subscriber 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 fraud or intentional misrepresentation of material fact, 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/privacy.

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.

Ethical and Religious Directives

This Policy may provide payment for certain Covered Services which conflict with, or may conflict with, directives contained in the *Ethical and Religious Directives for Catholic Health Care Services,* 6th Edition, as adopted by the United States Conference for Catholic Bishops and as amended from time to time. Said payment does not constitute Our recommendation or endorsement that you consider or receive such Covered Services.

Limit on Assignability of Benefits

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

Limit of Liability

We shall not be held liable for injuries, damages, 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 and material 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 and material 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 an intentional and material 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.

Doctor and Hospital Reports

Doctors 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 Our Member Services 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 211404
Eagan, MN 55121

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 Subscriber and/or dependent as an actively at work employee is primary for that Subscriber and/or dependent over a plan that covers a Subscriber as a laid off or retired employee. 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 Our Member Services.

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.

   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 Our Member Services 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, 2019, the recovery will go back to October 1, 2018).

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 Member Services. We will document and investigate your complaint and notify you of the outcome. If your complaint is not resolved to your satisfaction you have the right to file a grievance/appeal. Any written expression of dissatisfaction will automatically be addressed as a grievance/appeal. (See "B. Grievance")

B. Grievance/Appeal

A grievance/appeal is any dissatisfaction with Us, including adverse determinations, the way We provide services or process claims, a decision to change or rescind a policy or a decision to deny a benefit. A grievance must be expressed in writing to Us by, or on behalf of, a Member.

If you wish to receive a free copy of any documents relevant to the outcome of your grievance/appeal, send a written request to the address listed below. All standard grievances/appeals will be resolved within 30 calendar days of the day We receive your request. All expedited grievances/appeals will be resolved within 72 hours of the time We receive your request.

This grievance/appeal process does not apply when a Member is requesting coverage of a Drug or item not listed on Our formulary. These requests are subject to the non-formulary exception process described later in this section.

To file a grievance/appeal, you or your authorized representative must send your grievance to Us in writing at the following address:

Dean Health Plan, Inc.
Attention: Grievance and Appeal Department
Route CW595
P.O. Box 9310
Minneapolis, MN 55440-9310

When We receive your grievance/appeal, Our Grievance and Appeal Department will send you 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 Grievance and Appeal Committee meeting. This meeting will not be less than 7 calendar days from the date of your acknowledgment letter but will occur within 30 calendar days of the date We received your grievance.

If you choose to meet with the Grievance and Appeal Committee you may do so either in person or over the phone via teleconference. As described in the acknowledgement letter you must call and schedule a meeting time.

Your grievance/appeal will be documented and investigated. So that you will have time to respond prior to Our decision, We will automatically send you the following information:

1. Any new or additional evidence We consider, rely upon, or generate in the course of considering your grievance/appeal; or
2. Any new or additional rationale We use to make Our decision.

C. Expedited Grievance/Appeal

If We decide your grievance/appeal is urgent according to Our criteria, We will resolve your request within 72 hours of the time We receive it. Our criteria are based on the expedited grievance/appeal provisions of applicable law. For situations involving Ongoing Course of Treatment and/or concurrent review, coverage will continue during the grievance/appeal process.

We will automatically treat your grievance/appeal as expedited if:

1. Your concerns are related to a facility admission or concurrent review of a continued facility stay;
2. Our Medical Director decides your life, health, or ability to regain maximum function could be jeopardized by the standard review timeframe;
3. Your Health Care Provider notifies Us that you would be subject to severe pain that cannot be adequately managed without the services you requested; or
4. Your Health Care Provider notifies Us that he or she has decided you need care urgently.

You, your authorized representative or your Health Care Provider may request an expedited grievance/appeal either orally or in writing. You can make this request in your initial request or in a separate communication.

If you are eligible for an expedited internal grievance and also for external review, you can request that your internal and external reviews happen at the same time.

D. Independent External Review

You may also be entitled to an independent external review (IER). You can ask for an external review if We denied your grievance and it involves care that We have determined does not meet the Policy requirements for reasons involving medical judgement. Those reasons include, but are not limited to:

1. Medical Necessity;
2. Appropriateness;
3. Health care setting;
4. Level of care; or
5. Effectiveness of a covered benefit.

You can also request an external review if your requested services are considered Experimental or Investigational, for claims subject to the No Surprise Act under the Consolidated Appropriations Act, or if We have rescinded your Policy.

You must exhaust Our internal review process before you can request 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 wishes to request an external review, you or your authorized representative have four months from the date you receive the grievance determination letter.

There are two categories of external review, standard and expedited. Most requests for external review will follow the standard timeline; however in some cases you may ask for an expedited review. This review will be coordinated by Dean Health Plan. A decision made by the IRO is binding for both you (the Member) and Us. You are not responsible for the costs associated with the IER.

Standard External Review

You may request a standard external review by contacting Us at the address and telephone numbers listed above.

Please note you may also provide additional documentation such as:

1. Documents to support the claim, such as letters from your Health Care Provider, reports, bills, medical records, explanation of benefits (EOB) forms (optional);
2. Letters sent to your health insurance plan about the denied claim (optional); and
3. Letters received from the health insurance plan (optional).

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

Expedited External Review

In some cases you may ask for an expedited external review. An expedited review may be requested, if (a) waiting the standard 45-day turnaround time might jeopardize your life, health or ability to regain maximum function, or (b) if this timeframe would subject you to severe pain that cannot be managed without the care or treatment you are requesting, or, (c) a physician with knowledge of your condition determines that the grievance should be treated as expedited. The expedited review, if accepted as such by the external independent review organization, shall be completed within 72 hours of receipt of the grievance.

You may request an expedited external review by contacting Us at the address and telephone numbers listed above.

The IRO will notify you and Us of its decision as soon as possible, but no later than 72 hours after it receives your request for external review.

E. Office of the Commissioner of Insurance

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

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

F. Non-Formulary Exception to Coverage

If you or your prescribing Health Care Provider wish to request review of a denied non-formulary exception to coverage request you may do so in writing or orally.

Our timeline for considering your exception to coverage will vary based on the urgency of your situation.

Standard Non-Formulary Exception

If your request is not urgent We will follow Our standard non-formulary exception timeline.

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. During the exception to coverage process, We will cover the Drug for the duration of the

prescription during a standard exception request. If We approve your request, We will cover the Drug until your prescription expires, including refills.

If We deny your standard non-formulary exception, you, your authorized representative, or your prescribing Health Care Provider may ask to have Our denial reviewed by the IRO. You must ask for external review within four months of Our denial. You may submit to Us in writing at the following address:

Dean Health Plan, Inc.
Attention: Grievance and Appeal Department
Route CW595
P.O. Box 9310
Minneapolis, MN 55440-9310

You or your authorized representative must select an IRO from the list of IROs certified by the Office of the Commissioner of Insurance. In addition, your written request must contain the name of the IRO selected. The selected IRO will send you a notice of acceptance within one business day of receipt, advising you of the right to submit additional information. The selected IRO will also deliver a notice of the final external review decision in writing to you and Us within the timeline required based on Wisconsin State Law. A decision made by an 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 Non-Formulary Exception

If you need the requested Drug more urgently, and We determine your request meets Our expedited criteria We will follow Our expedited non-formulary request timeline. Our criteria are based on the expedited provisions of applicable law as listed below:

Urgent circumstances exist 1) when you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain function, or 2) you are undergoing a current course of treatment using a non-formulary Drug. When you submit your 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. During the exception to coverage process, We will cover the Drug for the duration of the exigency during an expedited exception request. If We approve your request, We will cover the Drug until your prescription expires, including refills.

If We deny your expedited non-formulary exception request, you, your authorized representative, or your prescribing Health Care Provider may ask to have Our denial reviewed by the IRO. You must ask for external review within four months of Our denial. You may submit orally by calling **1 (800) 279-1301** (TTY: **711**), or submit to Us in writing at the following address:

Dean Health Plan, Inc.
Attention: Grievance and Appeal Department
Route CW595
P.O. Box 9310
Minneapolis, MN 55440-9310

You or your authorized representative must select an IRO from the list of IROs certified by the Office of the Commissioner of Insurance. In addition, your written request must contain the name of the IRO selected. The selected IRO will send you a notice of acceptance within one business day of receipt, advising you of the right to submit additional information. The selected IRO will also deliver a notice of the final external review decision in writing to you and Us within the timeline required based on Wisconsin State Law. A decision made by an 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.

End of Section VIII

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