



DeanTM

HEALTH PLAN

Underwriting Guide

TABLE OF CONTENTS

Group Business	3
Small Employer Group	3
Large Employer Group	3
Eligibility	3
Participation	3
Contribution	4
Portability and Creditable Coverage	4
Pre-existing	4
Dual Choice	5
Open Enrollment	5
Submission Requirements	5
Rates	6
Plan Options	6
Renewals	7
Reinstatement	7
Non-Standard Provisions	8
Business Ownership Changes, Acquisitions, Mergers and Expansions	8
Chamber Group Health Insurance	10
Individual Policy Business	10
Plan Options	10
Individual Applicant Eligibility	10
Pricing	11
Application	11
Other Submission Requirements	12
Underwriting Requirements	12
Uninsurable Conditions	12
Pre-existing Condition Limitation	13
Renewals	13
Reinstatement	14
Association Policy Business	14
Types of Individual Association Policies	14
Plan Options	14
Association Applicant Eligibility	15
Pricing	15
Application	15
Other Submission Requirements	16
Underwriting Requirements	16
Uninsurable Conditions	17
Pre-existing Condition Limitation	17
Renewals	17

Group Business

Small Employer Group

A Small Employer Group is an employer that has had a total number of employees (part-time, seasonal, temporary, etc.) between 2 and 50 on a monthly average over the last calendar year.

Large Employer Group

A Large Employer Group is an employer that has had a total number of employees (part-time, seasonal, temporary, etc.) on a monthly average of 51 or more over the last calendar year.

Eligibility

An eligible employee is one who: (a) appears on the Policyholder's or designated employer's payroll records; (b) is active at work/active status performing his/her duties on the date his/her coverage is to become effective; (c) works at least the minimum number of hours per week required as indicated in the Overview of Coverage Conditions in the Group Master Policy; and (d) has completed any waiting period required before coverage is effective. Eligible employees also include commissioned salespeople for whom the Policyholder or designated employer is paying Workers' compensation, premiums, unemployment taxes, and social security.

- **1099/contracted employees** –Dean Health Plan (DHP) does not consider 1099 employees eligible.
- **Limited Term/Temporary employees** - DHP does not consider limited term or temporary employees eligible.
- **Permanent Seasonal employees** – A seasonal employee is considered a permanent employee by the employer and is expected to return each year for the peak season if a layoff occurs. A seasonal employee is eligible for DHP coverage if he/she works at least 8 consecutive months out of the year.

Dependent Eligibility

DHP considers a qualified dependent to be:

- The legally married spouse of the subscriber.
- A recognized domestic partner if domestic partner eligibility is chosen by the group. (see Non-Standard provisions)
- The legal ward of the subscriber to the age described in the member certificate. Maximum age is to age 26..
- Grandchild of the policyholder until the dependent child reaches age 18. The dependent child must remain on the policy as a covered dependent in order for the grandchild to be covered.
- The subscriber's biological child, step child, adopted child, and any child placed for adoption (by another State), to the age described in the member certificate. All placements and adoptions must follow Wisconsin's placement and adoption laws.

Participation

When determining participation, "eligible employees" do not include those with other creditable health coverage (except those employees with other creditable coverage offered through this employer group); those with group continuation coverage (or any other non-working class of employees); or those serving their waiting period. DHP's minimum participation requirements are as follows:

Number of Eligible Employees	Participation Requirement
2 through 4	2 Participants
5 or 6	3 Participants
7	4 Participants
8 or 9	5 Participants

10	6 Participants
11 through 25	50% of eligible employees
26 or more	50% (20% of dual choice and a Large Employer Group) of eligible employees

Contribution

DHP's minimum employer contribution requirement is 25% of the single coverage cost and is applicable across all coverage tiers.

Portability and Creditable Coverage

Portability means an employee/dependent is given credit against the policy's pre-existing conditions limitations for the amount of time he/she has been insured under a creditable health plan prior to becoming covered under the current plan. Proof of prior creditable coverage is indicated by the Certificate of Creditable Coverage, provided by a prior carrier, to employees/dependents that have terminated from their group coverage plan. The credit is applied to either reduce or waive the pre-existing condition limitation to the extent that such limitations were satisfied under previous qualifying coverage, as long as there has not been a lapse in coverage of 63 days or more. An employee must have been insured under one of the following types of health plans in order to qualify for portability of coverage:

- Group or Individual health insurance coverage
- Medicare or Medicaid
- Health Insurance Risk Sharing Plan (HIRSP)
- Federal Employees Health Benefits Plan
- Public Health Plan (i.e. Badger Health Care)
- Medicaid Care Program of the Indian Health Service or "Tribal Organization"
- Military sponsored health care or Peace Corps Plan

Note: National Health Care of a foreign country is not considered creditable coverage.

Pre-existing

A pre-existing condition is a disease, mental or physical condition, excluding pregnancy, that manifested itself through diagnosis or treatment, in the six (6) month period prior to the enrollment date. Those enrolled at initial DHP offering are not subject to pre-existing periods. New hires and timely new entrants after the initial enrollment period will be subject to a twelve (12) month pre-existing period. Late enrollees will be subject to an eighteen (18) month pre-existing waiting period.

DHP applies a pre-existing clause to all Small Employer Groups, regardless of contracts insured, and any Large Employer Groups that have 2-25 contracts insured. Upon request of the Employer Group, DHP may also add a pre-existing condition limitation clause to those Large Employer Groups that have 26+ employees. As of 10/1/10, dependent children under the age of 19 are not subject to pre-existing condition limitations.

Pre-existing/Portability example:

If an employee is hired June 15 and employer waiting period for coverage is the 1st of the month following date of hire, coverage would be effective on July 1.

Therefore, a condition for which treatment was recommended or received in the 6 months prior to the date of hire, June 15 (6 months prior would be December 15), would be considered a pre-existing condition, and would not be covered for 12 months (until June 15 of the following year) or 18 months (until December 15 of the following year) if a late enrollee.

If this employee had other prior creditable coverage in force for 12 months that ended on April 30, portability would apply, since there was not a lapse in coverage of 63 days or more (from the end date of coverage of April 30 to the date of hire, June 15; this is a 45 day lapse). The employee would be given 12 months of credit towards the pre-existing exclusion period; therefore, this employee would have immediate coverage for pre-existing conditions if a timely enrollee.

However, if this employee had other prior creditable coverage in force for only 3 months and 15 days, he/she would be given credit for 3 months and 15 days of prior coverage. He/she would have a balance of 8 months and 15 days of the pre-existing period to still satisfy if a timely enrollee.

Dual Choice

Employer groups that have more than one covered plan option or more than one insurance carrier covering the health insurance benefits for their employees will have an annual dual choice enrollment period for their employees. The dual choice enrollment period shall be the period of time established by the Employer and agreed upon by Dean and it shall be consistent with the Dual Choice period applicable to all other group health benefit plans offered by the Employer. The dual choice enrollment period is typically the month of the group's renewal unless otherwise requested and agreed upon by Dean.

The Employer shall permit employees to change carriers or plan options, whichever applicable, during this dual choice enrollment. The change of carriers or plan options is only permitted during this dual choice enrollment period. Employees that enroll from the employer's other dual choice insurance carrier plan into the Dean plan during the dual choice enrollment period are considered timely add-ons to the policy. If applicable, employees that switch from one Dean option to another Dean plan option will have any remaining pre-existing limitation period continue on the new plan option.

- Large Employer Groups are allowed to offer more than one insurance carrier option to their employees.
- Both Small and Large Employer groups of 11 or more subscribers are allowed to offer more than one DHP plan option.

Open Enrollment

Annual Open Enrollment in which non-covered employees and dependents may enroll in the DHP plan without late enrollee penalties must be requested on the Employer Group Application and approved by DHP. DHP allows groups that insure 100 or more employees to request an-Open Enrollment provision. All Open Enrollment requests must be approved by DHP.

The Employer shall permit non-covered employees to enroll in the DHP plan during the open enrollment period. The enrollment without late enrollee penalties is only permitted during this open enrollment period. Employees that enroll during the open enrollment period are considered timely add-ons to the policy.

Submission Requirements

New Business Submissions:

Small Employer Group:

- DHP Employer Group Application (Form # EGA_DHI-DHP_1108)
- Current Quarterly Unemployment Compensation Wage & Tax Form (UCT-101 and attachments) with the status of each employee indicated
- Most recent Current Carrier Premium Billing statement
- Solicitation Disclosure Form (Form #2002-0199)
- Employee Applications or Waivers (Small Group Uniform Application Form #OC126-501) for every eligible employee
- First month's premium check (required prior to enrollment)

Large Employer Group:

- DHP Employer Group Application (Form # EGA_DHI-DHP_1108)
- Most recent Current Carrier Premium Billing statement
- Current Census with names, employment status and dates of birth of all employees
- Details regarding special segments or retiree segments
- Employee Applications
 - 2-10 employees currently insured as reflected on the Current Carrier Billing - DHP requires the employee to complete a full health history application (DHP form number: 1106-0296)

- 11-25 employees currently insured as reflected on the Current Carrier Billing – DHP requires the employee to complete an employee application and a health addendum form (DHP form numbers: 2003-1004 [application] and 1124-0904 [health addendum])
- 26+ employees currently insured as reflected on the Current Carrier Billing – DHP requires standard employee applications. (DHP form number: 2003-1004)

Enrollment Form Requirements after the initial enrollment period:

Small and Large Employer Group Employee application:

- Employee Application for Group Coverage (Form #203-1004)

Small Employer Group Waiver of Coverage form (required for eligible employees of small employer groups that are waiving coverage)

- Dean Health Plan Waiver of Coverage (Form #2006-0403)

Rates

Groups with 2-10 covered medical employees are age rated. Groups with 11 or more covered medical employees are composite rated. Rating methodology for the upcoming year is determined by the census count at renewal preparation time and is determined by looking at the number of covered medical employees at that time.

Rate Tiers – DHP offers the following tier structures:

- **Age/Gender Rated:** This is available for groups that have 2-10 covered medical employees. Each covered employees rate is based off his/her age, gender and these factors of his/her covered family members
- **2-Tier:** This is available for groups that have 11+ covered medical employees. This Tier will have Subscriber and Subscriber + Family coverage levels.
- **3-Tier:** This is available for groups that have 11+ covered medical employees. This Tier will have Subscriber, Subscriber + One and Subscriber + Family coverage levels.
- **4-Tier:** This is available for groups that have 11+ covered medical employees. This Tier will have Subscriber, Subscriber + Spouse, Subscriber + Child(ren) and Subscriber + Family coverage levels.

Industry and/or SIC Code Rating - DHP does not use industry and/or SIC code rating factors when calculating rates for group business.

Plan Options

Small Employer Groups

Small Employer Groups have a wide variety of standard plan options to choose from with deductible options ranging from \$0 to \$5000. Small Employer Groups may also choose from two different pharmacy options. Benefit modifications to standard medical or pharmacy plans are not allowed due to WI Small Group Reform restrictions.

Small Employer Groups with 11+ covered employees may choose up to two different standard medical or pharmacy plan options.

Large Employer Groups

Large Employer Groups have a broader choice of medical plan options to choose from with deductible options up to \$10,000 single/\$20,000 family. Large Employer Groups may choose from three different pharmacy options.

Large Employer Groups with 11-50 covered employees may choose up to two medical or pharmacy plan options.

Large Employer Groups with 51+ covered employees may choose up to three plan options. Employer Groups requesting more than three plan options will require prior approval by DHP underwriting.

When choosing plan options, Employer Groups should select plans that have a premium differential of at least 10%. Exceptions to this require DHP underwriting approval.

Rate blending of POS and PPO products is available and must be approved by DHP underwriting.

Large Employer Groups with 51+ covered employees may request modifications from the standard suite of products. Modifications may be made to deductible, co-insurance, maximum out-of-pocket, office visit copayment, prescription drug plan, inpatient facility benefit and ER service copayment benefits. Modification requests must be approved by DHP underwriting.

PPO Plan Options – Employer Groups with 11 or more covered employees can elect a PPO product to accompany either an HMO or POS offering. PPO is available to all employees that reside outside of the DHP service area. The PPO product may also be selected in place of an HMO or POS product for those employees that live in the fringe counties of the DHP service area (counties include: Crawford, Vernon, Juneau, Adams, Marquette, Green Lake, Fond du Lac, Washington, Waukesha, Racine, Kenosha and Walworth). PPO participation may not exceed 50% of the covered employees.

HRA Plan Options – Dean Consumer Driven Plans were developed to provide options that encourage members to become more involved in health care decision making. These plans feature deductibles, co-insurance and copayments on most services and are sold with an option to accommodate a health care reimbursement account (HRA) to offset the employee's out-of-pocket costs to some degree. An automatic claim data feed to accommodate the HRA portion of the plan is administered through Employee Benefits Corporation (EBC).

Mid-Year Plan Changes – Changes to the plan option are usually limited to the Employer Group's anniversary date. Any plan change requests off anniversary or any plan change to a better benefit must be approved by DHP Underwriting.

Renewals

Renewal dates will occur 12 months from the original effective date unless, for large employer groups, otherwise approved by DHP underwriting. Benefit accumulators will run concurrent with the contract year unless state or federal mandates otherwise dictate a calendar year benefit accumulation period.

DHP will not cancel or non-renew the employer group policy except for any of the following reasons:

- A cease in an eligible group due to the Employer no longer having at least two covered employees with a minimum of one eligible individual who resides, lives, or works in the service area in which DHP is authorized to do business.
- Upon the last day of the grace period the entire monthly premium due is not paid by the Employer Group.
- The Employer Group requests termination of the contract.
- The Employer breaches any part of the contract.
- The Employer's business is dissolved or there is cessation of business activity.
- The Employer has failed to comply with the minimum employer contribution or participation requirements.
- Fraud or intentional misrepresentation by the Employer or with respect to coverage for an eligible employee or qualified dependent.
- DHP ceases to offer coverage in the market in which the Employer group's health benefit plan is included.

Reinstatement

All reinstatement requests are subject to review and approval by the DHP Enrollment Department.

Non-Standard Provisions

DHP is able to offer several non-standard provision options to employer groups. All provisions must be approved by DHP Underwriting.

Retiree Coverage – A group may apply for coverage at time of the initial group enrollment or during their annual renewal period to become effective upon the renewal date. Any group, regardless of size, may request a retiree coverage provision for long-term employees that retire before turning age 65. A written employer policy indentifying minimum age, length of service and employer contribution requirements for retirees should be in place prior to DHP's review of the retiree policy request. Approved retiree policies will be outlined in "Addendum to Group Master Policy – Retiree Addendum" and will be attached to the Group Master Policy.

Domestic Partner (DP) Coverage – A group may apply for DP coverage at time of the initial group enrollment or during their annual renewal period to become effective upon the renewal date. Any group, regardless of size, may request domestic partner coverage. A written employer policy should be in place prior to DHP's review of the domestic partner provision request. Approved domestic partner policies will have the Domestic Partner Rider attached to the Group Master Policy. Besides the standard DHP DP Rider, which is applied at no additional cost, a Dane County version of the DP Rider is also available at an additional cost. Other deviations require prior DHP approval and may include an additional cost implementation.

Medical Leave of Absence Coverage - A medical leave of absence provision enables groups to continue medical coverage beyond the last day worked for employees that are off of work due to a medical-related leave. A group may apply for a medical leave of absence coverage provision at the time of the initial group enrollment or at any time during the plan year. Any group, regardless of size, may request a medical leave of absence provision. A written employer policy should be in place prior to DHP's review of the medical leave of absence provision request. Small Employer Groups or Large Employer Groups with 50 or less employees insured may request a medical leave of absence provision to extend coverage up to a maximum of 60 days beyond the last day of work. Large Employer Groups with 51 or more employees insured may request a medical leave of absence provision to extend coverage up to a maximum of 12 months beyond the last day of work. If approved, details of the coverage extension will be outlined in the Group Master Policy document.

Lay-off Provision, Part-time to Full-time Employee Provision, Rehire Provision, Severance Provision, Military Leave Provision – DHP is willing to work with Employer Groups on a variety of other special provisions they may need. A written employer policy should be in place prior to DHP's review of the request. If approved, details of the coverage extension will be outlined in the Group Master Policy document.

Business Ownership Changes, Acquisitions, Mergers and Expansions

Employer Groups may be faced with business structure changes that could involve additional clarification and/or application materials to be required by DHP. The possible business structure changes involve:

Business Purchase or Ownership Change with no additional employees to be added

Requirements:

- Letter of explanation from the employer group explaining the transaction taking place.

Business Purchase or Ownership Change/New Location being added/New Class being added and employees will be added as a result

Scenario #1: Population being added is less than 10% of the active population DHP insures:

Rating Impact: None

Requirements:

- Employer Group Application (DHP form number: EGA_DHI-DHP_1108) must be completed to reflect information specific to the new group/location/class
 - Please note, the ownership of the employer group that DHP currently insures must have at least 50% ownership in this new segment to be added in order for this segment to qualify for DHP insurance.
- Letter of explanation from the employer group explaining the transaction taking place
- Eligibility listing of the new employees to be added
- Most recent current carrier billing statement from this new group segment of employee's current insurance carrier

Scenario #2: Population being added is greater than 10% of the active population DHP insures:

Rating Impact: Possible rate adjustment

Requirements:

- Employer Group Application (DHP form number: EGA_DHI-DHP_1108) must be completed to reflect information specific to the new group/location/class
 - Please note, the employer group that DHP currently insures must have at least 50% ownership in this new segment to be added in order for this segment to qualify for DHP insurance.
- Letter of explanation from the employer group regarding the transaction taking place
- Eligibility listing of the new employees to be added
- Most recent current carrier billing statement from this new grouping of employee's current carrier
- Employee Enrollment Forms must be submitted as follows and are subject to underwriting review and approval (please note that revised rates may be necessary depending on the additional health risk presented with this new segment of employees):
 - 1 – 10 employees being added requires a full health history application to be completed (DHP form number: 1106-0296)
 - 11-25 employees being added requires an employee application and health addendum to be completed (DHP form numbers: 2003-1004 [application] and 1124-0904 [health addendum])
 - 26 or more employees being added requires an employee application to be completed (DHP form number: 2003-1004)

Scenario #3: Partial Sale/Partnership Split of DHP Insured Employer Group:

Rating Impact: Possible rate adjustment

Requirements:

- Letter of explanation from the group(s) explaining the transaction and ongoing operation of the employer group
- Listing of employees still employed by the Employer Group to continue to be insured
- For partnership splits, if the partner that is splitting off wants to retain DHP coverage under a new business name, an Employer Group Application is required (DHP form number: EGA_DHI-DHP_1108). If employees will be added as a result, health history applications may be required. Please contact the DHP Retention Department regarding this requirement.
- Revised rates may be necessary depending on either the risk remaining with DHP, or any additional health risk presented by the addition of employees to DHP coverage.

Scenario 4: Business Expansion in which no new insured are being added

Rating Impact: Possible rate adjustment

Requirements:

- Letter of explanation from the group is required. This letter must include the address of the new location to be insured and should provide indication if there will be any coverage provisions that are different from the currently covered group. The letter should also indicate whether the new location should be under the same group number or if it should be set up with a different group number from the Employer Group and if they are to be rated together or separate from the currently insured DHP population.

Scenario 5: DHP Group Merges with another DHP Group

5a: Group wants to remain separate businesses from an insurance perspective

Rating Impact: None

Requirements:

- Letter of explanation from the group is required. This letter must indicate why they wish to remain separate and is subject to DHP Underwriting approval. The Employer Group must clearly define how they are being segmented.

5b: Group wants to combine insurances

Rating Impact: Possible rate adjustment

Requirements:

- Letter of explanation from the group.
- Re-rating of Employer Group rates may be necessary at the time of the transaction. Underwriting will review and determine if re-rating is necessary.

Chamber Group Health Insurance

Chamber Group Health Insurance is for businesses that are located in the Dean Health Plan service area and have 2 through 99 employees. To begin coverage in Dean Health Plan's Chamber Program, businesses need to become a member of the applicable Chamber of Commerce and that Chamber of Commerce must be a part of the DHP Chamber program.

Some of the benefits of the Chamber Health Insurance Program include:

- New Dean Health Plan member businesses receive a 3% discount on insurance premiums.
- Renewals are stabilized because businesses that are part of any particular Chamber are pooled with other participating businesses within that Chamber.
- Choice of any standard DHP benefit design options available for Small Group business.

Underwriting submission materials for the Chamber Group Health Insurance match the normal DHP submission material requirements. Please see the Submission Requirements section.

Individual Policy Business

Plan Options

DHP offers multiple plan options with various deductible, co-insurances and copays available as well as optional drug and maternity riders. Some high deductible health plans (HDHP) qualify to be used for health savings accounts. Please see www.deancare.com for product listing.

HDHP (High Deductible Health Plan) - With high deductible health plans, as required by federal law, both the covered member's prescription drug costs and their medical costs will accumulate toward the plan deductible. This means that if the drug plan option is chosen with a HDHP, the member must pay 100% of the cost of the prescription drugs until the plan deductible is met. Once the plan deductible is met, the member's prescription drug costs will revert to the standard 3-tier copay amounts. Additionally, if a policyholder has selected family type coverage, the full family deductible must be satisfied before benefits are payable to any family member under the policy. Applicants that are interested in the HDHP option should contact a trusted bank or financial institution for more information about setting up a health savings account.

Individual Applicant Eligibility

- Applicants who meet DHP Medical Underwriting requirements.
- Applicants who permanently reside within the HMO service area and are between the ages of 18 and 64.
- Applicants who are self-employed, unemployed, retired, or employed at a company where group coverage is not available through DHP.
- Temporary, part-time or seasonal employees who don't qualify for their employer sponsored health plan.
- Foreign citizens who have been United States residents for more than one year. A copy of a valid green card is required to accompany the application for insurance.
- Applicants that reside outside of the service area for a portion of the year must live within the DHP service area for at least 9 months each year to be eligible for insurance.
- Applicants that are full-time students must still reside within our service area in order to be eligible for the individual policy.

Qualified Dependent Eligibility

- Spouse under the age of 65

- Children under the age of 27 if unmarried and under age 26 if married
- Grandchild of the policyholder until the dependent child reaches age 18. The dependent child must remain on the policy as a covered dependent in order for the grandchild to be covered.
- In the case of adding newborns and adopted children to an active policy, the subscriber must file an application within 60 days of birth or placement in the home. If DHP does not receive an application, coverage beyond the 60 days will be refused unless, within one year after the birth of the child, the insured makes all past due payments including interest at the rate of 5 ½% per year.
- Unmarried children who are incapable of self-sustaining employment by reason of mental or physical disability may continue coverage beyond age 27 and are subject to underwriting review and approval. Initial proof of disability from the attending physician is required. An ongoing annual review of the disabling condition by underwriting will take place in order to maintain continued eligibility under the plan as a disabled dependent.
- In the case of insuring dependents of a legal guardian, copies of the legal documents supporting the guardianship must accompany the application. These will be reviewed by underwriting to determine the eligibility of the applying dependent.

Pricing

Rates are based on geography, tobacco use, gender, one year age bands, plan design requested and medical history. Ages of applicants are based on their age at the beginning of the quarter in which they are effective.

Application

- All offers of coverage will be for a 1st of the month effective date.
- Application for coverage must be received by the 15th of the month prior to coverage in order to allow enough time to process the application for a 1st of the month effective date. Although every attempt will be made by underwriting to finalize the processing of applications by the 1st, in the situations where additional information may be needed, a future month effective date offer may be necessary.
- The application must be completed and signed by the applicant and any dependents over the age of 18.
- Any applications submitted with a signature date older than 60 days will be returned for completion of a new current health history application form. Incomplete applications received by DHP will also be returned for completion.
- Applicants may submit their applications within 60 days of the desired effective date. Applications that are submitted greater than 60 days prior to the desired effective date will have their application closed and will be asked to submit closer to the desired effective date.
- Married couples that desire two separate plans should submit two separate applications.
- DHP does not allow a domestic partner to be covered as a dependent under an individual policy. If coverage is desired for a domestic partner, two separate applications will need to be submitted.
- Any request to add new dependents to a policy must submit a full health history application and be subject to underwriting review and approval. The exception to this rule is the addition of newborns or newly adopted children as outlined in the "Qualified Dependent Eligibility" section. When applying to have dependents added, the active subscriber should be identified as the "applicant" and the applicable selection made in the "Member/Dependent Information" section as to the reason for submitting the application. Only the newly applying family member must report health information in the "Health Questions" section of the application. Signature pages must still be completely filled out with both the primary subscriber and applicable dependents, over the age of 17, signing and dating the appropriate signature sections of the application.
- Maternity coverage may only be added when the policy is first issued or if there is a qualifying event of marriage in which a spouse is being added to the policy. In the event of marriage, the application must be received within 30 days of the date of marriage in order to qualify for the addition of the maternity benefit. Maternity coverage may not be added at any other point during the lifetime of the policy.
- A policyholder that initiates a termination of their DHP individual policy and then decides to re-apply for the DHP individual coverage at a later date is required to have no less than a 90 day lapse between the termination date of the original policy and the issue date of the new policy.
- Applicants that have had previous DHP individual type coverage that have an outstanding premium balance still due on that previous account will need to pay the outstanding premium balance in full prior to applying for a new individual type policy.
- Upon issuance the newly insured policyholder has 10 days from the date of the Approval/Acceptance letter to cancel their policy or request changes to their policy. Any changes require a written request and are subject to underwriting review and approval.

Other Submission Requirements

- First month's premium or complete ACH information (found within the body of the enrollment form) must accompany the application. The premium check will not be cashed or ACH deduction will not take place until DHP has approved the application. In the case of an alternative offer, DHP will not cash the premium check or initiate an ACH deduction until DHP has received verification from the applicant that the offer has been accepted.

Underwriting Requirements

- Applicants age 50 and older or foreign citizens, living in the US more than a year with a valid green card, that have not had a full physical exam within the last 2 years preceding the application will be required to complete an insurance screening exam by a DHP provider. Insurance screening exams also require certain lab tests to be completed as defined on the insurance screening exam request form. DHP will pay a set amount for this insurance screening exam and labs. Charges relating to services beyond what is identified on the insurance screening exam request form will be the responsibility of the applicant.
- Other condition specific questionnaires, to be completed by the applicant's physician, may be requested by Underwriting. Examples of such questionnaires include, but are not limited to: blood pressure questionnaire and height/weight questionnaire. Requests for such questionnaires will be mailed to the applicant.
- Underwriting requires that newborns of applicants must have completed an initial newborn check-up with their pediatrician. Mothers of newborns are also required to have visited their physician for the post-partum check-up if they are applying for the insurance as well.
- Underwriting may complete telephone interviews with applicant(s) or medical records may be ordered if additional information regarding the status of the applicant(s) medical condition(s) is needed. Regarding telephone interviews, Underwriting will make two attempts to contact the applicant to obtain medical information. The application will be closed out after two attempts have been made to contact the applicant. Applicants that prefer to complete the questionnaire vs. providing this information over the telephone to the Underwriter may request this from the Underwriter. The questionnaire will then be mailed to the applicant for completion.
- Applicants that are currently covered under a DHP group policy as the primary subscriber are not eligible for the individual product unless they become ineligible to remain on the group insurance policy.
- Alternative coverage offerings (ex: medical risk load, alternative plan option offering, etc.) require a signature of acceptance from the applicant before the policy will activate.
- Applicants and/or applying family members that use any type of tobacco product or nicotine substitute will be subject to a tobacco surcharge. Previous tobacco users must be tobacco free at least 12 months prior to the application to avoid the tobacco surcharge.

Uninsurable Conditions

While every effort is made to offer Individual Health Plan coverage to all who apply, not everyone qualifies for individual health insurance. Listed below are conditions which will prevent coverage on the DHP Individual Policy:

- Previous Heart Attack
- Heart Disease
- Peripheral Vascular Disease
- Previous Stroke
- Current Enlarged Heart
- Aneurysm within the last 2 years
- Parkinson's Disease
- Multiple Sclerosis
- Diabetic – Insulin
- Current Ulcer
- Hepatitis C
- Current Liver Disease
- Current Pancreatitis
- Emphysema
- Chronic Obstructive Pulmonary Disease
- Cystic Fibrosis
- Muscular Dystrophy
- SLE- Systemic Lupus Erythematosus
- Most Recent Cancers or Recurrent Cancer
- Eating disorder-Within the last year
- Suicide Attempt-Within the last 3 years
- Alcohol Abuse-Within the last 2 years
- DWI less than one year ago
- Drug Abuse-Within the last 3 years

- Current Pregnancy
- Pending Surgery for a known medical condition
- HIV, AIDS or ARC (Aids Related Complex)
- History of Gastric By-pass
- Undergoing Transgender change or history of Transgender operation(s)
- End Stage Renal Disease
- Pending Transplants
- High risk height/weight relationship (contact underwriting for information)

Please Note: this is not an all inclusive list. All health conditions will still be underwritten when submitting an individual policy application and may be offered a rate increase or may be declined based on additional information obtained during the underwriting process. As of 10/1/10 children under age 19 applying as a dependent under a parent's policy will not be declined for any medical condition. There must, however, be an adult parent as a policyholder for this dependent to be covered.

Pre-existing Condition Limitation

DHP will apply a pre-existing condition limitation to all newly issued policies. Any health condition not disclosed on the application or during the initial underwriting process, that manifested itself through medical diagnosis or treatment in the six-month period prior to the effective date, will be subject to a pre-existing limitation. Changes in medical history prior to the effective date of coverage, but not reported to DHP, will be considered misstatements and may be subject to a pre-existing limitation or potential rescission by DHP. Pre-existing conditions will be considered eligible for benefits 12 months after the effective date. As of 10/1/10, children under the age of 19 will not be subject to pre-existing condition limitations.

Maternity Rider Coverage - There is a 270 day waiting period before normal maternity related services are covered. Regardless of the maternity rider benefit, complications of pregnancy are treated the same as any other medical illness or sickness and benefits for these services are available under any individual policy as they would be for any related illness or sickness.

Renewals

Individual policy renews annually on July 1. New policyholders initiating coverage other than July 1 may have less than a 12 month rate up to the next July 1 but will have a 12 month rate thereafter. Renewal rates are available 60 days prior to the July 1 renewal date.

Individual policy increases will be based on the entire individual block performance and not on any individual policyholder's claims experience. Increases will be calculated by product level, coverage level and age band of the policyholder and family members covered.

Change in coverage requests:

- Downgrade in benefits requests at renewal time may be submitted in writing to the underwriting department. These requests are not underwritten and will be processed for a July 1 effective date.
- A one-time off-renewal downgrade in benefits is available per the lifetime of the policy. This request must be submitted in writing to the Underwriting Department and will not be underwritten. The effective date of the change will be the 1st of the month following the receipt of the request. Once the one-time off-renewal option has been used, all future downgrade in coverage changes will be limited to the July 1 renewal time. Policy year deductibles and other benefit limitations will start over with this mid-year change.
- Upgrades in coverage, including the addition of a drug rider, will require full medical underwriting. The policyholder must submit a full health history application for review and approval by the underwriting department. Benefit upgrades can only be effective on a July 1 renewal date.
- Policyholders that have a tobacco surcharge on their policy of which tobacco use has ceased may apply to have this surcharge removed. An application must be submitted to request this change. The member must be tobacco free for at least 12 months prior to the renewal and will be subject to continued testing verification.
- Policyholders that have a medical risk load on their policy may apply to have that removed. The policyholder must submit a full health history application for review and approval by the underwriting department. Requests to remove a medical risk load can only be effective on a July 1 renewal date.
- Policyholders may cancel the maternity coverage rider at a July 1 renewal date. This rider may not be added again during the lifetime of the policy.

- Policyholders are not able to add the maternity rider as an upgrade request upon renewal. The maternity benefit may only be added as defined in the "Application" section of this document.

Removal of the HSA (Health Savings Account) benefit is limited to the July 1 renewal period. Policyholders must submit a request in writing to have this removed from their plan.

Reinstatement

If a member is terminated for non-payment of premiums, coverage may be reinstated according to the following rules:

- Policyholder's plan must have lapsed due to non-payment of premium
- Policyholder must apply for reinstatement within one year of termination
- DHP will only allow one reinstatement per lifetime of the policy
- Policyholder can only be reinstated under the benefits he/she had
- Policyholder must pay all back premium prior to the reinstatement taking place

Association Policy Business

Types of Individual Association Policies

- Realtor Association
- Tavern League Association
- Chamber One Association

Plan Options

DHP offers six plan options along with optional drug and maternity riders.

The base medical plan options include the following:

- Dean Copay Plan - \$35 Office Visit Copay option (includes maternity coverage)
- Dean 250 - annual deductible of \$250 single/\$500 family
- Dean 750 - annual deductible of \$750 single/\$1500 family
- Dean 1250 - annual deductible of \$1250 single/\$2500 family
- Dean 1500 (HSA compatible) - annual deductible of \$1500 single/\$3000 family*
- Dean 3000 (HSA compatible) - annual deductible of \$3000 single/\$6000 family*

Optional riders available:

- Prescription Drug Rider - \$0 deductible, \$10/\$40/\$75 copay/co-insurance

HDHP (High Deductible Health Plan) - With high deductible health plan, as required by federal law, both the covered member's prescription drug costs and their medical costs will accumulate toward the plan deductible. This means that if the drug plan option is chosen with a HDHP, the member must pay 100% of the cost of the prescription drugs until the plan deductible is met. Once the plan deductible is met, the member's prescription drug costs will revert to the standard 3-tier copay amounts. Additionally, if a policyholder has selected family type coverage, the full family

deductible must be satisfied before benefits are payable under the policy. Applicants that are interested in the HDHP option should contact a trusted bank or financial institution for more information about setting up a health savings account.

*Applicants who select the Dean 1500 or Dean 3000 will automatically be enrolled with the HSA benefit.

Association Applicant Eligibility

- Applicants who permanently reside within the HMO service area and are between the ages of 18 and 64.
- Realtor Association and Wisconsin Tavern League Associations: Applicants must be a current, valid member of the Association as indicated on the current Association Membership lists.
- ChamberOne Association: Applicant must be a current, valid member of a participating Chamber. Eligible applicants must be a sole practitioner, a sole proprietor, or any entity doing business with no more than one full-time, year-round employee. One full-time employee includes the owner or operator of the business. Owners working full-time and have a full-time employee qualify for group coverage and would not be eligible for the ChamberOne Product. To qualify for the ChamberOne, the business owner cannot otherwise have access to group health benefits under an employer sponsored group health plan.
- Foreign citizens follow the same rules as the Individual Policy. Please see the "Individual Applicant Eligibility" under the Individual Policy Business section of this guide.
- Applicants that reside outside of the service area for a portion of the year must live within the DHP service area for at least 9 months to be eligible for the Association Individual Policy business. The applicant's association membership must remain in-force while residing outside of the service area.

Qualified Dependent Eligibility

- Same as the "Qualified Dependent Eligibility" of the Individual Policy Business

Pricing

Rates are based on geography, tobacco use, gender, one year age bands, coverage requested and medical history. Ages of applicants are based on their age at the beginning of the quarter.

Application

- Enrollment is available on one of 4 quarterly effective dates – January 1, April 1, July 1 or October 1.
- Application for coverage must be received by the 15th of the month prior to coverage in order to allow enough time to underwrite for a 1st of the month effective date. Although every attempt will be made by underwriting to finalize the underwriting of applications by the 1st, in the situations where additional information may be needed, a future quarterly effective date offer may be necessary.
- The application must be completed and signed by the applicant and any dependents over the age of 18.
- Any applications submitted with a signature date older than 60 days will be returned for completion of a new current health history application form. Incomplete applications received by DHP will also be returned for completion.
- Applicants may submit their applications within 60 days of the desired effective date. Applications that are submitted greater than 60 days prior to the desired effective date will have their application closed and will be asked to submit closer to the desired effective date.
- DHP does not allow a domestic partner to be covered as a dependent under this policy.
- Any request to add new dependents to a policy must submit a full health history application and be subject to underwriting review and approval. The exception to this rule is the addition of newborns or newly adopted children as outlined in the, "Qualified Dependent Eligibility" section. When applying to have dependents added, the active subscriber should be identified as the "applicant" and the applicable selection made in the "Member/Dependent Information" section as to the reason for submitting the application. Only the newly applying family member must report health information in the "Health Questions" section of the application. Signature pages must still be completely filled out with both the primary subscriber and applicable dependents signing and dating the appropriate signature sections of the application.

- Maternity is a covered benefit under the Dean Copay Association Plan. It is not a covered benefit under any other plan option available under the Association Plans.
- DHP will provide a guarantee offer of coverage with the first application submitted. If this first application is closed out or the applicant does not accept the offer of coverage, their subsequent applications will not be a guarantee offer of coverage. Additionally, if the primary subscriber is insured with DHP and wants to add dependents at a later time, there will not be a guarantee offer of coverage for these dependents.
- A policyholder that initiates a termination of their DHP Association Policy and then decides to re-apply for the DHP Association Policy at a later date is required to have no less than 90 day lapse between the termination date of the original policy and the issue date of the new policy. The applicant would no longer be eligible for guarantee of coverage offer since this would not be their first application submitted.
- Applicants that have had previous DHP individual type coverage that have an outstanding balance still due on that previous account will need to pay the outstanding balance in full prior to applying for an Association Plan.
- Upon issuance the newly insured policyholder has 10 days from the date of the Approval/Acceptance letter to cancel their policy or request changes to their policy. Any changes require a written request and are subject to underwriting review and approval.

Other Submission Requirements

- Realtor Association and Wisconsin Tavern League Associations: Applicants must be a current, valid member of the Association as indicated on the current Association Membership lists. Underwriting will verify membership upon receipt of the application materials. Applicants that are not Association members are not eligible.
- ChamberOne Association: Applicant must be a current, valid member of a participating Chamber. Underwriting will verify membership in Chamber upon receipt of the application materials.
- ChamberOne Association Tax Documents: Documentation of sole proprietorship or sole practitioner status must be provided with enrollment materials. Examples of acceptable documentation include, but are not limited to: Schedule 1040 including either of the following: Schedule SE, C C-EZ, F, K-1 or E.
- First month's premium or complete ACH information (found within the body of the enrollment form) must accompany the application. The premium check will not be cashed or ACH deduction will not take place until DHP has verified that the offer of coverage has been accepted by the applicant.

Underwriting Requirements

- Applicants age 50 and older or foreign citizens, living in the US more than a year with a valid green card, that have not had a full physical exam within the last 2 years preceding the application will be required to complete an insurance screening exam by a DHP provider. Insurance screening exams also require certain lab tests to be completed as defined on the insurance screening exam request form. DHP will pay a set amount for this insurance screening exam and labs. Charges relating to services beyond what is identified on the insurance screening exam request form will be the responsibility of the applicant.
- Other condition specific questionnaires, to be completed by the applicant's physician, may be requested by Underwriting. Examples of such questionnaires include, but are not limited to: blood pressure questionnaire and height/weight questionnaire. Requests for such questionnaires will be mailed to the applicant.
- Underwriting requires that newborns of applicants must have completed an initial newborn check-up with their pediatrician. Mothers of newborns are also required to have visited their physician for the post-partum check-up if they are applying for the insurance as well.
- Underwriting may complete telephone interviews with applicant(s) or medical records may be ordered if additional information regarding the status of the applicant(s) medical condition(s) is needed. Regarding telephone interviews, Underwriting will make two attempts to contact the applicant to obtain medical information. The application will be closed out after two attempts have been made to contact the applicant. Applicants that prefer to complete the questionnaire vs. providing this information over the telephone to the Underwriter may request this from the Underwriter. The questionnaire will be mailed to the applicant for completion.
- Applicants that are currently covered under a DHP group policy as the primary subscriber are not eligible for the Association Plan unless they become ineligible to remain on the group insurance policy.

- Alternative coverage offerings (ex: medical risk load, alternative plan option offering, etc.) require a signature of acceptance from the applicant before the policy will activate.
- Applicants and/or applying family members that use any type of tobacco product or nicotine substitute will be subject to a tobacco surcharge. Previous tobacco users must be tobacco free at least 12 months prior to the application to avoid the tobacco surcharge.

Uninsurable Conditions

The Association Plan has the guarantee of offer upon first application feature. Therefore there are no uninsurable conditions with the first application submitted. However, any subsequent application for insurance through the Association Plan may potentially be declined based on an applicant's health history. Please see the list of "Uninsurable Conditions" found in the Individual Policy Application section for a list of conditions that would cause a decline decision.

Pre-existing Condition Limitation

DHP will apply a pre-existing condition limitation to all newly issued policies. Any health condition not disclosed on the application or during the initial health underwriting that manifested itself through medical diagnosis or treatment in the twelve-month period prior to the enrollment date will be subject to a pre-existing limitation. Changes in medical history prior to the effective date of coverage, but not reported to DHP, will be considered misstatements and may be subject to a pre-existing limitation or potential rescission by DHP. Pre-existing conditions will be covered 24 months after the enrollment date. As of 10/1/10, children under the age of 19 will not be subject to pre-existing condition limitations.

Renewals

Association Plan policyholders initially have a 12 month rate guarantee and will renew on an annual basis. Renewal rates are available 60 days in advance of the renewal date.

Association Plan renewal increases will be based on the entire Association block performance. Increases will be calculated by product level, coverage level and age band of the policyholder and family members covered.

Change in coverage requests:

- Downgrade in benefits requests at renewal time may be submitted in writing to the Underwriting Department. These requests are not underwritten and will be processed for the policyholder's renewal date.
- A one-time off-anniversary downgrade in benefits is available per the lifetime of the policy. This request must be submitted in writing to the Underwriting Department and will not be underwritten. The effective date of the change will be the 1st of the month following the receipt of the request. If the one-time option has been used, all future downgrade in coverage changes will be limited to the annual renewal period. Policy year deductibles and other benefit limitations will start over with this mid-year change.
- Upgrades in coverage, including the addition of a drug rider, will require full medical underwriting. The policyholder must submit a full health history application for review and approval by the underwriting department. Benefit upgrades are limited to the renewal period.
- Policyholders that have a tobacco surcharge on their policy of which tobacco use has ceased may apply to have this surcharge removed. An application must be submitted to request this change. The member must be tobacco free for at least 12 months prior to the renewal and will be subject to continued testing.
- Policyholders that have a medical risk load on their policy may apply to have that removed. The policyholder must submit a full health history application for review and approval by the underwriting department. Requests to remove of a medical risk load are limited to the renewal period.