DeanHealthPlan

A member of SSM Health

Dean Health Plan

DeanCare Member Policy and Benefit Summary

Medicare Select Policy

Dean Health Plan
1277 Deming Way
Madison, WI 53717
1-608-827-4372, 1-888-422-3326 or
TTY 1-877-733-6456

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

IMPORTANT INFORMATION

DEANCARE SELECT

MEDICARE SELECT POLICY

The Wisconsin Insurance Commissioner has set standards for Medicare Select Insurance. This Policy meets these standards. It, along with Medicare, may not cover all of your medical costs. You should carefully review all Policy limitations. For an explanation of these standards and other important information, see the "Wisconsin Guide to Health Insurance for People with Medicare" guide given to you when you applied for this Policy. Do not buy this Policy if you did not get this guide.

IMPORTANT NOTICE CONCERNING STATEMENTS IN THE APPLICATION FOR YOUR MEDICARE SELECT INSURANCE

Please read the copy of your Application attached to this Policy. Omissions or misstatements in your Application could cause an otherwise valid claim to be denied. Carefully check the Application and write to us within 30 days if any information shown on the Application is not correct and complete, including your current medical status listed under the Application's underwriting question. The Application is part of your contract. The insurance contract was issued on the basis that the answers to all questions and any other material information shown on the Application are correct and complete.

YOUR RIGHT TO RETURN THIS POLICY

PLEASE READ THIS POLICY RIGHT AWAY.

Upon receipt of your premium payment, our issuance of this Policy and a Dean Health Plan. identification card, we agree to provide the benefits described in this Policy. If you are not satisfied with this Policy for any reason, you can return it within 30 days. Upon return, this Policy becomes invalid. We will refund any premium payments you have made on it.

GUARANTEED RENEWABLE FOR LIFE - PREMIUM SUBJECT TO CHANGE

This Policy is guaranteed renewable for life, as long as you pay your premium payment, and it can't be canceled or non-renewed because you have used or overused benefits. Of course, you can end your Policy as of the last day of any month by writing to us, in accordance with the provisions outlined in the "Policy, Renewal and Premium Information" section.

We can raise your premium only if we raise the premium for all policies like yours. Your premium will also change at the next renewal date when you attain the following ages: 65, 70, 75, 80 and 85. Your premium will not increase on the basis of age after you reach age 85.

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I. Managed Care Provisions

Why Choose Dean Health Plan, Inc.?

ACCESS TO CARE

We have numerous plan providers in our service area that can provide you with care. You also have access to our free 24-hour nurse line, Dean- On-Call, 1-800-57-NURSE (1-800-576-8773) or 1-608-250-1393. The service area is the area included within the boundaries of: Adams, Brown, Calumet, Columbia, Crawford, Dane, Dodge, Door, Fond du Lac, Grant, Green, Green Lake, Iowa, Jefferson, Juneau, Kenosha, Kewaunee, Lafayette, Manitowoc, Marinette, Marquette, Oconto, Outagamie, Racine, Richland, Rock, Shawano, Sauk, Vernon, Walworth, Washington, Waukesha, Waupaca, Waushara, and Winnebago counties in the State of Wisconsin. The service area is subject to change. If there is a change, notification will be provided.

PLAN PROVIDERS

Dean Health Plan utilizes providers in a specific geographic area. When you become a member of Dean Health Plan, you will choose one of these plan providers to be your primary care provider (**PCP**). Being part of Dean Health Plan means that you agree to use providers that are part of our provider network. Any care that you need should be provided by plan doctors, specialists, and hospitals. As listed in the most current edition of our DeanCare Select Provider Directory (which is also located on-line at deancare.com), plan providers include, but are not limited to, dentists (DDS), podiatrists (DPM), optometrists (OD), chiropractors (DC), hospitals, pharmacies, and nurse practitioners.

A PCP is a plan provider who evaluates your total health needs and provides personal medical care in one or more medical fields. When medically needed, the PCP preserves the continuity of care. The PCP is also in charge of coordinating other provider health services.

Please note that physician/patient relationships will not be affected, or interfered with, by virtue of the fact that plan providers have entered into participating agreements with Dean Health Plan. Medical judgments and decisions of a medical nature remain with the health care providers, and they are responsible for all such medical judgments and related treatments. Any plan of treatment recommended by your physician must meet the Policy's benefit provision requirements in order to be covered.

NON-PLAN PROVIDERS

Non-plan providers are providers who are not listed in the most current edition of our DeanCare Select Provider Directory. Dean Health Plan has no ability to monitor the quality of care provided by a non- plan provider.

REFERRALS

Dean Health Plan uses a referral process as the basic foundation of managed care. Referrals allow PCPs to manage your care. You must choose a Dean Health Plan provider as your PCP. **A written referral is not required to receive services at any other** Dean Health Plan **provider or specialist locations.** A complete listing of DHP providers can be found in the DeanCare Select Provider Directory.

If you have a chronic, complex or serious medical condition that requires you to see a plan specialist frequently, please consult your PCP. If your PCP refers you to a non-plan provider, a written referral request must be submitted to, and approved by, our Medical Affairs Division prior to receiving services. A verbal request for a referral does not guarantee authorization of the referral or the services. You will receive written notification from our Medical Affairs Division after review of the referral request has been completed. Referrals to a non-plan provider are only considered when there are no plan providers that can provide the care that is needed. If your request for a referral is denied, please see the options available in the "Complaint, Grievance and Independent External Review Procedure" section.

End of Section I.

II. Benefit Provisions

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

PLEASE SEE YOUR OUTLINE OF COVERAGE FOR ADDITIONAL COVERAGE INFORMATION.

Emergency Care and Urgent Care

BENEFITS CHART – Medicare & DHP covered and non-covered services	WHAT YOU MUST PAY – when you get these services
Emergency Care	You pay Nothing for each Medicare-covered emergency room visit received in the United States

What is Emergency Care?

Emergency care is care you need due to the onset of a medical condition that, if you do not seek immediate medical attention, could result in your death or serious injury. Some examples of conditions that may require emergency care are heart attacks, strokes, severe shortness of breath, and significant blood loss.

What to do in case of emergency:

Most of the time, you will be able to receive emergency care from a plan provider. However, if you are unable to reach a plan provider, you should go to the nearest medical facility for assistance. If you seek emergency or urgent care from a non-plan provider, call our Customer Care Center as soon as possible and tell us where you are receiving emergency care. If the emergency care you receive results in a hospital admission to a non-plan hospital, you or the hospital must call us by the next business day following the admission.

Urgent Care	You pay Nothing for Medicare covered urgently needed care received in the United States

What is Urgent Care?

Urgent care is care that you need sooner than a routine doctors visit. Some examples of conditions that may require urgent care are broken bones, sprains, minor cuts and burns, drug reactions, and non-severe bleeding. If you are outside the service area, go to the nearest appropriate medical facility, unless you can safely return to the service area to receive care from a plan provider. Urgent care is not follow-up care, unless such care is necessary to prevent your health from getting significantly worse before you can reach your primary care provider. It does not include care that can be safely postponed until you return to the service area to receive care from a plan provider.

What to do if you need Urgent Care:

Urgent care should be received at the nearest appropriate medical facility, unless you can safely return to the service area. Please call our Customer Care Center as soon as possible after seeing a non-plan provider. When we receive a claim for the services, it will be reviewed to determine if the diagnosis or symptoms were urgent. If you have a question regarding when to seek emergency or urgent care, you can call our 24-hour nurse access line at 1-800-57 NURSE (1-800-576-8773) or 1-608-250-1393.

World-wide coverage For emergency and urgently needed care not covered by Medicare, but related to foreign travel outside of the United States (U.S.) and received within the first 60 consecutive days of departure from the U.S.	Each trip you pay 20%, after a $250 deductible, up to a lifetime maximum benefit of $50,000

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

BENEFITS CHART – Medicare & DHP covered and non-covered services	WHAT YOU MUST PAY – when you get these services
Inpatient Hospital Care Covered services include, but are not limited to, the following: • Semiprivate room (a private room if medically necessary) • Meals, including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Rehabilitation services, such as physical therapy, occupational therapy and speech therapy services • Blood – Medicare coverage begins with the fourth pint of blood that you need; coverage for storage and administration begin with the first pint of blood that you need • Physician services	✱You pay Nothing for the following Medicare covered services: • Each stay in a plan hospital • Each day and additional day in a plan hospital After you reach Medicare's hospital benefit maximum, you will pay Nothing for all Medicare Part A hospitalization expenses no longer covered by Medicare for an additional 365 days (to the extent the hospital is permitted, by federal law and regulation, to charge for these expenses and the expenses are subject to the Medicare reimbursement rate) ✱You pay $0 for blood beginning with the first pint
• Coverage will also be provided for hospital and ambulatory surgery center charges incurred, and anesthetics used in connection with, dental care provided to a member in a hospital or ambulatory surgery center, if the service is prior authorized by our Medical Affairs Division, and if: – You have a chronic disability, or – You have a medical condition that requires hospitalization or general anesthesia for dental care.	✱You pay Nothing for these medical services.

A Hospital is a facility that is certified by the Medicare program and licensed by the State to provide inpatient, outpatient, diagnostic and therapeutic services.

The term Hospital does not include facilities that mainly provide custodial care (such as convalescent nursing homes or rest homes).

Hospital confinement, or being confined in a hospital, means: (1) being registered as a patient in a hospital on the advice of a plan provider; or (2) receiving emergency care for an illness or injury in a hospital. Hospital swing-bed confinement is considered the same as confinement in a skilled nursing facility.

✱ You pay nothing only when you use plan providers (or receive a Dean Health Plan approved referral from a plan provider). Otherwise, you are responsible for any Medicare cost sharing amounts.

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

BENEFITS CHART – Medicare & DHP covered and non-covered services	WHAT YOU MUST PAY – when you get these services
Non-Covered Services: ……	100%

1. Take home drugs and supplies dispensed at the time of hospital discharge, unless a written prescription is obtained and filled at a plan pharmacy.
2. Hospital stays that are extended for reasons other than medical necessity (e.g., lack of transportation, lack of caregiver or inclement weather).
3. A continued hospital stay, if the attending physician has documented that care could effectively be provided in a less acute care setting (e.g., skilled nursing facility or member's home).
4. Any surgical treatment or hospitalization for the treatment of morbid obesity.
5. Personal comfort or convenience items such as in-hospital television, telephone, private room, housekeeping and homemaker services, and meal services as part of home health care.

Outpatient Surgical Services • Surgical procedures to care for illness and accidental injury. Covered services include preoperative and postoperative care and needed services of assistants and consultants	✱You pay Nothing for each Medicare-covered visit to an ambulatory surgical center and/or an outpatient hospital facility

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:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications of all stages of mastectomy, including lymphedemas.

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

Non-Covered Services: ……	100%

1. Procedures, services, medications and supplies related to sex transformation.
2. Reversal of voluntary sterilization procedures and related procedures.
3. Cosmetic or plastic surgery, unless representing a medical/surgical necessity, except coverage is provided for breast reconstruction of the affected tissue incident to a mastectomy. Psychological reasons do not represent a medical/surgical necessity.
4. Any surgical treatment or hospitalization for the treatment of morbid obesity.
5. Cochlear implants, unless Medicare approved.

Detoxification Services • Medically necessary detoxification services provided by an approved health care provider	✱You pay Nothing for medically necessary services

✱ You pay nothing only when you use plan providers (or receive a Dean Health Plan approved referral from a plan provider). Otherwise, you are responsible for any Medicare cost sharing amounts.

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

BENEFITS CHART – Medicare & DHP covered and non-covered services	WHAT YOU MUST PAY – when you get these services
Skilled Nursing Facility care A member must be admitted within 30 days of discharge following at least a 3-day hospital stay. Covered services include, but are not limited to, the following: • Semiprivate room (private room if medically necessary) • Meals, including special diets • Regular nursing services • Physical therapy, occupational therapy and speech therapy • Drugs (this includes substances that are naturally present in the body, such as blood clotting factors) • Blood – Medicare coverage begins with the fourth pint of blood that you need; coverage for storage and administration begin with the first pint of blood that you need • Medical and surgical supplies • Laboratory tests • X-rays and other radiology services • Use of appliances, such as wheelchairs • Physician services A Skilled Nursing Facility is an institution that is licensed by the State of Wisconsin as a Skilled Nursing Facility.	✱You pay Nothing for each Medicare-covered stay, for days 1-100 There is a limit of 100 days each benefit period (please see the "benefit period" definition in the **Glossary of Terms** section) ✱You pay $0 for blood beginning with the first pint
If your stay is NOT covered by Medicare, because you do not have a Medicare "qualifying hospital stay," we will cover up to 30 days of skilled nursing care in a licensed facility as long as it meets Dean Health Plan's Medical Necessity Guidelines.	✱You pay Nothing for these services.
Inpatient Services (when the hospital or SNF days are no longer covered) • Physician services • Diagnostic tests (e.g X-ray or lab tests) • X-ray, radium, and isotope therapy, including technician materials and services • Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations • Prosthetic devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices	✱You pay Nothing for Medicare covered items and services

✱ You pay nothing only when you use plan providers (or receive a Dean Health Plan approved referral from a plan provider). Otherwise, you are responsible for any Medicare cost sharing amounts.

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

BENEFITS CHART – Medicare & DHP covered and non-covered services	WHAT YOU MUST PAY – when you get these services
Inpatient services (when the hospital or SNF days are no longer covered) ***continued…*****:** • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes, including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	✱You pay Nothing for Medicare covered items and services

What is a "skilled nursing facility" (or "SNF")?

A skilled nursing facility is often referred to as a SNF.. A SNF is a place that provides skilled nursing or rehabilitation services. It can be a separate facility, or part of a hospital or other health care facility. The term "skilled nursing facility" does not include places that mainly provide custodial care, such as convalescent nursing homes or rest homes. (Nursing home coverage means for care that is convalescent or custodial care or care for a chronic condition or terminal illness and provided in an institutional or community-based setting.)

What is SNF care?

A level of care ordered by a physician that must be given or supervised by licensed health care professionals. It can be skilled nursing care, or skilled rehabilitation services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services include physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body, it may include e training on how to use special equipment such as how to use a walker or get in and out of a wheel chair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps individuals recuperating from physical or mental illness and encourages rehabilitation through the performance of activities required in daily life, such as eating and dressing by yourself.

Non-Covered Services: …… 100%

1. Custodial or domiciliary care. "Custodial care" is care for personal needs rather than medically necessary needs. Custodial care consists of any non-medical care that can reasonably and safely be provided by non-licensed care givers. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication.
2. Charges for injectable medications administered during a nursing home stay, when the nursing home stay is not covered by this Policy.

Home Health care • Part-time or intermittent skilled nursing and home health aide services; physical therapy, occupational therapy, and speech therapy; medical social services; and medical equipment and supplies	✱You pay Nothing for Medicare covered home health visits ✱You pay Nothing for home health visits and services up to 365 visits in any 12 month period (includes those visits paid by Medicare)

✱ You pay nothing only when you use plan providers (or receive a Dean Health Plan approved referral from a plan provider). Otherwise, you are responsible for any Medicare cost sharing amounts.

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

BENEFITS CHART – Medicare & DHP covered and non-covered services	WHAT YOU MUST PAY – when you get these services
Home care benefits are limited to a maximum number of visits. • Each visit by a qualified person providing services under a home care plan, evaluating your needs or developing a plan will be considered by us as one visit. • Each period of 4 straight hours, in a 24-hour period of home health aide services, counts as one home care visit. The attending physician must establish a home health care plan, approve it in writing, and review it at least every 2 months, unless the physician determines less frequent reviews are sufficient.	
Home care means one or more of the following: 1. Home nursing care that is given part-time or from time to time. It must be given or supervised by a registered nurse. 2. Home health aide services that are given part-time or from time to time. They must be medically necessary as part of the home care plan and must consist solely of caring for the patient. A registered nurse or medical social worker must supervise them. 3. Physical, respiratory, occupational, and speech therapy. 4. Medical supplies prescribed by a plan physician; and lab services by or for a hospital. These must be medically necessary under the home care plan and are covered to the same extent as if the member was confined to a hospital. 5. Nutritional counseling. It must be medically necessary as part of the home care plan and a registered or certified dietitian must give or supervise these services. 6. The assessment of the need for a home care plan and its development. A registered nurse, physician's assistant or medical social worker must do this assessment and the attending physician must request or approve this service. If a member was confined in a hospital just before care began, the home care plan must be approved, at its start, by the physician who was the primary provider of care during the hospital confinement. Hospital confinement, or being confined in a hospital, means being registered as a patient in a hospital on the advice of a plan provider, or receiving emergency care for an illness or injury in a hospital. (Hospital swing-bed confinement is considered the same as confinement in a skilled nursing facility).	
Non-Covered Services: ……	100%
1. Prescription drugs that are covered under Medicare Part D. 2. Home care is not covered, unless the attending physician certifies that: (a) hospital confinement, or confinement in a skilled nursing facility, would be needed if home care was not provided; (b) the member's immediate family, or others living with the member, cannot provide the needed care and treatment without undue hardship; or (c) a state licensed or Medicare certified home health agency or certified rehabilitation agency will provide or coordinate the home care.	

✱ You pay nothing only when you use plan providers (or receive a Dean Health Plan approved referral from a plan provider). Otherwise, you are responsible for any Medicare cost sharing amounts.

Facility Services (Hospital Inpatient Care, Outpatient Care and Skilled Nursing Facility), Home Health and Hospice *continued…*	
BENEFITS CHART – **Medicare & DHP covered and non-covered services**	**WHAT YOU MUST PAY –** **when you get these services**
Hospice care • Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by Medicare • Home care • Hospice consultation services (one time only) for a terminally ill individual who has not yet elected the hospice benefit.	✱You pay Nothing when you enroll in a Medicare-certified Hospice ✱You pay Nothing, one time only, for Hospice consultation services
Non-Covered Services: …… 1. Respite and Residential care.	100%

✱ You pay nothing only when you use plan providers (or receive a Dean Health Plan approved referral from a plan provider). Otherwise, you are responsible for any Medicare cost sharing amounts.

General Medical and Diagnostic Services

BENEFITS CHART – Medicare & DHP covered and non-covered services	WHAT YOU MUST PAY – when you get these services
Any service that is covered under this Policy is also covered when it is provided for the treatment of cancer when administered in a clinical trial that meets the definition of "**CLINICAL CANCER TRIAL**" in the **Glossary of Terms** section of this Policy.	
Ambulance services • Includes medically necessary ambulance services to an institution (like a hospital or SNF), from one institution to another institution, from an institution to your home, and services dispatched through 911, where other means of transportation could endanger your health • Air ambulance is paid only in emergency situations	✱You pay Nothing for Medicare covered ambulance services
Non-Covered Services: ……	100%
1. Ambulance service that is not an emergency transportation, unless prior authorized by our Medical Affairs Division. 2. Charges for, or in connection with, any other form of travel, unless otherwise stated in this Section. 3. Air transportation that does not meet the criteria established by our Medical Affairs Division.	
Anesthesia Services • Provided in connection with covered services	✱You pay Nothing for Medicare covered anesthesia services
Non-Covered Services: ……	100%
1. Any anesthesia services provided for non-covered services.	
Chiropractic services • Manual manipulation of the spine to correct subluxation	✱You pay Nothing for Medicare covered chiropractic services ✱You pay Nothing for medically necessary services that are not covered by Medicare
Non-Covered Services: ……	100%
1. Maintenance or long-term therapy, or routine services. 2. Chiropractic services performed by a non-plan provider.	
Dental services • Limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor	✱You pay Nothing for these Medicare covered dental services
Non-Covered Services: ……	100%
1. All services performed by dentists, and other dental services including dentures and oral surgery, unless the oral surgery is covered by Medicare.	
Diagnostic Services • Lab tests* • X-rays* • Outpatient Facility MRI* *(given with general physical examinations or as part of a diagnostic evaluation)	✱You pay Nothing for Medicare covered diagnostic services

✱ You pay nothing only when you use plan providers (or receive a Dean Health Plan approved referral from a plan provider). Otherwise, you are responsible for any Medicare cost sharing amounts.

General Medical and Diagnostic Services *continued…*

BENEFITS CHART – Medicare & DHP covered and non-covered services	WHAT YOU MUST PAY – when you get these services
Diagnostic Services ***continued…*** • Outpatient Facility CAT Scan • Sleep studies (diagnostic and portable) • Mammography screening: – One baseline exam between ages 35 and 39 – One screening every 12 months for women age 40 and older (Services of a nurse practitioner will be covered in connection with mammography screening.)	✱You pay Nothing for Medicare covered diagnostic services
• Pap Smears, Pelvic Exam, and Clinical Breast Exams – Pap tests, pelvic exams and clinical breast exams are covered once every 24 months, for all women – One Pap test every 12 months if you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age (Services of a nurse practitioner will be covered in connection with these services.)	✱You pay Nothing for Medicare covered gynecological services
• Bone Mass measurements for qualified individuals (*generally, this means people at risk of losing bone mass or at risk of osteoporosis*) – Procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results are covered every 2 years, or more frequently if medically necessary	✱You pay Nothing for Medicare covered bone mass measurements
• Colorectal Screening *For people age 50 and older:* – Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months – Fecal occult blood test, every 12 months *For people at high risk of colorectal cancer:* – Screening colonoscopy (or screening barium enema as an alternative) every 24 months *For people who are not at high risk of colorectal cancer:* – Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy	✱You pay Nothing for Medicare covered screening services
• Prostate Cancer screening exams: *For men over age 50, the following are covered once every 12 months:* – Digital rectal exam • Prostate Specific Antigen (PSA) test	✱You pay Nothing for Medicare covered prostate services

✱ You pay nothing only when you use plan providers (or receive a Dean Health Plan approved referral from a plan provider). Otherwise, you are responsible for any Medicare cost sharing amounts.

General Medical and Diagnostic Services *continued…*

BENEFITS CHART – Medicare & DHP covered and non-covered services	WHAT YOU MUST PAY – when you get these services
Hearing Services • Diagnostic hearing exams to determine if correction is needed	✱You pay Nothing for each Medicare-covered hearing exams
Immunizations • Pneumonia vaccine • Flu shots, once a year in the fall or winter • Hepatitis B vaccine if you are at high or immediate risk of getting Hepatitis B • Other vaccines if you may have been exposed to rabies	✱You pay Nothing for Medicare covered immunization services
Medical Nutrition Therapy For members with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor	✱You pay Nothing for Medicare covered medical nutrition therapy services
Physical Examinations • Routine annual exam	✱You pay Nothing for each physical exam
Podiatry Services • Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs	✱You pay Nothing for Medicare covered podiatry services
Non-Covered Services: ……	100%
1. All other routine foot care and services.	
Radiation Therapy • Accepted therapeutic methods, such as x-rays, radium and radioactive isotopes, which are administered and billed by an approved health care provider	✱You pay Nothing for Medicare covered services
Outpatient Rehabilitation Services • **Physical Therapy, Occupational Therapy, Cardiac Rehabilitation, Speech & Language Therapy** Cardiac rehabilitation therapy is covered for patients who have had a heart attack in the last 12 months, have had coronary bypass surgery, and/or have stable angina pectoris	✱You pay Nothing for each Medicare-covered Physical Therapy visit, Occupational Therapy visit, Speech and Language Therapy visit, and each Cardiac Rehabilitation visit
Non-Covered Services: ……	100%
1. Vocational rehabilitation including work hardening programs. 2. Hearing therapy for communication delay, therapy for perceptual disorders, mental disability and related conditions, and other long-term special therapy.	

✱ You pay nothing only when you use plan providers (or receive a Dean Health Plan approved referral from a plan provider). Otherwise, you are responsible for any Medicare cost sharing amounts.

General Medical and Diagnostic Services *continued…*

BENEFITS CHART – Medicare & DHP covered and non-covered services	WHAT YOU MUST PAY – when you get these services
Outpatient Rehabilitation services)	
Non-Covered Services: ……	100%
3. Long-term therapy and maintenance therapy. Examples of long-term/maintenance conditions include, but are not limited to, learning disabilities such as: attention deficit hyperactivity disorder (ADHD), sensory defensiveness, auditory defensiveness, mental disability and related conditions, hearing therapy for communication delay, and therapy for perceptual disorders. 4. Therapy services such as recreational or educational therapy or physical fitness or exercise programs. 5. Biofeedback, except as provided by a physical therapist for treatment of headaches and spastic torticollis.	
Vision Services • Routine eye exam, limited to 1 every year	✱You pay Nothing for each routine eye exam
• Outpatient physician services for eye care • Annual glaucoma screening *for people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older* • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular corrective lenses needed after a cataract removal without a lens implant	✱You pay Nothing for Medicare covered vision services
Non-Covered Services: ……	100%
1. Refractive eye surgery, including but not limited to, radial keratotomy. 2. Eyeglasses and contact lenses, fitting of contact lenses, except after cataract surgery. 3. Replacement lenses. 4. Orthoptics (eye exercise training)	

✱ You pay nothing only when you use plan providers (or receive a Dean Health Plan approved referral from a plan provider). Otherwise, you are responsible for any Medicare cost sharing amounts.

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

BENEFITS CHART – Medicare & DHP covered and non-covered services	WHAT YOU MUST PAY – when you get these services
Any item that is covered under this Policy is also covered for use in the treatment of cancer when administered in a clinical trial that meets the definition of "**CLINICAL CANCER TRIAL**" in the **Glossary of Terms** section of this Policy.	
Durable Medical Equipment (DME) and related supplies Equipment that is needed for medical reasons and is sturdy enough to be used many time without wearing out. Examples include, wheelchairs, crutches, hospital beds, IV infusion pumps, oxygen equipment, nebulizers and walkers. A person normally needs this kind of equipment only when ill or injured. It can be used at home.	✱You pay Nothing for Medicare covered DME and related items
Prosthetic Devices and related supplies (other than dental), which replace a body part or function, includes • Colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy) • certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices • Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" for more detail	✱You pay Nothing for Medicare covered prosthetic devices and related items
Other Therapeutic Supplies • Surgical supplies, such as dressings • Supplies, such as splints and casts • Blood - coverage, including storage and administration, begins with the first pint of blood that you need	✱You pay Nothing for each Medicare covered service ✱You pay Nothing for blood
Non-Covered Services: ……..…….	100%

✱ You pay nothing only when you use plan providers (or receive a Dean Health Plan approved referral from a plan provider). Otherwise, you are responsible for any Medicare cost sharing amounts.

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

BENEFITS CHART – Medicare & DHP covered and non-covered services	WHAT YOU MUST PAY – when you get these services
Non-Covered Services *continued* ……	100%
1. Medical supplies and DME for comfort, personal hygiene and convenience, such as, but not limited to: air conditioners, air cleaners, humidifiers, physical fitness equipment, physician's equipment, disposable supplies, alternative communication devices, and self-help devices not medical in nature. 2. Home testing and monitoring supplies and related equipment. 3. Equipment, models or devices that have features over and above what is medically necessary. Coverage will be limited to the standard model as determined by our Medical Affairs Division. 4. Elastic support or antiembolism stockings. 5. Shoes or orthotics not custom-made and purchased over the counter. 6. Any DME or supplies used for work, athletic or job enhancement. 7. Implantable birth control devices (e.g., Norplant). 8. Cranial bands (e.g., Dynamic Orthotic Cranioplasty). 9. Back up equipment (a second piece). 10. Replacement of lost or stolen items. 11. Repairs and replacement of DME, unless Medicare approved. Oxygen therapy and other home inhalation therapy, and related items for home use, unless Medicare approved.	
Diabetes Self-Monitoring, training and supplies for all people who have diabetes (insulin and non-insulin users) • Includes blood glucose monitors, test strips, lancet devices and lancets, and glucose solutions for checking the accuracy of test strips and monitors • One pair, per calendar year, of therapeutic shoes for people who have severe diabetic foot disease, including fitting of shoes or inserts • Self-management training is covered under certain conditions • *For persons at risk of diabetes,* fasting plasma glucose tests	✱You pay Nothing for Medicare Part B-covered services. ✱You pay 100% for Medicare Part D-covered drugs or supplies.
Non-Covered Services: ……	100%
1. Diabetic services, drugs or supplies covered under Medicare Part D.	

✱ You pay nothing only when you use plan providers (or receive a Dean Health Plan approved referral from a plan provider). Otherwise, you are responsible for any Medicare cost sharing amounts.

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

BENEFITS CHART – Medicare & DHP covered and non-covered services	WHAT YOU MUST PAY – when you get these services
Outpatient Mental Health Care and Partial Hospitalization Services • Mental health services may be provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other mental health care professional as allowed under applicable Wisconsin laws "Partial Hospitalization" is a structured program of active treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	✱You pay Nothing for each individual and group visit for Medicare covered services
Outpatient Substance Abuse Services	✱You pay Nothing for each individual and group visit for Medicare covered services
Inpatient Mental Health Care, including services that require a hospital stay, up to 190 days per lifetime. Medicare may cover additional care for services provided in a special psychiatric hospital or unit of a general hospital.	✱You pay Nothing for Medicare covered services. ✱You pay $0 for an additional 175 days per lifetime in a plan facility. Contact Dean Health Plan for details
Non-Covered Services for Outpatient, Transitional, Inpatient Mental Health and AODA: ……	100%

1. Biofeedback.
2. Family counseling for non-medical reasons.
3. Gambling addiction.
4. Halfway houses.
5. Hypnotherapy.
6. Long-term or maintenance therapy.
7. Marriage counseling.
8. Phototherapy.
9. Residential care, except for transitional care.

✱ You pay nothing only when you use plan providers (or receive a Dean Health Plan approved referral from a plan provider). Otherwise, you are responsible for any Medicare cost sharing amounts.

Prescription Drugs

BENEFITS CHART – Medicare & Dean covered and non-covered services	WHAT YOU MUST PAY – when you get these services
Any drug that is covered under this Policy is also covered for use in the treatment of cancer when administered in a clinical trial that meets the definition of "**CLINICAL CANCER TRIAL**" in the **Glossary of Terms** section of this Policy.	
Drugs Covered under Medicare Part A and Part B • Drugs that are covered for everyone with Medicare Part A and/or Part B	✱You pay Nothing for drugs covered under Medicare Part A and Part B Please call our Customer Care Center for more information about which drugs are covered under Medicare Part A and Part B
All Other Prescription Drugs	✱You pay 100% for all other prescription drugs

✱ You pay nothing only when you use plan providers (or receive a Dean Health Plan approved referral from a plan provider). Otherwise, you are responsible for any Medicare cost sharing amounts.

Transplants Services and Kidney Disease Treatment

BENEFITS CHART – Medicare & DHP covered and non-covered services	WHAT YOU MUST PAY – when you get these services
Organ Transplants • All services, including transplant workups, must have prior authorization from our Medical Affairs Division in order for Dean Health Plan to cover Medicare cost sharing amounts • If you need an organ transplant, Medicare will arrange to have your case reviewed by one of the transplant centers that is approved by Medicare (some hospitals that perform transplants are approved by Medicare, and others are not) – The Medicare-approved transplant center will decide whether you are a candidate for a transplant • When all requirements are met, the following types of transplants are covered by Medicare: corneal, kidney, pancreas (when performed with or after a Medicare-covered kidney transplant), liver, heart, lung, heart-lung, bone marrow, intestinal/multivisceral, and stem cell – Please be aware that the following transplants are covered only if they are performed in a Medicare-approved transplant center: heart, liver, lung, heart-lung, and intestinal and multivisceral transplants	✱You pay Nothing for Medicare covered organ transplant services
Kidney Disease Treatment. • Inpatient and outpatient kidney disease treatment is limited to all services and supplies directly related to kidney disease, including but not limited to: dialysis, transplantation, donor-related charges, and related physician charges – Benefits for donor-related charges are only payable if the recipient of the kidney is a Dean Health Plan member – The covered donor-related charges (including compatibility testing charges) are those charges related to the person actually donating the kidney We are not required to duplicate coverage available to you under Medicare or under any other insurance coverage you may have.	✱You pay Nothing, up to an annual maximum of $30,000

✱ You pay nothing only when you use plan providers (or receive a Dean Health Plan approved referral from a plan provider). Otherwise, you are responsible for any Medicare cost sharing amounts.

General Exclusions and Limitations	You Pay 100%
1. Prescription drugs covered under Medicare Part D. This includes insulin and medical supplies associated with the injection of insulin. 2. Acupuncture. 3. Autopsy. 4. Chelation therapy for atherosclerosis. 5. Coma Stimulation programs. 6. Court ordered care, unless medically necessary. 7. Cytotoxic testing in conjunction with allergy testing. 8. Examinations required for employment, licensing, insurance, adoption, participation in athletics or examinations, and/or treatment ordered by a court. 9. Experimental or investigational services, treatments or procedures, and any related complications including, but not limited to, high dose chemotherapy, radiation therapy or immunosuppressive drugs. 10. Services provided by members of the subscriber's immediate family or any person residing with the subscriber. 11. Holistic medicine - services or other programs with an objective to provide personal fulfillment. 12. Lyme disease vaccination. 13. Massage therapy 14. Swim or pool therapy. 15. Treatment, services, and supplies for any injury/illness that is the result of war, declared or undeclared, enemy action or action of the Armed Forces of the U.S., or any state of the U.S., or its allies, or while serving in the armed forces of any country. 16. Treatment, services, and supplies furnished by the U.S. Veterans Administration or which are a direct result of a military injury or condition, to the extent the member is eligible for Veterans benefits and the U.S. Veterans Administration is the primary payer. 17. Injury or illness caused by atomic or thermonuclear explosion or resulting radiation. 18. Any services to the extent a member receives or is entitled to receive any benefits, settlement, award or damages for any reason of, or following any claim under, any Workers' Compensation Act, employer's liability insurance plan or similar law or act. "Entitled" means the member is actually insured under Workers' Compensation. 19. Treatment, services, and supplies provided in connection with any illness or injury caused by: (a) a member's engaging in an illegal occupation or (b) a member's commission of, or an attempt to commit, a felony. *20.* Treatment, services, and supplies provided to a member while the member is held or detained in custody of law enforcement officials, or imprisoned in a local, state or federal penal or correctional institution. *Wis. Stat. 609.65* 21. Hair analysis (unless lead or arsenic poisoning is suspected). 22. Weight loss programs, including dietary and nutritional treatment, unless covered by Medicare. 23. Any service not reasonably and medically necessary or not required in accordance with accepted standards of medical, surgical, chiropractic or psychiatric practice.	**You pay 100% for all listed exclusions and limitations.**

General Exclusions and Limitations	You Pay 100%
24. Any hospital service or medical care not listed in this Policy, unless covered by Medicare. 25. Services and supplies rendered outside the scope of the provider's license. 26. An expense incurred before the supply or service is actually provided. 27. Services or supplies related to a non-covered service, denied referral or prior authorization, or denied admission. 28. Hearing aids.	**You pay 100% for all listed exclusions and limitations.**

End of Section II.

III. Policy, Renewal, & Premium Information

Effective Date of Coverage

Your effective date is the date you become enrolled, as stated in Dean Health Plans letter of acceptance, and are entitled to the Policy benefits. Your coverage is in effect as long as you pay the premium due before the end of your grace period. If you are confined in a nursing home or hospital at the time your Policy is issued, your coverage will not take effect until the confinement ends.

Periods of Coverage/Policy Renewal Period

This Policy will continue to renew as long as you pay your premium payment and it cannot be canceled or non-renewed because you have used or overused benefits. Of course, you can end your Policy as of the last day of any month by writing to us. We will need written notification prior to the end of the month. If you end your Policy, it will not affect any outstanding claims incurred during the time that your Policy was in effect. **We will not issue retroactive premium refunds.**

Premium Rates/Changes in Premium

Premiums are the fees established by Dean Health Plan, and charged to the policyholder, to cover the provision of benefits. The premium rates for this Policy were determined before your Application was accepted by us. We will not change your premium unless we change the premium of every member that we have issued this type of policy to. The premium will increase if you change age brackets. If there is a premium change, it will occur on your Policy renewal date (which is not less than 3 months). We will notify you of a change at least 30 days before any renewal period.

Premium Notices

Each billing period, we will only bill you once to tell you when your premium is due.

Premium Due Date

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

Grace Period

Your grace period for paying premiums is 31 days from the first day of the month. If a premium payment is not received by the end of the grace period, your coverage under this Policy will terminate at the end of the last month for which premium was received in full.

Policy Cancellation

We will allow cancellation of this Policy upon written notification. This notification must be received prior to the end of the month in which the termination is requested, and coverage will end on the last day of the month. We will issue a refund of any unused premium to you.

We will allow mid-term cancellation of this Policy in the event of your death. We will issue a pro-rated refund to your estate.

DHP Disenrollment

You may be disenrolled for any of the following reasons:

1. You fail to pay required premiums by the end of the grace period.
2. You have committed acts of physical or verbal abuse which pose a threat to providers or other members of the organization.
3. You allowed someone else to use your Dean Health Plan ID Card to obtain services.

4. You knowingly provided fraudulent information in applying for coverage, or fraudulently attempted to obtain benefits.
5. You no longer permanently reside in the service area or are out of the service area for more than 3 months each year.
6. You are unable to establish or maintain a satisfactory physician-patient relationship with the physician responsible for your care. You can only be disenrolled for this reason if we have provided you an opportunity to select another PCP, made a reasonable effort to assist you in establishing a satisfactory physician- patient relationship, and informed you that you may file a grievance.
7. You are no longer eligible for this plan.

Suspension of Coverage

If you become entitled to Medical Assistance *(Title XIX of the United States Social Security Act)*, you may suspend coverage under this Policy for up to 24 months, but only if we are notified within 90 days after your Medical Assistance entitlement. Coverage under this Policy will be reinstated when you are no longer entitled to Medical Assistance and we are notified within 90 days of loss of entitlement. Premium will be due from the date that Medical Assistance ended. If you do not reinstate coverage within the 24-month suspension period, your Policy will terminate.

If you become entitled to hospital insurance benefits *(under section 226(b) of the Social Security Act)* and you are covered under a group health plan, you may suspend coverage under this Policy. If you lose your group health plan coverage, this Policy will automatically be reinstated effective the date you lose coverage, if you notify us of this loss of coverage within 90 days after the date of loss. Premium will be due from the date your group health plan coverage terminated.

Reinstatement (after Policy cancellation for nonpayment of premium)

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

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

We have the right to charge you a reinstatement fee in accordance with the schedule that has been filed and expressly approved by the Office of the Commissioner of Insurance as not excessive and not unreasonably discriminatory. In all other respects, this Policy shall be treated as an uninterrupted contract.

End of Section III.

Advance Directives

If you do have an Advance Directive (a living will or durable power of attorney for health care), a copy should be given to your primary care provider (**PCP**). Also, please notify us in writing as we are required by law to advise your PCP that you have one. You do not need to send the forms to Dean Health Plan.. For more information, you should discuss the Advance Directives with your PCP, or you can contact our Customer Care Center.

Circumstances Beyond Dean Health Plan's Control

If, due to circumstances not reasonably within our control, such as complete or partial insurrection, labor disputes, disability of a significant part of hospital or medical group personnel or similar causes, the rendition or provision of services and other covered benefits is delayed or rendered impractical, Dean Health Plan and plan providers will use their best efforts to provide services and other covered benefits. However, neither Dean Health Plan nor any plan provider shall have any other liability or obligation on account of such delay or such failure to provide services or other benefits.

Confidentiality

Dean Health Plan respects the confidentiality of our members and will use reasonable efforts to keep confidential all medical information regarding a member. Please see our "Notice of Privacy Practices" brochure provided with your enrollment packet.

Conformity with State Laws

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

ID Card Information

Your Dean Health Plan ID Card provides useful information regarding important telephone numbers and billing information. The ID Card is not a guarantee of coverage or payment of benefits.

Limit on Assignability of Benefits

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

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 required written proof of loss.

Major Disaster or Epidemic

If a major disaster or epidemic occurs, plan providers and hospitals will render medical services (and arrange extended care services and home health service), insofar as practical, according to their best medical judgment, and within the limitation of available facilities and personnel. Dean Health Plan and plan providers have no liability, or obligation for delay or failure to provide or arrange for such services, if the disaster or epidemic causes unavailability of facilities or personnel. In this case, members may receive covered services from non-plan providers.

Oral Statements

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

Physician and Hospital Reports

Physicians and hospitals, from time to time, must give us reports to help us determine member benefits. By accepting coverage under the Policy, you have agreed to authorize providers to release

any necessary records to us. This is a condition of our issuing this contract and paying benefits. Please Note: Expenses billed for the release and review of any records are not covered.

Proof of Claim

As a member, it is your responsibility to show your Dean Health Plan ID Card each time you receive services. Failure to notify a provider of your membership in Dean Health Plan may result in claims not being filed on a timely basis. This could result in a denial of the claim and you would be billed for the charges involved.

Recovery of Excess Payments

If we pay more than we owe under this Policy, we can recover the excess payment from you. We can also recover from another insurance company or service plan, or from any other person or entity that has received any excess payment from us.

Right to Collect Needed Information

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

1. Authorizing the release of medical information, including the names of all providers from whom you received medical attention;
2. Providing information about the circumstances of any injury or accident; and
3. Providing information about other insurance coverage and benefits.

Your failure to assist us may result in our denial of claims.

Right to Exchange Information

By accepting coverage under the Policy with Dean Health Plan, you give your permission to Dean Health Plan, the plan provider and/or clinic to obtain and share any information (including medical records), when that information is necessary to administer the terms of this Policy. You also agree to provide any pertinent information to Dean Health Plan, plan providers and/or clinics, if it is needed to administer the terms of this Policy. The information obtained will be kept confidential, and used only for the purpose of administering this Plan. You have a right to access their medical records.

Severability

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

Subrogation

If you are entitled to special damages for an illness or injury caused by a third party or for which a third party is liable, you agree that Dean Health Plan has a claim for subrogation as to those damages. Our subrogation claim is for the reasonable value of the medical care and services you receive related to that illness or injury. We have the right to recover payments you are entitled to receive from a responsible third party, from the insurance company of the third party, and from a company that provides medical payment coverage or uninsured or underinsured motorist protection for you.

You agree to honor our subrogation rights, to cooperate with Dean Health Plan in the enforcement of its subrogation rights, and to take no action which would prejudice the rights and interests of the Plan, without obtaining Dean Health Plan's prior consent before you take any action, so we may protect our subrogation rights and interests.

Under applicable state law, we may have no right to recover from you if you have not been "made whole." Furthermore, we may be entitled to recover directly from a third party, the third party's insurer or any other liable insurer. You agree to provide us with written notice of any claim or lawsuit that you initiate against a third party, if that claim or lawsuit includes any special damages for an illness or injury. You also agree that any settlement or compromise of a claim or lawsuit will not terminate our rights to subrogation, unless we have provided prior written consent. Before any settlement is reached, you must notify the third party or parties of the amount of Dean Health Plan's subrogation claim.

Dean Health Plan will not pay for any fees or costs associated with a claim or lawsuit, unless we give prior, express written approval. If Dean Health Plan erroneously pays for or provides medical services which are the result of a work related illness or injury for which you may be eligible for workers' compensation benefits, you agree to reimburse Dean Health Plan to the extent of the value of such services.

Timely Submission of Claims

If you receive services from a health care provider that requires that you submit the claim to us for reimbursement, you must obtain an itemized bill and submit it along with the Explanation of Benefits from Medicare to:

Dean Health Plan
Attention: Claims Department
P.O. Box 56099
Madison, WI
53705-9399

Claims must be submitted within 60 days after the services are received, or as soon as possible. If we do not receive the claim within 12 months after the date it was otherwise required, we may deny coverage of the claim. If you do not notify a provider that you have coverage with Dean Health Plan, resulting in a claim not being filed in a timely manner, we may deny coverage of the claim. If DHP is the secondary payor, the time limit for timely submission begins with the date of notice of payment or rejection by the primary payor. If the services were received outside the United States, it is your responsibility to submit to us the original bill along with an itemized bill translated into English, and to indicate the appropriate exchange rate at the time the services were received.

End of Section IV.

IV. Coordination of Benefits

Dean Health Plan, Inc.'s (DHP) Coordination of Benefits Provision

This Coordination of Benefits (COB) provision applies when you have coverage through more than one health Plan. When you have other health insurance besides DeanCare Select it is important to use that other coverage, *in combination with* this coverage, to pay for the care you receive. This is called "coordination of benefits" because it involves *coordinating* all of the health *benefits* that are available to you.

Let us know if you have additional insurance.

You must tell us if you have any other health insurance coverage besides DeanCare Select, and let us know whenever there are any *changes* in your additional insurance coverage. The types of additional insurance you might have include the following:

- Coverage that you have from an employer's group health insurance for *employees* or *retirees*, either through yourself or your spouse.
- Coverage that you have under Workers' Compensation because of a job-related illness or injury, or under the Federal Black Lung Program.
- Coverage you have for an accident where no-fault insurance or liability insurance is involved.
- Coverage you have through Medicaid.
- Coverage through the "Tricare for Life" program (veteran's benefits).
- Coverage you have for dental.
- Continuation coverage" that you have through COBRA (COBRA is a law that requires employers with 20 or more employees to let employees and their dependents keep their group health coverage for a time after they leave their group health plan under certain conditions)

Who pays first when you have additional insurance?

When you have additional insurance coverage, how we coordinate your benefits as a DeanCare Select, with your benefits from other insurance, depends on your situation. With coordination of benefits, you will often get your care as usual through DeanCare Select, and the other insurance you have will simply help pay for the care you receive. In other situations, such as for benefits that are not covered by DeanCare Select, you may get your care outside of the DeanCare Select provider network.

In general, the insurance company that pays its share of your bills *first* is called the "**primary payer**." Then the other company or companies that are involved, called the "**secondary payers**," each pay their share of what is left of your bills. Often your other insurance company will settle its share of payment directly with us and you will not have to be involved. However, if payment owed to us is sent directly to you, you are required to give this payment to us.

When you have additional health insurance, whether we pay first or second, or at all, depends on what type or types of additional insurance you have and the rules that apply to your situation. **Many of these rules are set by Medicare.** Some of them take into account whether you have a disability or have End-Stage Renal Disease (permanent kidney failure), or how many employees are covered by an employer's group insurance. If you have additional health insurance, please call our Customer Care Center, at the phone number shown on the cover of this Policy, to find out which rules apply to your situation and how payment will be handled. Also, the Medicare program has written a booklet with general information about what happens when people with Medicare have additional insurance.

It is called *Medicare and Other Health Benefits: Your Guide to Who Pays First.* You can get a copy by calling 1-800-MEDICARE (1-800-633- 4227) or TTY 1-877-486-2048, or by visiting the medicare.gov website.

Calculating Benefits With DeanCare Select

As a Medicare Select plan, this Policy supplements your Medicare coverage. This Policy will pay benefits immediately following Medicare's payment of benefits, regardless of whether Medicare is primary or secondary. Therefore, if Medicare is primary, this Policy pays following Medicare's payments, and any secondary plans pay after DeanCare Select. If Medicare is secondary, the primary plan pays first, Medicare pays second, and this Policy pays following Medicare's payments.

Dean Health Plan Rights Under the COB Provision

We will need certain information periodically to coordinate benefits appropriately. We have the right to decide what information we need to determine our payment, and to obtain that information from any organization or person. We can get the information without consent, but we will do so only as it's needed to apply the COB rules. Also, we have the right to give necessary information to another organization or person to coordinate benefits. Medical records remain confidential as required by law.

We also have the right to make a payment to another plan if the other plan made a payment that this Policy should have made. If we make such a payment on your behalf, it will be considered a benefit payment for your Policy and we will not have to pay that amount again.

Additionally, we have the right to 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.

End of Section V.

V. Complaint, Grievance and Independent External Review Procedure

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

A. Complaint

A complaint is any expression of dissatisfaction expressed to us by you, or your authorized representative, about us or our providers with whom we have a direct or indirect contract. Dean Health Plan, takes all member complaints seriously and is committed to responding to them in an appropriate and timely manner.

If you have a complaint regarding any aspect of care or decision made by us, please contact our Customer Care Center We will document and investigate your complaint and notify you of the outcome of your complaint. If your complaint is not resolved to your satisfaction you can file a grievance. Any written expression of dissatisfaction will automatically be addressed as a grievance. (See "**B. Grievance**")

B. Grievance

A Grievance is dissatisfaction with the provision of services or claims practices that is expressed in writing to us by you, or on your behalf. To file a grievance, you or your authorized representative must submit it to us in writing at:

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

Upon receipt of the grievance, the Grievance and Appeal Department will send an acknowledgement letter within 5 business days. Our acknowledgment letter will advise you of your right to submit written comments, documents or other information regarding your grievance, to be assisted or represented by another person of your choice, to appear before the Grievance and Appeal, and the date and time of the next scheduled meeting, which will not be less than 7 calendar days from the date of your acknowledgment and within 30 calendar days of receiving the grievance. If you choose to meet with the Committee you may do so in person or via telephone conference. You must call (as indicated in the acknowledgement letter) and schedule a meeting time.

Your grievance will be documented and investigated. All grievances will be resolved within 30 calendar days of receipt. You have the right to request a copy of documents, free of charge relevant to the outcome of your grievance by sending a written request to the address listed above.

C. Independent External Review

You may also be entitled to an independent external review if the outcome of your grievance involves care that has been determined not to meet the policy requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness of care or where the requested services are considered experimental or investigational. Pre-existing Condition determinations and Policy Rescissions are also eligible for independent external review.

You must exhaust all appeal/grievance options before requesting an independent external review. However, if we agree with you that the matter should proceed directly to independent review, or if you need immediate medical treatment and believe that the time period for resolving an internal grievance will cause a delay that could jeopardize your life or health, you may ask to bypass our internal grievance process. In these situations, your request will be processed on an expedited basis.

If you or your authorized representative wish to file a request for an independent review, your request must be submitted in writing to the address listed above and received within four months of the decision date of your grievance. Upon receipt of your request, a URAC accredited independent review organization (IRO) will be assigned to your case through an unbiased random selection process. The assigned IRO will send you a notice of acceptance within one business day of receipt, advising you of the right to submit additional information. The assigned IRO will also deliver a

notice of the final external review decision in writing to you and Dean within 45 calendar days of their receipt of the request. A decision made by an IRO is binding for both Dean and the member with the exception of Pre-existing Condition exclusions and the Rescission of a policy or certificate. You are not responsible for the costs associated to the IRO.

D. Expedited Grievance

If the grievance is determined to be urgent in nature, according to Dean Health Plan's criteria (which is based upon the expedited grievance provisions of state law) the grievance will be resolved within 72 hours of receipt. The request may be oral or written.

E. Office of the Commissioner of Insurance

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

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

or you can call 1-608- 266-0103 or toll free a 1-800-236-8517, and request a complaint form.

End of Section VI.

VI. Glossary of Terms

The terms below have special meanings in this Policy.

ADVERSE DETERMINATION:
A determination by, or on behalf of, Dean Health Plan, Inc. to which all of the following apply:

1. An admission to a health care facility, the availability of care, the continued stay, or other treatment that is a covered benefit has been reviewed.
2. Based on the information provided, the treatment under "1." *(above)* does not meet our requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.
3. Based on the information provided, we reduced, denied or terminated payment for the treatment under "1."

BENEFIT PERIOD:
A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

CLINICAL CANCER TRIAL:
A clinical cancer trial must satisfy the following criteria: (1) a purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes; (2) the treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes; (3) the trial has therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology; and
(4) the trial does one of the following: (a) tests how to administer a health care service, item, or drug for the treatment of cancer; (b) tests responses to a health care service, item or drug for the treatment of cancer; (c) compares the effectiveness of health care services, items, or drugs for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer; or (d) studies new uses of health care services, items, or drugs for the treatment of cancer.

The clinical trial must be approved by one of the following: A National Institute of Health, or one of its cooperative groups or centers, under the federal Department of Health and Human Services; the federal Food and Drug Administration; the federal Department of Defense; or the federal Department of Veterans Affairs.

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

EXPERIMENTAL OR INVESTIGATIONAL SERVICES, TREATMENTS OR PROCEDURES:
Those services, treatments or procedures that are determined by our Medical Affairs Division (with input from the Utilization Management Committee or the Quality Improvement Committee, as part of our quality improvement structure) to meet, as of the date of treatment, one or more of the following criteria:

1. The services, treatments or procedures involve the administration of a drug or the use of a device that is not approved by the U.S. Food and Drug Administration for treatment of the

medical condition or symptoms for which the drug is being administered or the device is being used.

2. Reliable evidence shows that the services, treatments or procedures are subject to ongoing Phase I, II or III clinical trials or under study to determine their maximum tolerated dose, their toxicity, their safety, their efficacy or their efficacy as compared with a standard means of treatment or diagnosis.
3. Reliable evidence shows that the prevailing opinion among experts regarding the services, treatments or procedures is that further clinical trials are necessary to determine their maximum tolerated dose, their toxicity, their safety, their efficacy or their efficacy as compared with a standard means of treatment or diagnosis.

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

EXPERIMENTAL TREATMENT DETERMINATION:
A determination by, or on behalf of, Dean Health Plan, Inc. to which all of the following apply:

1. A proposed treatment has been reviewed by our Medical Affairs Division.
2. Based on the information provided, the treatment under "1." *(above)* is determined to be experimental under the terms of the Policy.
3. Based on the information provided, we denied the payment for the treatment under "1."

HEALTH CARE PROVIDERS:
Doctors, hospitals, clinics, and any other person or entity properly licensed, certified or otherwise authorized, pursuant to the law of jurisdiction in which care or treatment is received, to provide one or more Plan benefits within the scope of their license.

IMMEDIATE FAMILY:
Your spouse, as well as dependents, parents, brothers, and sisters and their spouses.

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

MAINTENANCE THERAPY:
Ongoing therapy delivered after the acute phase of an illness or injury has passed. It begins when a patient's recovery has reached a plateau or improvement in his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated. The determination of what constitutes "maintenance therapy" is made by our Medical Affairs Division after reviewing an individual's case history or treatment plan submitted by a health care provider.

MEDICAID:
A program instituted pursuant to Title XIX (Grants to States for Medical Assistance Program) of the United States Social Security Act *(as added by the Social Security Amendments of 1965 now or hereafter amended*).

MEDICALLY NECESSARY:
The services or supplies provided by a hospital or health care provider that are required to identify or treat a member's illness or injury and which, as determined by our Medical Affairs Division, are: (a) consistent with the illness or injury; (b) in accordance with generally accepted standards of acceptable medical practice; (c) not solely for the convenience of a member, hospital, or other provider; and (d) the most appropriate supply or level of service that can be safely provided to the member.

MEDICARE:
Title XVIII (Health Insurance Act for the Aged) of the United States Social Security Act *(as added by the Social Security Amendments of 1965 now or hereafter amended)*.

MEMBER:
Any person who (1) is eligible for and enrolled in Medicare Parts A and B and (2) for whom Dean Health Plan has accepted proper application and the correct prepaid Premium

PRIOR AUTHORIZATION:
A written approval from our Medical Affairs Division prior to the member receiving services. The authorization will state the type and extent of the treatment or benefit authorized. A verbal or written request does not constitute prior authorization.

WE, US, OUR:
Dean Health Plan

End of Section VII.

VII. Index

End of Section VIII.