Essential Health Plan

CERTIFICATE OF COVERAGE

Underwritten by the WEA Insurance Corporation

45 Nob Hill Road
Madison, Wisconsin 53713
(800) 279-4000
(608) 276-4000
TTY 711

CERTIFICATE OF COVERAGE
FOR
WEA Trust Essential Health PPO

IMPORTANT LEGAL NOTICES

YOUR RIGHT TO RETURN POLICY

Please read this Certificate of Coverage within 24 hours of receipt. If you are not satisfied with this Policy for any reason, you may cancel it within 10 days of receipt of your Policy. Upon cancellation, this Certificate will become invalid. WEA Trust will refund any Premium payments to your Employer. You have the right to purchase your own health insurance Plan if your Employer-sponsored Policy does not meet Federal affordability requirements.

YOUR RESPONSIBILITY TO BE CORRECT AND COMPLETE

Please review the data we received about you and/or your Family attached to your Policy. Your application form is part of your Policy. Errors or missing facts could cause a valid Claim to be denied. Carefully check the form and contact WEA Trust within 10 days if any facts on the form are not correct and complete.

This Policy can be canceled should it be found that you applied using false, missing or misleading information. This Policy can also be canceled if you submit a Claim for coverage using false or misleading information.

NOTICE REGARDING PEDIATRIC DENTAL COVERAGE

This Policy does not include pediatric dental services as included under the Patient Protection and Affordable Care Act. Health insurance Plans in Wisconsin are not required to provide pediatric dental services, since the coverage is available in the Wisconsin insurance market and can be purchased as a stand-alone product. If your Employer did not include separate dental coverage as a benefit of employment, you may contact an Insurance Agent or the Federally-Facilitated Marketplace (FFM) if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

GUARANTEED COMPLIANT

This Policy is guaranteed to meet or exceed all rules from Federal and State of Wisconsin agencies that oversee insurance, including those relating to Healthcare Reform. You may receive Amendments to this Policy as these laws evolve. For questions about Healthcare Reform, visit www.healthcare.gov.

INTRODUCTION TO
WEA TRUST LARGE GROUP PPO

This is a Preferred Provider Organization (PPO) health insurance plan. We reimburse, or pay, for covered health care services provided to Members according to the terms described in this Certificate and other Policy documents. Policy terms that impact coverage decisions and reimbursement amounts include, but are not limited to:

- Deductible, Copayment and Coinsurance amounts.
- Prior Authorization requirements, which are based on whether a service or item is:
    - Needed to diagnose or treat an Illness or Injury;
    - Medically Necessary; and
    - Medically Appropriate.
- Whether the provider is In-Network or Out-of-Network.
- Your Plan's Maximum Out-of-Pocket amount, and whether you have met it for the current Plan year.
- Benefit limits.

To provide care to our members, we have contracted with a group of Health Care Providers to form our provider network. We only include Health Care Providers in our network that meet our quality standards.

As a PPO plan Member, while you may choose which providers you see, we encourage you to see providers we have included in our network. This is because the amount you pay out of pocket will generally be much lower if you see an In-Network provider than if you see an Out-of-Network provider.

You can find much more detailed information about each of the topics described above throughout this Certificate. If you have any questions about the benefits or requirements of this Certificate, call us at (800) 279-4000 or (608) 276-4000 (TTY 711).

IMPORTANT NOTICES

Optional Eligibility and Benefit Provisions: The Appendix in the back of this document contains a series of Optional Eligibility Provisions and Optional Benefit Provisions. The eligibility criteria for coverage and/or the benefits described in this Certificate may be changed by one of these Optional Eligibility Provisions or Optional Benefit Provisions. Your Benefit Summary indicates which Optional Eligibility Provisions and/or Optional Benefit Provisions, if any, apply to your coverage.

Maximum Allowable Fee: Covered Services provided by Out-of-Network Providers are limited to the "Maximum Allowable Fee" as defined in this Certificate. The amount we pay for your Covered Services may be less than the billed charges you receive from the provider. For more details see the "General Provisions That Apply to All Benefits" section, or contact Customer Service at (800) 279-4000 (TTY 711).

Prior Authorization for OB/GYN: You do not need Prior Authorization from WEA Trust to receive care from an In-Network specialist in obstetrics and/or gynecology. The specialist, however, may need to obtain approval from WEA Trust for certain services. For a list of In-Network providers, contact Customer Service at (800) 279-4000 (TTY 711).

Our Commitment to You

Because WEA Trust is here to serve you, we want to ensure that:

- You are well-informed about your legal rights.

- There is mutual respect and cooperation between you, your Health Care Providers and employees of WEA Trust.
- You have access to high-quality healthcare at a fair cost.

This document summarizes some Federal and State laws that are in place to protect you, the rules we expect you to follow as a Member, and the methods we use to oversee the quality of care you are receiving. As a customer of WEA Trust, we welcome your feedback and we will look into any concerns that you share with our team.

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DEFINITIONS

Active Status
Active Status means that an employee is performing his or her job on a regular, full-time basis as defined in the Group Application. On Your first day of coverage you are deemed to be an Active Status employee, even if you were absent from work:

- On a regular paid vacation or any regular non-working holiday, if you were an Active Status employee on your last regular working day; or
- Due to a health factor.

Activity of Daily Living (ADL)
A basic task that most people are able to do each day without any help, such as, but not limited to walking, talking, bathing, sitting up, getting dressed, eating, etc.

Adverse Benefit Determination
A decision that results in:

- A denial, reduction, or termination of a benefit;
- A failure to provide or pay for a benefit (in whole or in part); or
- A denial of eligibility to participate in the Plan.

For healthcare coverage, an Adverse Benefit Determination includes a decision to deny coverage of benefits based on:

- An individual being ineligible to participate in the Plan;
- A utilization review decision;
- A decision that a service or item is experimental or investigational; or
- A decision that a service or item is not Medically Necessary or appropriate.

A Rescission of coverage is also an Adverse Benefit Determination, regardless of whether there is an adverse effect on any particular benefit at that time.

Appeal
A request for review of an Adverse Benefit Determination. An Appeal is a type of Grievance.

Attest
When an adult (person over the age of 18) signs that they will be accountable for a contract under penalty of law.

Authorized Representative
A person who is appointed by you with the right to act on your behalf. To appoint someone with this right, you must tell WEA Trust in writing, unless certain conditions apply. In the case of Emergency or Urgent Care, a Healthcare Provider with knowledge of a Member's medical condition can act as an Authorized Representative for a Member.

Autism Spectrum Disorder
Autism Disorder, Asperger's syndrome, or pervasive developmental disorder not otherwise specified.

Behavior Analyst
A person certified by the Behavior Analyst Certification Board, Inc., or successor organization as a board-certified Behavior Analyst and has been granted a license to engage in the practice of behavior analysis.

Behavioral Therapy
Interactive therapies that target observable behaviors to build needed skills and to reduce problem behaviors using well-established principles of learning utilized to change socially important behaviors with the goal of building a range of communication, social and learning skills, as well as reducing challenging behaviors. **NOTE: only applies in the context of Autism Spectrum Disorder Treatment/coverage.**

Benefit Period
The 12-month period specified on the Benefit Summary. Some Benefit Periods begin in September and run through August of the following year. Others may begin in January and run through December, or some other variation, so please refer to your Benefit Summary to learn when your Benefit Period begins and ends.

Benefit Summary
The document that lists your Cost Sharing Amounts for the Covered Services under your Benefit Plan.

Bone-Anchored Hearing Aid
A surgically-implanted hearing device that transmits sound vibrations to the inner ear by direct bone conduction through the skull, bypassing the external auditory canal and middle ear.

Calendar Year
One-year period from January 1st to December 31st.

Certificate
This Certificate of Coverage, which summarizes the terms, conditions and limitations of your health care coverage.

Claim
A request for payment from WEA Trust.

Cochlear Implant
An implanted electronic hearing device designed to produce useful hearing sensations to a person with severe to profound nerve deafness by electrically stimulating nerves inside the inner ear.

Coinsurance
A specified percentage of the Maximum Allowable Fee you are required to pay each time you receive Covered Services. Please see the Benefit Summary for the specific Coinsurance percentage you must pay for In-Network and Out-of-Network Covered Services, and to which Covered Services they apply.

Complaint
Any expression of dissatisfaction you or your Authorized Representative make to us about us, an In-Network Provider, or any other provider with whom we have a direct or indirect contract.

Confinement
When a Member is admitted for observation or Inpatient Care. The Confinement Period ends when the Member is discharged from continued care for the same Episode of Illness, or when coverage ends. If the Member must be transferred for continued Inpatient Care, it may be part of the same Confinement.

Confinement Period
A Confinement Period begins when you enter a Skilled Nursing Facility and ends after you have sufficiently recovered and are released. If you later have to return to the Skilled Nursing Facility for the same health condition, all the days during your second Skilled Nursing Facility stay will count toward your first, original Confinement Period. For example, this can happen when:

- You leave a Skilled Nursing Facility for a necessary Hospital stay, and then must return due to the same health condition for which you initially entered the Skilled Nursing Facility; or

- Thinking you have sufficiently recovered, you are discharged and leave the Skilled Nursing Facility. However, after a short period of time, you realize that you left too soon, and must return to the Skilled Nursing Facility due to the same health condition for which you initially entered.

Copayment
A specified dollar amount you are required to pay each time you receive Covered Services. Please see the Benefit Summary for the specific dollar amounts you must pay for In-Network and Out-of-Network Covered Services, and to which Covered Services they apply.

Cosmetic Surgery
Elective surgery performed primarily to improve appearance. The procedure would not restore a bodily function and would provide little or no meaningful improvement in how a malformed body part function.

Cost-Effective or Cost-Effectiveness Limit
The service that meets both of these conditions:
- The service is the least costly of alternative services that are comparably equivalent in safety and effectiveness for your medical condition; and
- The service is received in the least costly setting required for safe delivery of those services.

Cost Sharing Amounts
The dollar amounts you pay for Covered Services due to Coinsurance, Copayment and/or Deductible, as defined below. The Benefit Summary lists any Cost Sharing Amounts that apply. Healthcare Providers may bill you directly or ask for payment at the time care is provided.

Covered Service
A service, item or supply that is:
- Needed due to an Illness or Injury;
- Medically Necessary; and
- Eligible for payment under this Plan.

Custodial or Long-Term Care
Services that can generally be provided by someone who does not have professional medical training or skills. They are Custodial even if provided by a registered nurse, licensed practical nurse, or other training medical personnel.

The purpose of Custodial or Long-Term Care services are primarily for one or more of the following purposes:
- Maintaining an individual's existing physical and mental health and sense of wellbeing.
- Preventing an individual's health from declining further.
- Helping someone perform the Activities of Daily Living, such as:
    - Bathing;
    - Eating;
    - Dressing;
    - Toileting; and
    - Transferring.

Deductible
The amount that you must pay each Benefit Period before We start to pay for Covered Services. For more specific information about your Deductible, including the difference between the single and Family Deductible amounts, please see the "General Provisions That Apply to All Benefits" section of this Certificate.

Dependent
The following individuals are considered a Dependent under this Policy:
- A Subscriber's lawful Spouse;

- A Spouse ceases to be a Dependent on the date in which a divorce decree is granted.
- A Subscriber's natural blood-related child; adopted child; child placed for adoption with the eligible individual; stepchild(ren); or child(ren) under the age of 26 for whom the Subscriber acts as legal guardian.
    - "Placed for adoption" is defined in Wis. Stat. § 632.896.
    - If the Subscriber is the father of a child born outside of marriage, the child does not qualify as a Dependent unless there is a court order declaring paternity or acknowledgment of paternity is filed with the Wisconsin Department of Health Services or the equivalent agency if the birth was outside of the state of Wisconsin. Upon qualification, coverage for the child will be effective according to the Eligibility and Effective Date of Coverage section.
    - A stepchild ceases to be a Dependent on the date in which a divorce decree is granted.
    - A child who is considered a Dependent ceases to be a Dependent on the date the child becomes insured as an Employee.
    - A covered Dependent child who attains the limiting age while insured under the Policy shall remain eligible for benefits if he or she is incapable of self-sustaining employment because of mental retardation or physical handicap which existed before the Dependent attained the limiting age.
        - The Dependent must continue to be chiefly Dependent on the Subscriber for support and maintenance.
        - Written proof of incapacity and dependency must be provided to Us in a form satisfactory to Us within 31 days after the Dependent's attainment of the limiting age.
        - We may require the Dependent to be examined from time to time by an In-Network Provider for the purpose of determining the existence of the incapacity prior to granting continued coverage. Such examinations may occur at reasonable intervals during the first two years after continuation under this section is granted and annually thereafter.
        - The Employee must notify Us immediately of a cessation of incapacity or dependency.
- A Dependent child (as described in item 2, above, regardless of age) who is a Full-Time Student as defined in this Policy, if the child was called to federal active duty in the National Guard or in a reserve component of the
- U.S. armed forces while the child was under 27 years of age when attending, on a full-time basis, an institution of higher learning.
    - To qualify under this item, the child must apply to an institution of higher education as a Full-Time Student within 12 months of the date the child fulfilled his or her active duty obligation.
    - If the child is called to active duty more than once within a 4-year period of time, we will use the adult child's age when first called to active duty for determining eligibility under this paragraph.
    - The child ceases to be a Dependent when the child ceases to be Full-Time Student.
        - Proof of attendance is required upon request from WE A Trust.
        - Full-Time Student status is to be defined by the institution in which the student is enrolled. Full-Time Student status includes any intervening vacation period if the child continues to be a Full-Time Student. Full-Time Student status also includes a Medically Necessary leave of absence during which the child ceases to be a Full-Time Student. We may require the child to submit documentation and certification of the medical necessity of the leave of absence from the child's attending Physician. Full-Time Student status due to a Medically Necessary leave of absence ends when any of the following occurs:

- The child advises Us that he or she does not intend to return to school full time.
- The child becomes employed full time.
- The child obtains other health care coverage.
- The child marries and is eligible for coverage under his or her Spouse's health care coverage.
- Coverage of the eligible individual is discontinued or not renewed.
- One year has elapsed since the child ceased to be a Full-Time Student due to the Medically Necessary leave of absence, and the child has not returned to school full- time.

- An unmarried, natural child of a Dependent child (as described above) (e.g. grandchild(ren)) until the Dependent child is 18 years of age.

Disability or Disabled
The inability of an employee to perform adequately the material and substantial duties of his or her regular occupation due to involuntary, medically proven, and documented physical or mental impairment(s). The physical or mental impairment(s) causing the Disability must be substantiated in objective, contemporaneous medical records and documentation. For purposes of this definition, the regular occupation is the position the covered employee held on the date that we determine to be the first day on which the employee was Disabled.

Efficacious Treatment or Strategy
Treatment or strategies designed to address cognitive, social or behavioral conditions associated with Autism Spectrum Disorders; to sustain and maximum gains made during Intensive-Level Services; or to improve the condition of an individual with Autism Spectrum Disorder.

Eligible Employee
An employee qualified under the terms of the contract between us and the employer.

Eligible Person
An individual who meets the rules to enroll with WEA Trust as listed in Enrollment and Effective Date of Coverage. An Eligible Person is not necessarily a Member under this Benefit Plan.

Emergency Care
- A medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department, to evaluate such Emergency Medical Condition.
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities at the Hospital, as are required to Stabilize the patient.

Emergency Detention
When a law enforcement officer, or person authorized to take a child or juvenile into custody, detains an individual because he or she has cause to believe that:
- The individual is mentally ill, drug Dependent, or developmentally Disabled; and
- The individual displays signs or symptoms of any of the conditions included in Wis. Stat. § 51.15.

Detention includes detainment in:
- A Hospital approved as a detention facility by the Wisconsin Department of Health Services;
- A Hospital under contract with a county department;
- An approved public treatment facility;
- A center for the developmentally Disabled;
- A state treatment facility; or
- An approved private treatment facility if the facility agreed to detain the individual.

Emergency Detention must follow all requirements included in Wis. Stat. § 51.15 and any other applicable state regulatory requirements to be covered under this Policy

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

- Serious jeopardy to the person's health or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child.
- Serious impairment to the person's bodily functions.
- Serious dysfunction of one or more of the person's body organs or parts.

Evidence-Based Therapy
Therapy, service and treatment that is:

- Based upon medical and scientific evidence.
- Determined to be an Efficacious Treatment or Strategy;
- Has been approved by the federal Food and Drug Administration (FDA), if the treatment is subject to the approval of the FDA;
- Medically and scientifically accepted evidence clearly demonstrates that the treatment is safe; and
- Prescribed to improve the individual's condition to achieve social, cognitive, communication, self-care or behavioral goals that are clearly defined within the Member's treatment plan.

Expedited External Review
An External Review that, due to the severity or urgent nature of your health condition, requires investigation and resolution in a shorter timeframe than is afforded a standard External Review.

Expedited Grievance
A Grievance that, due to the severity or urgent nature of the Member's health condition, requires investigation and resolution in a shorter timeframe than is afforded a standard Grievance.

Experimental/Investigative
Services are those which, in the medical opinion of our Medical Director or other medical professionals with whom we consult, do not meet our criteria for Medically Necessary and Medically Appropriate treatment for an Illness or Injury. A service is Experimental/Investigative if:

- It has not been granted approval by the appropriate federal or other governmental agency that governs its use, licensing, or marketing, e.g., the federal Food and Drug Administration (FDA).
- It is not recognized as the current standard for medical practice throughout the United States to treat the patient's specific condition.
- It is the subject of a written investigational or research protocol; an experimental, investigative, educational or research study for which informed consent is required by the treating facility; it poses an uncertain outcome or unusual risk; is an ongoing clinical trial that meets the definition of a Phase I, II, or III clinical trial set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight (except as required by law); and/or is the subject of an ongoing review by an Institutional Review Board.
- It does not have the support of contemporary medical consensus, as we define that term.

External Review
A review of an Adverse Benefit Determination (including a Final Adverse Benefit Determination) that follows the required External Review process as described in applicable state and/or federal law.

Family
The Subscriber and enrolled Dependents.

Final Adverse Benefit Determination
An Adverse Benefit Determination that we have upheld after the internal Grievance and appeals process has been completed, exhausted or deemed exhausted.

Final External Review Decision
A determination by an Independent Review Organization (IRO) at the conclusion of an External Review.

Formulary
A WEA Trust-developed list of preferred Prescription Drugs.

Full-Time Student
A covered Dependent who is enrolled in an accredited institution of higher education. The school in which the student is enrolled defines full-time status.
A Full-Time Student is considered enrolled on the date that he or she is recognized as a Full-Time Student by the school, which is typically the first day of classes. Full-Time Student status includes any intervening vacation period if the Dependent continues to be a Full-Time Student immediately following such vacation period. A person stopes being a Full-Time Student at the end of the calendar month during which he or she graduates or otherwise stops meeting the criteria for Full-Time Student status.

Generic Drug
A drug product similar to a brand name drug, but is not advertised, generally resulting in a lower cost. Generic Drugs are defined by MediSpan (or similar organization). MediSpan is a national organization that determines brand and generic classification.

Genetic Testing
A type of lab test that identifies changes in chromosomes, genes, or proteins. Most of the time, testing is used to find changes that are associated with inherited disorders. The results of a genetic test can confirm or rule out a suspected genetic condition or help determine a person's change of developing or passing on a genetic disorder.

Grievance
Any dissatisfaction you have with us, or how we administer this Plan, that you submit to us in writing, or that someone submits to us in writing on your behalf. You, or someone on your behalf, can also submit an Expedited Grievance orally.

Examples of issues for which you could express dissatisfaction include, but are not limited to:

- How we provide services;
- How we process Claims;
- A determination we make to reform or rescind a policy; or
- A determination of a diagnosis or level of service required for evidence-based treatment of Autism Spectrum Disorder.

For example, you can file a Grievance when we deny your request for a Referral, we deny coverage for a treatment you believe you need, or you are dissatisfied with the quality of the treatment provided by a Network Provider.

Habilitative Services
Health care services that help a person keep, learn or improve skills and functioning for daily living.

Hearing Aid
An instrument or device, including related parts, attachments, or accessories, that is worn externally and designed to aid or compensate for impaired hearing.

Health Care Provider
- Physicians, Hospitals and clinics.
- Podiatrists, physical therapists, Physician's assistants, psychologists, chiropractors, nurse practitioners, and dentists licensed by the State of Wisconsin, or other applicable jurisdiction, to provide Covered Services.
- Nurses licensed by the State of Wisconsin and certified as a nurse anesthetist to provide Covered Services.
- Nurse midwives licensed by the state in which they practice to provide Covered Services.
- Licensed clinical psychologist, licensed clinical social worker.

HIPAA
The Health Insurance Portability and Accountability Act (HIPAA) protects your privacy and restricts who can see your health information.

Home Health Aide Services
Nonmedical services performed by a home health aide which:
- Are not required to be performed by a registered nurse or licensed practical nurse; and
- Primarily aid the patient in performing normal Activities of Daily Living.

Home Health Care Visit
The period of a visit to provide home health care. There is no limitation on the duration of a visit, except that one home health aide visit consists of each consecutive four hours in a 24-hour period.

Hospital
A duly licensed and lawfully operating institution that provides diagnostic and therapeutic services to confined patients. Its chief function is to provide facilities for the surgical and medical diagnosis, treatment, and care of sick or injured persons. A professional staff of licensed Physicians and Surgeons provides and/or supervises its services. It provides 24-hour continuous registered nurse supervision and other nursing services, diagnostic X ray services, clinical laboratory services, and surgical facilities and services. The following institutions normally do not fulfill all aspects of this definition and are not considered a Hospital:

- Skilled nursing facilities.
- Clinics.
- Freestanding surgical centers.
- Nursing homes, rest homes, convalescent homes, extended care facilities, or facilities that provide primarily rehabilitation, education, or custodial care. This includes a convalescent or extended care unit or floor within, or affiliated with, a Hospital.
- Institutions operated primarily for the treatment of nervous or mental disorders, drug abuse, or alcoholism.
- Health resorts, spas, or sanitariums.

Illness
A physical or mental disease or ailment that affects general soundness and healthfulness significantly and seriously and that undermines or diminishes health, vigor, or capability.

Immediate Family
The Subscriber, the Subscriber's Spouse, children, parents, grandparents, siblings, and their Spouses.

Independent Review Organization
An entity that conducts independent External Reviews of Adverse Benefit Determinations and Final Adverse Benefit Determinations pursuant to applicable state and/or federal law.

Injury
An occurrence or event that hurts, damages, or wounds the body to the extent that it impairs the soundness of health or bodily functions.

In-Network Provider
A Health Care Provider who has a contract with WEA Trust Health Plan to provide services, items or supplies to Member. In-Network Providers are listed in the most current provider directory.

Intensive-Level Services
- Evidence-Based Behavioral Therapy that is designed to help an individual with Autism Spectrum Disorder overcome the cognitive, social, and behavioral deficits associated with that disorder; and
- Evidence-Based Behavioral Therapies that are directly based on, and related to, a Member's therapeutic goals and skills as prescribed by a Physician familiar with the Member.
- May include Evidence-based speech therapy and occupational therapy provided by a qualified therapist when such therapy is based on, or related to, an individual's therapeutic goals and skills, and is concomitant with Evidence-Based behaviorally therapy.

Maximum Allowable Fee
The maximum amount we will pay for a Covered Service, based upon our Maximum Allowable Fee schedule.

Maximum Benefit Amount
The total amount this Plan will reimburse, per Member for certain types of Covered Services during the Benefit Period. Please review the Benefit Summary to determine which Covered Services are subject to a Maximum Benefit Amount, and what how much we will pay for those Covered Services.

Maximum Out-of-Pocket Limit
The most you will pay in Deductible, Coinsurance, and Copayment amounts for Covered Services during any Benefit Period. Please see the Benefit Summary for the Maximum Out-of-Pocket Limit that applies to your Plan.

Medically Appropriate/Medical Appropriateness
Health care services, supplies or items we have determined, based on your medical circumstances, to be safe, effective, and of value.

To be Medically Appropriate, the services, supplies, and/or items must:

1. Be consistent with generally accepted standards of contemporary medical consensus and medical practice for your medical condition;
2. Be provided in the most appropriate site and at the most appropriate level of service or level of care for your medical condition.
3. Not be provided solely to improve your condition beyond normal variation in individual development, appearance and aging.
4. Not be for the sole convenience for you, your Immediate Family, or your provider.

Medically Appropriate services exclude all treatments of unproven safety and effectiveness, even when no other responsive medical alternatives exist.

Medically Necessary/Medical Necessity
Health care services, supplies or items needed to prevent, diagnose, or treat an Illness, Injury, condition, disease or its symptoms and that meet accepted standards of medicine.
Medically Necessary care must:

- Help restore your health;
- Prevent your health from getting worse;
- Prevent the onset of a health problem; or
- Help detect a problem.

The fact that a Healthcare Provider has prescribed, ordered, recommended, or approved a treatment, service, or supply, or has informed the Member of its availability does not, in itself, make it Medically Necessary. WEA Trust will make the final determination of whether a Covered Service constitutes Medically Necessary Care.

Member
A Subscriber or Dependent who is enrolled in the Benefit Plan.

Member ID Card
The card issued in the Subscriber's name with the identification number of the Subscriber and any Dependents covered under this Plan.

Non-Intensive Level Services

- Evidence-Based Therapy that occurs after the completion of treatment with Intensive-Level Services and that is designed to sustain and maximize gains made during treatment with Intensive-Level Services; or
- For an individual who has not and will not receive Intensive-Level Services, Evidence-Based Therapy that will improve the individual's condition.

Out-of-Network Provider
A Health Care Provider that is not in the most current Provider Directory.

Outpatient Care
Describes medical care or treatment that does not require an overnight stay in a Hospital or medical facility.

Physician or Surgeon
A qualified practitioner other than the covered individual or his or her covered Dependent who is licensed to diagnose and treat physical or mental impairments. This includes only the following practitioners and only to the extent that the services provided are within the scope of the practitioner's professional license:

- M.D. – Doctor of Medicine
- D.O. – Doctor of Osteopathy
- D.S.C. – Doctor of Surgical Chiropody
- D.P.M. – Doctor of Podiatric Medicine
- O.D. – Doctor of Optometry
- D.C. – Doctor of Chiropractic
- D.D.S. – Doctor of Dental Surgery
- D.M.D. – Doctor of Medical Dentistry

We cover services performed by a licensed dentist within the scope of the dentist's license if those services are covered under this Certificate when performed by a Physician or Surgeon.

Plan
The health insurance coverage offered by WEA Trust Health Plan, as described in this Certificate and other contract documents. For more information about which documents, when combined, constitute the entire contract of insurance, please see the "General Provisions" section, "Entire Contract and Changes" subsection of this Certificate.

Post-Service Claim
Any Claim for a benefit under this Plan that is not a pre-service Claim.

Premium
The amount that must be paid for your health insurance or Plan. You and/or your employer usually pay it monthly, quarterly, or yearly.

Prescription Drug
Drugs and medications that by law require a prescription.

Pre-Service Claim
Any Claim for a benefit under this Plan for which coverage requires obtaining prior approval before receiving medical care. This does not include an Urgent Care Claim.

Primary Care
Services provided by a Primary Care Provider who is responsible for coordinating all of your medical care. This includes delivering services, responding to your health care questions and concerns, recommending treatment and appropriate preventive services, maintaining your medical history, and recommending appropriate specialists. Please see our website, www.weatrust.com, for a list of medical services providers that we consider Primary Care Providers.

Primary Care Provider (PCP)
A Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or Physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of Healthcare Services.

Prior Authorization
A decision that a Covered Service:

- Relates to an Illness or Injury;
- Is Medically Necessary; and
- Is Medically Appropriate.

You or your Health Care Provider must request from us, and we must provide, Prior Authorization for certain Covered Services before we will cover them.

Prosthetic
A fixed or removable device that replaces a missing or impaired part of the body, such as, but not limited to an artificial limb.

Qualified Behavioral Health and Substance Use Treatment Facility
A Hospital, facility, institution or clinic licensed and/or certified by the state in which it is located to provide behavioral health and/or substance use treatment.

Qualified Behavioral Health and/or Substance Use Treatment Disorder Provider
A Health Care Provider who is:

- Licensed or certified by the state in which he or she is working;

- Practicing within the scope of his or her license or certification; and
- Is one of the following types of Health Care Providers:
    - Psychiatrist;
    - Psychologist;
    - Licensed Clinical Social Worker (LCSW);
    - Licensed Independent Social Worker (LISW);
    - Advanced Practice Social Worker (APSW);
    - Licensed Professional Counselor (LPC);
    - Licensed Marriage & Family Therapist (LMFT);
    - Substance use Counselor (SAC);
    - Clinical Substance use Counselor (CSAC);
    - Art Therapist (ATRL);
    - Behavior Analyst;
    - Registered nurse with a master's degree and certified as a specialist in psychiatric and behavioral health nursing;
    - Physician Assistant (PA-C).

Qualified Intensive-Level Professional
An individual working under the supervision of an outpatient mental health clinic who is a licensed treatment professional as defined in s. DHS 35.03 (9g), and who has completed at least 2080 hours of training, education and experience, including all the following:

- 1500 hours supervised training involving direct one-on-one work with individuals with Autism Spectrum Disorders using Evidence-Based, Efficacious therapy models.
- Supervised experience with all of the following:
    - Working with families as part of a treatment team and ensuring treatment compliance.
    - Treating individuals with Autism Spectrum Disorders who function at a variety of cognitive levels and exhibit a variety of skill deficits and strengths.
    - Treating individuals with Autism Spectrum Disorders with a variety of behavioral challenges.
    - Treating individuals with Autism Spectrum Disorders who have shown improvement to the average range in cognitive functioning, language ability, adaptive and social interaction skills.
    - Designing and implementing progressive treatment programs for individuals with Autism Spectrum Disorders.
- Academic coursework from a regionally accredited higher education institution with demonstrated coursework in the Application of Evidence-Based Therapy models consistent with best practice and research on effectiveness for individuals with Autism Spectrum Disorders.

Qualified Intensive-Level Provider
- Any of the following providers who provide Evidence-Based Behavioral Therapy which qualifies as Intensive-Level Services and has completed at least 2080 hours of training, education and experience as described below in section B., or a Qualified Paraprofessional working under the supervision of one of these providers:
    - A psychiatrist acting within the scope of a currently valid, state-issued license for psychiatry.
    - A person who practices psychology that is acting within the scope of a currently valid, state-issued license for psychology.
    - A social worker acting within the scope of a currently valid, state-issued certificate or license to practice psychotherapy.
    - A Behavior Analyst who is acting with the scope of a currently valid, stated-issued license for behavior analysis.
- Required training, education and experience:
    - Fifteen hundred hours supervised training involving direct one-on-one work with individuals with Autism Spectrum Disorders using Evidence-Based, Efficacious therapy models.
    - Supervised experience with all of the following:

- Working with families as the primary provider and ensuring treatment compliance.
    - Treating individuals with Autism Spectrum Disorders who function at a variety of cognitive levels and exhibit a variety of skill deficits and strengths.
    - Treating individuals with Autism Spectrum Disorders with a variety of behavioral challenges.
    - Treating individuals with Autism Spectrum Disorders who have shown improvement to the average range in cognitive functioning, language ability, adaptive and social interaction skills.
    - Designing and implementing progressive treatment programs for individuals with Autism Spectrum Disorders.
- Academic coursework from a regionally accredited higher education institution with demonstrated coursework in the Application of Evidence-Based Therapy models consistent with best practice and research on effectiveness for individuals with Autism Spectrum Disorders.

Qualified Paraprofessional
An individual working under the active supervision of a Qualified Supervising Provider, Qualified Intensive-Level Provider, or Qualified Provider and who complies with all of the following:

- Attains at least 18 years of age.
- Obtains a high school diploma.
- Completes a criminal background check.
- Obtains at least 20 hours of training that includes subjects related to autism, evidence-based treatment methods, communication, teaching techniques, problem behavior issues, ethics, special topics, natural environment, and first aid.
- Obtains at least ten hours of training in the use of behavioral Evidence-Based Therapy including the direct application of training techniques with an individual who has Autism Spectrum Disorder present.
- Receives regular, scheduled oversight by a Qualified Supervising Provider in implementing the treatment Plan for the individual.

Qualified Professional
A professional, acting within the scope of a currently valid state-issued license, who:

- Provides Evidence-Based Therapy; and
- Works under a Qualified Supervising Provider who periodically reviews all treatment Plans developed by Qualified Professionals for individuals with Autism Spectrum Disorders.

Qualified Provider
One of the following types of providers who provides Evidence-Based Therapy:

- A psychiatrist, as defined in § 146.34(1)(h), who is acting within the scope of a currently valid, state-issued license for psychiatry.
- A person who practices psychology, as described in § 455.01(5), who is acting within the scope of a currently valid, state-issued license for psychology.
- A social worker, as defined in § 252.15(1), who is acting within the scope of a currently valid, state-issued certificate or license to practice psychotherapy, as defined in § 457.01(8m).
- A Behavior Analyst who is licensed under § 440.312 who is acting within the scope of a currently valid, state-issued license for behavior analysis.
- A paraprofessional working under the supervision of a provider listed above in numbers 1-4.

Qualified Supervising Provider
A Qualified Intensive-Level Provider who has completed at least 4160 hours of experience as a supervisor of less experienced providers, professionals and paraprofessionals.

Qualified Therapist
A speech-language pathologist or occupational therapist who is acting within the scope of a currently valid, state-issued license and who provides services concomitant with intensive-level, Evidence-Based Behavioral Therapy and all of the following:

- The Qualified Therapist provides Evidence-Based Therapy to an individual who has a primary diagnosis of an Autism Spectrum Disorder.
- The individual is actively receiving behavioral services from a Qualified Intensive-Level Provider or a Qualified Intensive-Level Professional.
- The Qualified Therapist develops and implements a treatment Plan consistent with their license and the laws and regulations governing coverage of Autism Spectrum Disorder services.

Referral
A written request from an In-Network Provider requesting services from an Out-of-Network Provider.

Rehabilitative Services
Health care services to help a person regain skills and functioning for daily living that were lost or impaired due to Illness or Injury. Also includes health care services that help slow down or minimize the loss of skills and functioning due to a chronic, progressive Illness such as multiple sclerosis.

Rescission
A decision we make to:
- Withdraw coverage back to the initial date of coverage;
- Modify the terms of the policy, or
- Adjust the Premium rate by more than 25% from the Premium in effect during the period of contestability.

Routine Foot Care
Includes, but is not limited to:
- Services rendered in the examination, treatment or removal of all or part of corns, calluses, or plantar keratosis; and
- Services related to the cutting, trimming, or other non-operative partial removal of toenails.

Service Area
The geographical area in which we are authorized to offer a health plan.

Skilled Nursing Facility
A licensed facility, other than a Hospital, that is certified to provide continuous, 24-hour inpatient Skilled Nursing Services. It can be a freestanding facility, or a separate unit of a Hospital or other institution.

None of the following are a Skilled Nursing Facility:
- An institution that primarily cares for and treats individuals with behavioral health or substance use disorders.
- A facility that primarily provides residential, retirement, Custodial or Long-Term Care.
- A private room or apartment.

Skilled Nursing Services
Services ordered by a Physician that:
- Require the skills of a registered nurse (RN) or a licensed practical nurse (LPN); and
- Are provided either directly by or under the supervision of an RN or LPN.

Skilled Rehabilitation Facility
A licensed facility that is certified to provide continuous, 24-hour inpatient Skilled Rehabilitation care. It can be a separate rehabilitation unit of a Hospital, a freestanding special rehabilitation Hospital, or other health care institution.

Skilled Rehabilitation Services
Services ordered by a Physician that:

- Require the skills of a licensed physical therapist, occupational therapist, speech pathologist, speech-language pathologist, audiologist or respiratory therapist; and
- Are provided either directly by or under the supervision of these qualified skilled rehabilitation personnel.

Specialty Care
Services provided by a medical practitioner who devotes attention to a particular branch of medicine. A specialist is any type of medical provider who we do not consider a Primary Care Provider.

Spouse
A person legally married to a Subscriber, as defined by Wisconsin law.

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

Subscriber
The employee qualified under the terms of the Policy between Us and the employer.

Telehealth
The use of electronic information and telecommunication technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration. Technologies include video conferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.

Total Disability/Totally Disabled
The inability to engage in any substantial, gainful activity due to any medically-determined physical or mental impairment. Reference: 42 USC section 423(d) and section 1382(a)(3).

Urgent Care Claim
A Claim for a benefit under this Plan where any of the following applies:

- The length of time it normally takes to resolve a Grievance would result in serious jeopardy to your life or health or would limit your ability to regain maximum function.
- Your Physician requests the expedited process because your pain is too severe to be adequately managed without the care or treatment you are requesting.
- Your Physician determines the Grievance should be treated as an Expedited Grievance.

When we, or someone on our behalf, are deciding whether an Urgent Care Claim should be expedited, the decision is made by someone who is applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

Virtual Visit
A Member-initiated online medical evaluation performed by a medical practitioner through real-time audio/visual interaction using a secured electronic channel. Does not include real-time audio/visual interaction where the Member is in a clinic or Hospital setting; this type of interaction is covered under the “Medical Benefits” section, “Office Visits and Outpatient Care” subsection of this Certificate.

Walk-In Retail Clinic
A walk-in health clinic location, other than a doctor's office, urgent care facility, pharmacy or independent clinic, that is located within a retail operation. Care in a Walk-In Retail Clinic is usually provided by a nurse practitioner, and services are limited to the following:

- Treatment of minor acute conditions;
- Limited preventive services; and
- Vaccinations.

Note: In addition to the above capitalized terms, the following definitions also apply:

- Any time the word "services" appears in this Certificate, it refers to any professional service, medical or health care treatment, Hospitalization and other use of facilities, laboratory services, durable medical equipment, medical supplies, and pharmaceuticals.
- Any time the words "we", "us," or "our" appear in this Certificate, they refer to the WEA Trust Health Plan.
- Any time the words "you" or "your" appear in this Certificate, they refer to any individual who is covered by the Plan. The exception to this is in Section 3, "Eligibility and Coverage of Employees and Their Dependents" where "you" and "your" refer only to the employee of the employer who purchased this group health insurance Plan.
- Any time the word "covered" appears in the benefit provisions of this Certificate, it refers to services that are reimbursable if we find them to be Medically Necessary and Medically Appropriate in your specific circumstances. Reimbursement is subject to our Maximum Allowable Fee; any Deductible, Coinsurance, or Copayments that apply; this Certificate's Cost-Effectiveness Limits; and our Prior Authorization requirements.

GENERAL PROVISIONS THAT APPLY TO ALL BENEFITS

This Plan covers a comprehensive range of health care services, including benefits required by state and federal law. However, we do not cover all health care services, even if they are beneficial and recommended by a Health Care Provider.

This section describes how we determine whether services are covered, as well as the factors that can affect how much we reimburse for Covered Services.

First, there are some services that are explicitly excluded from coverage. For more information about services that are explicitly excluded from coverage, please see the Medical Benefits, Prescription Drug Benefits, and Limitations and Exclusions sections of this Certificate.

Next, for services not explicitly excluded from coverage, there are several criteria we examine to determine if the Plan will cover them. To be covered, your service must be:

- Needed due to an Illness or Injury;
- Medically Necessary; and
- Medically Appropriate.

In addition to the factors described above, some services require Prior Authorization. You can find a list of Covered Services requiring Prior Authorization on our website, www.weatrust.com, or you can get this information by calling our Customer Service Department.

Finally, this section also explains the factors that affect how much we reimburse for Covered Services. These factors are as follows:

- Your choice of Health Care Provider (In-Network or Out-of-Network Provider).
- Maximum Allowable Fee.
- Coding and billing standards.
- Reimbursement limit on services that require Prior Authorization
- Cost-effectiveness limit.
- Deductibles.
- Coinsurance.
- Copayments.
- Maximum Out-of-Pocket Limit.
- Maximum Benefit Amount.

Factors Used to Determine Coverage

In general, if a service is not explicitly excluded from coverage, we will cover it if it meets **all three** of the following coverage criteria:

- The service must be necessary due to an Illness or Injury;
- The service must be Medically Necessary; and
- The service must be Medically Appropriate.

Please see the “Definitions” section of this Certificate for more information how we define these terms.

When we have questions about whether a particular service meets these criteria, we rely on contemporaneous, clearly documented medical records and the advice of our medical consultants. If, after examining all of the available information and medical guidance, we cannot determine whether a service meets this coverage criteria, we will not authorize or reimburse for it. We make the final decision regarding coverage.

Additionally, we have the right to require that you be examined by a Health Care Provider of our choice if necessary to evaluate a Claim; we will pay for that cost.

Access to Health Care Providers

Your choice of Healthcare Provider determines how much we will pay for Covered Services, and how much you will pay in out-of-pocket expenses.

We have many In-Network Providers who can care for you. When you see an In-Network Provider, we will pay the amount we have contracted to pay for each Covered Service. You will be responsible for paying the In-Network Cost-Sharing Amount(s) specified in your Benefit Summary for the service.

When you see an Out-of-Network Provider, you will be responsible for paying the Out-of-Network Cost-Sharing Amount(s) specified in your Benefit Summary for the service. We will pay according to our Maximum Allowable Fee. Please see the "Maximum Allowable Fee" section below for more information about how we reimburse Out-of-Network Providers for Covered Services.

Continuity of Care

Under certain circumstances, if your Health Care Provider leaves the WEA Trust Health Plan provider network, you may continue to receive care from that Health Care Provider.

In cases where the is terminated without cause, a Member in an active course of treatment may continue treatment with this Health Care Provider until the treatment is complete or for 90 days, whichever is shorter. This coverage will be at In-Network cost-sharing rates. Member Cost Sharing Amounts shall apply, including amounts billed by the provider which are in excess of Usual and Customary Charges.

Active treatment is defined as:

- An ongoing course of treatment for a life-threatening condition;
- An ongoing course of treatment for a serious acute condition;
- The second or third trimester of pregnancy; or
- An ongoing course of treatment for a health condition for which a treating physician or Health Care Provider attests that discontinuing care by that physician or Health Care Provider would worsen the condition or interfere with anticipated outcomes.

Coding and Billing Standards

When your doctor submits a Claim for payment, he or she includes certain procedure and billing codes on the Claim. These codes describe the services that you received. We then look at medical records and other documents to see if the codes are appropriate according to the information included in the medical records.

If the records show that another code is more appropriate, we have the right to calculate our reimbursement amount based upon the more appropriate code. We also have the right to deny a Claim if it is billed inconsistently with industry-accepted coding standards.

Referrals

Your choice of Healthcare Provider determines how much we will pay for Covered Services, and how much you will pay in out-of-pocket expenses.

You may receive Covered Services from any In-Network Provider without a Referral. You can find a list of In-Network Providers in our Provider Directory.

You may receive Covered Services at the Out-of-Network benefit level from any Out-of-Network Provider within the United States without a Referral. Please note that if you choose to get covered Preventive Care from an Out-of-Network Provider, you will be required to pay the Cost-Sharing Amount applicable to the service.

To receive Covered Services from an Out-of-Network Provider at the In-Network benefit level, you must request, and we must approve, a Referral to see that provider. You must get the Referral from us before you see the Out-of-Network Provider. Benefits for services provided by the Out-of-Network Provider are limited to the type, frequency and duration of the services approved in the Referral.

You do not need a Referral to seek Emergency Care from an Out-of-Network Provider. Please see the "Medical Benefits" section, "Emergency Care" subsection for more information about how we cover Emergency Care from an Out-of-Network Provider.

Prior Authorization Requirements

We require Prior Authorization for many types of Covered Services. Our decision of whether to approve a Prior Authorization request depends upon the specific medical facts applicable to your medical condition, and whether the requested service meets the coverage requirements described in the "Determining Coverage" subsection above.

For a complete list of services requiring Prior Authorization, please visit our website at www.weatrust.com.

Hospital Admission Notification Requirements

You must notify us of any overnight hospitalization when you are admitted due to childbirth or after you receive Emergency Care. If you do not, your reimbursement will be reduced.

To notify us, you, an Immediate Family Member, a Physician, or Hospital employee must notify us within 72 hours of your admission, or as soon as is medically feasible for you to do so, whichever is later. We will ask you to provide the following information:

- Your Physician's name, address, and phone number.
- The Hospital name, address, and phone number.
- The date and reason for the hospitalization.

Depending on the situation, we may request additional information.

If you are hospitalized for childbirth, you must notify us within 72 hours of your hospitalization for childbirth, unless you or your baby(ies) has been discharged within 72 hours of your admission. This notification requirement applies for other maternity-related emergency admissions as well, such as for pre-term labor or other maternity complications when childbirth does not occur.

Cost-Sharing Amounts: Deductibles, Coinsurance and Copayments

You must pay a Deductible, Coinsurance and/or Copayment amount for most Covered Services. These are the different types of Cost-Sharing Amounts applicable to this Plan. You can find more information about these terms in the "Definitions" section of this Certificate.

You can find the specific Cost-Sharing Amounts you must pay in the Benefit Summary. These payments are due at the time of service, or when billed by your Health Care Provider.

Individual Deductible: The individual Deductible amount is the most that any Member must pay per Benefit Period. Once a Member has met the individual Deductible amount, we will begin paying Claims for that Member as described in the Benefit Summary.

Family Deductible: The Family Deductible amount is the most that the Subscriber and his or her covered Dependents must pay in a Benefit Year before we will pay for Covered Services. Once the Family Deductible is met, we will begin paying Claims for the entire Family as described in the Benefit Summary.

Coinsurance: Coinsurance payments begin once you meet any applicable Deductible amounts.

Non-Covered Services: You may be billed directly for services that do not qualify as Covered Services. These are not Cost-Sharing Amounts and will not apply toward your Deductible or your Maximum Out-of-Pocket Limit.

Maximum Out-of-Pocket Limit

The Maximum Out-of-Pocket Limit is the most you will pay in Deductible, Coinsurance and Copayment amounts for Covered Services during any Benefit Period. Please see the Benefit Summary for the Maximum Out-of-Pocket Limit that applies to your Plan, as well as which Cost-Sharing Amounts apply to the Maximum Out-of-Pocket Limit. The single Maximum Out-of-Pocket Limit is the most that each Member will pay out of pocket each Benefit Period. The Family Maximum Out-of-Pocket Limit is the most that the Subscriber and his or her covered Dependents, combined, will pay out of pocket each Benefit Period.

The following **never** apply to the Maximum Out-of-Pocket Limit:

- Amounts you pay that exceed the Maximum Benefit Amount specified in your Benefit Summary.
- Amounts you pay for non-Covered Services.
- Amounts you pay for charges that exceed our Maximum Allowable Fee.
- Amounts you pay that exceed our reimbursement limit on services for which you received Prior Authorization.
- Penalty amount for failure to comply with our Hospital admission notification requirements.
- Amounts you pay for charges that do not comply with the Certificate's reimbursement rules.

Maximum Allowable Fee

We reimburse for Covered Services according to our Maximum Allowable Fee Schedule. You may be responsible for paying the difference, if any, between the Maximum Allowable Fee and the amount your provider bills. This will not apply toward your Deductible or Maximum Out-of-Pocket Limit.

Generally, it will be an Out-of-Network Provider that will bill this difference to you. This includes Out-of-Network Emergency and Urgent Care Providers and Out-of-Network Providers for whom you have an approved Referral to see.

It will not apply for services you received from an In-Network Provider. However, you will be responsible for paying any Cost-Sharing Amounts applicable to this Plan.

Maximum Benefit Amount

This amount, which is specified on your Benefit Summary, is the total amount this Plan will reimburse for certain types of treatment or services for each covered individual during the Benefit Period. We encourage you to check

your Benefit Summary so you know which services are subject to a Maximum Benefit Amount and the Maximum Benefit Amount we will pay for these Covered Services.

Certificate Changes

If any provision is changed while your coverage is in force, the change applies only to Covered Services that are received after the effective date of the change.

Noncompliance with Certificate Requirements

Our waiver of any requirement of this Certificate will not constitute a continuing waiver of such requirement. Our failure to insist on compliance with any Certificate provision will not function as a waiver or amendment of that provision.

MEDICAL BENEFITS

Benefits

This section describes the healthcare services, equipment and supplies that make up the benefits covered by this Certificate.

When possible, we have identified services, equipment, and supplies that we do not cover. However, this is not a complete, all-inclusive list. Please see the "General Exclusions and Limitations" section for a list of general exclusions that apply to all benefits.

Please Note: We will only pay for benefits that are listed as "covered" in this Certificate if:

- All of the coverage requirements discussed below have been met; and
- When required, you have requested Prior Authorization, and we have approved your request.

Coverage Requirements

We will only cover a benefit if it meets all of the following criteria:

- Its purpose is to diagnose, treat or prevent an Illness or Injury; and
- We determine that it is Medically Necessary; and
- We determine that it is Medically Appropriate.

Prior Authorization

Certain services, equipment and supplies require Prior Authorization to be covered. When required, you or your Provider must request Prior Authorization, and we must approve your request, *before* you receive the service, equipment or supplies.

For a list of services, equipment or supplies which require Prior Authorization, please visit www.weatrust.com.

If you fail to get Prior Authorization when it is required, depending on the circumstances and at our sole discretion we will deny the claim. This will make you wholly responsible for payment.

For more information about coverage rules and requirements, please refer to the "General Provisions That Apply to All Benefits" section of this Certificate.

Advanced Imaging

Covered

- Advanced imaging in a Hospital or free-standing facility, including the following:
    - Magnetic resonance imaging (MRI)
    - Computerized axial tomography (CT)
    - Positron emission tomography (PET)

Allergy Treatment

Covered

- Initial diagnostic evaluation, including:
    - Initial history;
    - Physical examination;

- Relevant laboratory services; and
- The following diagnostic tests:
  - Scratch tests or specified intradermal tests.
  - Specific laboratory tests to determine respiratory function and blood levels of the immune system.
  - Blood allergy testing when:
    - Skin testing is not conclusive;
    - The patient has a condition that precludes the use of scratch testing or intradermal tests; or
    - Being used instead of scratch or intradermal testing.

- Immunotherapy (injection of antigens) to build up immunities.

Not Covered

- Any testing or treatment considered unproven or unconventional by the American Academy of Allergy, Asthma, and Immunology (AAAAI), including but not limited to:
  - Sublingual antigen drops.
  - Provocative and neutralization testing and treatment.
  - Repeated intradermal testing, unless indicated by AAAAI guidelines.
  - Skin test endpoint titration for evaluating the effectiveness of immunotherapy.
  - Food allergy desensitization therapy.

Ambulance Services

Covered

- Emergency ground or air ambulance transportation to the closest medical facility that can provide appropriate treatment.
  - We only cover air ambulance transportation when it is essential to rapidly reach safe and effective treatment.
  - Transportation must be provided by a licensed ambulance service provider.
- Non-emergency ground or air ambulance transportation between medical facilities.
  - We only cover non-emergency ground or air ambulance transportation between medical facilities when:
    - You are confined in a facility that cannot currently provide the appropriate level of care; and
    - You require medical attention during transportation.
  - You must be transported to the closest facility that can provide appropriate treatment.
  - Transportation must be provided by a licensed ambulance service provider.

Not Covered

- Ambulance transportation that is primarily for the convenience of You, Your Immediate Family, or a provider.
- The cost of ferry services, even when necessary to reach ground or air ambulance transportation.

Autism Spectrum Disorder Treatment

Covered

- Diagnostic testing and evaluation by a Qualified Provider (as defined by state law).
- Intensive-Level Services:
  - We cover up to four (4) cumulative years of Intensive-Level Services.
  - The Member must have a verified diagnosis of Autism Spectrum Disorder.
    - The diagnosis must have been made by a Health Care Provider skilled in testing and in the use of empirically-validated tools specific for Autism Spectrum Disorders.
  - Intensive-Level Services must begin after the Member turns two years old, but before the Member turns nine years old.

- Intensive-Level Services must:
  - Be provided at least 20 hours per week over a six-month period of time.
  - Be based on a treatment Plan developed by an individual who at least meets the requirements of a Qualified Intensive-Level Provider or a Qualified Intensive-Level Professional.
    - The treatment Plan must require that the Member be present and engaged in the intervention.
  - Be provided by a Qualified Intensive-Level Provider or Qualified Intensive-Level Professional who directly observes the Member at least once every two months.
  - Be implemented by Qualified Providers, Qualified Professionals, or Qualified Therapists, or Qualified Paraprofessionals.
  - Consist of intensive, Behavioral Evidence-Based Therapy, treatment and services with specific cognitive, social, communicative, self-care or behavioral goals.
  - Intensive-Level Services must:
    - Address the characteristics of Autism Spectrum Disorders;
    - Be clearly defined;
    - Be directly observed;
    - Be continually measured;
    - Be provided in an environment most conducive to achieving the goals of the Member's treatment Plan.
    - Be provided a majority of the time in the presence of an engaged parent or legal guardian; and
    - Implement identified therapeutic goals developed by the team, including:
      - Training and consultation;
      - Participating in team meetings; and
      - Active involvement of the Member's Immediate Family.
- The Member's progress must be assessed and documented throughout the course of treatment. We reserve the right to review the Member's treatment Plan and a summary of progress on a periodic basis.

- Non-Intensive Level Services:
  - The Member must have a verified diagnosis of Autism Spectrum Disorder.
    - The diagnosis must have been made by a diagnostician skilled in testing and in the use of empirically-validated tools specific for Autism Spectrum Disorders.
  - Non-Intensive Level Services must:
    - Be provided in either of the following circumstances:
      - After the completion of Intensive-Level Services and designed to sustain and maximize gains made during Intensive-Level Services treatment.
      - To a Member who has not and will not receive Intensive-Level Services, but for whom Non-Intensive Level Services will improve the Member's condition.
    - Be based upon a treatment Plan developed by an individual who at least meets the requirements of a Qualified Provider, a Qualified Professional, or a Qualified Therapist.
    - Be implemented by a person who is at least a Qualified Provider, Qualified Professional, Qualified Therapist, or a Qualified Paraprofessional.
    - Consist of specific Evidence-Based Therapy goals that are:
      - Clearly defined;
      - Directly observed;
      - Continually measured; and
      - That address the characteristics of Autism Spectrum Disorders.
    - Be provided in an environment most conducive to achieving the goals of the Member's treatment Plan.
    - Implement identified therapeutic goals developed by the team including:
      - Training and consultation,

        - Participation in team meetings; and
        - Active involvement of the Member's Immediate Family.
      - May include direct or consultative services when provided by Qualified Providers, Qualified Supervising Providers, Qualified Professionals, Qualified Therapists, or Qualified Paraprofessionals.
  - The Member's progress must be assessed and documented throughout the course of treatment.
  - We reserve the right to review the Member's treatment Plan and a summary of progress on a periodic basis.

Not Covered

- Acupuncture.
- Animal-based therapy including hippotherapy (horseback riding).
- Any services that do not qualify for reimbursement under the law.
- Auditory integration training.
- Chelation therapy.
- Child care fees.
- Cost for the facility or location or for the use of a facility or location when treatment, therapy, or services are provided outside a Member's home.
- Cranial sacral therapy.
- Custodial or respite care.
- Hyperbaric oxygen therapy.
- Services which duplicate those provided by a school.
- Special diets or supplements.
- Therapy, treatment or services for someone residing in a residential treatment center, inpatient treatment, or day treatment facility.
- Treatment rendered by parents or legal guardians who are otherwise Qualified Providers, supervising providers, therapists, professionals, or paraprofessionals for treatment rendered to their own children.

Behavioral Health and Substance Abuse Disorder Services

Covered

- Inpatient treatment, as described below:
  - Inpatient treatment you receive from a Qualified Behavioral Health and/or Substance use Treatment Provider while you are confined in a Qualified Treatment Facility.
- Transitional treatment, as described below:
  - Transitional treatment you receive from a Qualified Behavioral Health and/or Substance use Treatment Provider in a Qualified Treatment Facility.
    - Transitional treatment is more intensive than traditional Outpatient Care but less restrictive than traditional inpatient care. It includes:
      - Services at a residential treatment facility;
      - Partial hospitalization/day or evening treatment programs; or
      - Intensive outpatient treatment.
    - A qualified residential treatment facility program provides specialized 24-hour per day treatment and meets the following criteria:
      - The treatment program must be staffed by a multi-disciplinary team of Qualified Behavioral Health and/or Substance use Treatment Providers who provide transitional treatment;
      - For each patient, within 72 hours of admission the team must complete a personalized, problem-focused treatment Plan.
      - A psychiatrist must observe and assess each patient at least weekly.
- Outpatient treatment, as described below

- Outpatient treatment you receive from Qualified Behavioral Health and/or Substance use Treatment Provider in a Qualified Treatment Facility while not receiving inpatient or transitional treatment.
    - Psychological and neuropsychological testing is covered **only if all** of the following apply:
        - A thorough clinical assessment by a Qualified Behavioral Health and/or Substance use Treatment Provider has been conducted. It must include:
            - A review of mental status, social functioning, applicable medical information, history, and applicable collateral information.
        - There is significant uncertainty about a diagnosis that affects the choice of treatment interventions;
        - The patient's symptoms are complex or unusual so that diagnosis and clarification of symptoms can be accomplished only through such testing;
        - There are distinct treatment options based on the differential diagnosis that is clarified through the testing.
        - The testing is likely to produce the required diagnosis and clarification necessary for Planning treatment.
    - Nutritional counseling is covered when it is:
        - Part of an approved treatment Plan prescribed by a Physician;
        - Provided by a certified or registered dietician or nutritionist; and
        - Necessary for the effective treatment of a life-threatening Illness (e.g. anorexia nervosa or bulimia).
    - For Full-Time Students attending school in Wisconsin, but outside the Service Area:
        - A clinical assessment by an Out-of-Network Provider and five (5) visits for outpatient behavioral health or substance use treatment.
            - We retain the right to choose the provider.
            - You must get Prior Authorization for the clinical assessment and the five (5) outpatient visits described above. You must also get Prior Authorization for any additional treatment or services you receive from this, or another, Out-of-Network Provider.
            - We will not cover these services after your school enrollment terminates, or otherwise ends.
- Services provided pursuant to an Emergency Detention, court order or commitment:
    - These services may be provided by any Health Care Provider according to the terms and conditions laid out in this Certificate, including an Out-of-Network Provider.
    - If services are provided by an Out-of-Network Provider, we must be notified within 72 hours so that we can arrange for continuing care with an In-Network Provider.
        - We will not continue to cover services provided by an Out-of-Network Provider once we have arranged for services from an In-Network Provider.

Not Covered

- Custodial or Long-Term Care
- Residential treatment for the sole purpose of preventing relapse, for legal purposes, or for respite for the Immediate Family.
- Wilderness and camp programs, boarding schools, and academy-vocational programs.
- Psychological testing and assessments that are not likely to yield additional information that is useful for healing and curing or planning medical treatment. Examples include, but are not limited to:
    - Testing to assist with custody placement;
    - Vocational assessments; and
    - Academic assessments.
- Services for academic problems in the absence of a diagnosed mental health Illness, or for which the child's school is legally obligated to provide. This applies whether or not the school actually provides these services, and whether you choose to use those services.

- Treatment for a behavioral or psychological problem that was not caused by a clinically-diagnosed mental health Illness, even if it may be appropriate to seek professional help. Examples include, but are not limited to:
    - Antisocial behavior;
    - Uncomplicated bereavement;
    - Codependency;
    - Occupational problems such as job dissatisfaction or uncertainty about career choices;
    - Parent-child problems such as impaired communication or inadequate discipline;
    - Marital problems; and
    - Other interpersonal problems.
- Services related to or for the treatment of compulsive gambling or nicotine addiction, except as described under the "Tobacco Cessation Benefit" provision of this Certificate.
- Behavioral or mental health services for, or connected to, developmental delays (e.g. Rett Syndrome).
- Inpatient treatment that continues after inpatient treatment is no longer Medically Necessary. This includes, but is not limited to, patients awaiting placement in or transfer to another facility or level of care.
- Inpatient treatment of a chronic behavioral health or substance use disorder, unless:
    - Clinical records document significant physical or mental decline; or
    - The patient is an active danger to herself, himself, or others.

Chiropractic Services

Covered

- Chiropractic diagnostic services and treatment, as described below:
    - Diagnostic services and treatment must be provided by a Doctor of Chiropractic acting within the scope of his or her license.
    - The need for treatment must have resulted from Illness or Injury.
    - The treatment must be reasonably expected to:
        - Cure or alleviate your Illness or Injury; or
        - Restore a functional ability to its status prior to the Illness or Injury.

Not Covered

- Any chiropractic service or treatment which does not meet the criteria described above.
- Maintenance or Long-Term treatment.
- Supplies, or counseling in connection with any supplies, such as vitamins, herbs, nutritional supplements, cervical pillows, shoe and heel lifts, and lumbar rolls, unless required by law to cover them.
- Orthotic devices, unless custom made and prescribed by a Physician.

Dental Services and Oral Surgery

Covered

- Services related to the initial repair and restoration of an injured Sound Natural Tooth.
    - "Injured" does not include damage caused by eating, biting, disease or decay.
- Oral surgery:
    - Must be performed by a Doctor of Dental Surgery (D.D.S.) or a Doctor of Medical Dentistry (D.M.D.).
    - Coverage is limited to the following procedures:
        - Excision of partially or completely unerupted, impacted teeth;
        - Excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth;
        - Surgical procedures required to correct Accidental injuries to the jaw, cheeks, lips, tongue, roof and floor of the mouth;
        - Reduction of fractures and dislocations of the jaw;
        - External incision and drainage of cellulitis;
        - Incision of accessory sinuses, salivary glands or ducts;

        - Frenectomy (the cutting of the tissue in the midline of the tongue);
        - Functional osteotomy;
        - Osseous surgery;
        - Gingivectomy (the excision of diseased gum tissue to eliminate infection);
        - Gingival flap surgery;
        - Apicoectomy (the excision of the apex of the tooth root);
        - Alveolectomy (the leveling of the structures supporting the teeth when performed for reasons other than preparation for dentures)
- Hospital and ambulatory surgery center charges, including anesthesia, when:
    - You have a chronic Disability; or
    - You have a medical condition that requires hospitalization or general anesthesia for dental care.

Not Covered

- Any treatment after the initial treatment of an injured Sound Natural Tooth.
- Orthodontia, occlusal adjustment, or dental restorations unless required to repair and restore the functioning of an injured Sound Natural Tooth.
- Replacement of bridges, implants, crowns or partial or full dentures.
- Extraction or replacement of a Sound Natural Tooth because of disease or decay.
- Implants, including the oral surgery to place the implant(s), unless needed to repair and restore the functionality of an injured Sound Natural Tooth.
- Orthognathic surgery, unless required to correct a skeletal malocclusion that causes significant functional impairment.
- Behavior modification therapy or symptomatic care such as nutritional counseling and home therapy programs.
- Any service for which the only purpose is to improve the appearance of a tooth, such as bleaching.

Diabetes Supplies and Equipment

Covered

- Insulin and other Prescription Drugs prescribed for the treatment of diabetes.
- Test strips, swabs, wipes, autolets, lancets, syringes and hypodermic needles for administering insulin.
- Durable medical equipment, including but not limited to infusion pumps and non-invasive continuous glucose monitors.
    - Coverage limited to the purchase of one insulin infusion pump per Benefit Period.
    - We may require a 30-day trial period, at our expense, before authorizing the purchase.
- Diabetes self-management education programs.
- Nutritional Counseling

Not Covered

- Travel, lodging, meals or other incidental costs related to participation in a diabetes self-management program.

Durable Medical Equipment and Supplies

Covered

- Durable Medical Equipment, as described below:
    - Coverage includes, but is not limited to, the following:
        - Durable medical equipment for home use, including:
            - Morphine pumps.
            - Oxygen regulators.
            - Infusion pumps.

            - Specialized feeding equipment.
        - Prosthetic devices to replace a missing body part, including:
            - Artificial limbs;
            - Artificial eyes; and
            - Full cranial hair prostheses:
                - When sudden onset baldness occurs due to a disease, accident or medical treatment for which services are covered under this Certificate; and
                - The sudden onset baldness is so extensive that it significantly alters the Member's appearance.
                - Neither wigs nor other methods of hair restoration are covered for alopecia or other causes of hair loss.
        - Functional repair of durable medical equipment.
        - Durable mechanical equipment, such as a wheelchair or Hospital bed.
    - We reserve the right to determine to rent or purchase Durable Medical Equipment.
- Supplies, including:
    - Custom made orthotics prescribed by a Physician.
    - Casts, splints, trusses, braces and crutches for short-term or long-term use.
    - Supplies needed to properly operate covered Durable Medical Equipment.
    - Ostomy care items and catheter maintenance supplies.

Not Covered

- Equipment or supplies for which the only advantage over a suitable alternative is convenience or personal preference.
- Repair or replacement of equipment damaged because of negligent use or abuse.
- Routine maintenance of equipment, regardless of whether it was rented or purchased.
- Equipment or supplies to facilitate participation in physical activity or sports.
- Supplies, including batteries, that can be purchased over-the-counter, other than those listed above or those listed in the "Diabetes Supplies and Equipment subsection.
- Equipment or supplies for comfort, personal hygiene, convenience, or which are otherwise useful in the absence of Illness, Injury or Disability.

Emergency Care

Covered

- Emergency Care for an Emergency Medical Condition, as described below:
    - Examples of situations for which Emergency Care is appropriate include, but are not limited to:
        - Suspected heart attack.
        - Loss of consciousness.
        - Suspected or actual poisoning.
        - Acute appendicitis.
        - Convulsions.
        - Heat exhaustion.
        - Uncontrollable bleeding.
        - Fractures.
        - Other acute conditions that are of sufficient severity to warrant immediate medical care.
    - Prior Authorization is not required for Emergency Care.
    - If you are admitted as an inpatient after seeking Emergency Care, you must still notify us within 72 hours of your admission, or as soon as it is medically feasible.
    - Your Emergency Room Copayment will be waived if, after seeking Emergency Care, you are admitted as an inpatient for at least 24 hours.
    - We cover Emergency Care provided by an Out-of-Network Provider as described below:

- If you seek Emergency Care from an Out-of-Network Provider, once you are Stabilized we may request to transfer you to an In-Network facility. If you do not wish to be transferred to a Network facility, you will have to pay Out-of-Network Cost-Sharing Amounts for any additional care you receive.
- Payment for Emergency Care from an Out-of-Network Provider:
    - You will only owe the Deductible, Coinsurance and/or Copayment amounts that apply to Emergency Care provided by an In-Network Provider.
    - We pay for Emergency Care provided by an Out-of-Network Provider based on the Maximum Allowable Fee. If what we pay is less than what the Out-of-Network Provider bills, you may have to pay the remaining amount.

Genetic Testing / Counseling

Covered

- Genetic Testing and genetic counseling.

    - During pregnancy, Genetic Testing, genetic counseling, and chromosome studies if any of the following circumstances exist:
        - The pregnant woman is 35 years old or older.
        - The pregnant woman or her mate has a family history of a highly disabling hereditary disorder or has previously had a child with such a disorder.
        - The pregnant woman has previously experienced a miscarriage or stillbirth.
        - The pregnant woman is a known carrier of a genetic abnormality or disease.
        - The pregnant woman was exposed, before or during pregnancy, to diseases or chemicals strongly linked to birth defects.
        - The pregnant woman's mate was exposed, before pregnancy, to diseases or chemicals strongly linked to birth defects.
    - Genetic Testing, genetic counseling, and chromosome studies when:
        - A woman is not pregnant;
        - Genetic Testing, genetic counseling and/or chromosome studies are likely to reveal new information relevant to the woman's decision to have a child; and
        - Any of the following circumstances exist:
            - The woman or her mate has a family history of a highly disabling hereditary disorder.
            - The woman or her mate is a known carrier of a genetic abnormality or disease.
            - The woman or her mate has previously had a child with a genetic disorder, abnormality, or disease.
            - The woman has had multiple miscarriages or stillbirths.

Not Covered

- Genetic testing and/or counseling which is only performed:
    - For informational purposes; or
    - To answer questions or clarify issues when the results will not be helpful in preventing the Member's condition from deteriorating or developing into a significant health problem, now or in the future.
- Any testing, services, or procedures performed for gender selection, regardless of the reason they are performed.
- Testing to identify a mutation which is performed to benefit an Immediate Family member.

Hearing Services and Hearing Aids

Covered

- Diagnostic tests to establish or confirm hearing loss and determine the cause.

- Treatment of hearing impairment and hearing loss caused by an Illness or Injury.
- Surgery to repair malformed ear anatomy or malfunctioning hearing-related structures.
- Cochlear Implants, as described below:
    - A Physician or licensed audiologist must certify you as deaf or hearing impaired.
    - Covered devices and services:
        - The cost of the Cochlear Implant prescribed by a Physician or licensed audiologist;
        - Initial evaluation by an audiologist and otolaryngologist;
        - Physician and Hospital services; and
        - Aural and speech therapy following Cochlear Implant surgery.
- Bone-Anchored Hearing Aid, as described below:
    - A Physician or licensed audiologist must certify you as deaf or hearing impaired.
    - Covered devices and services:
        - Initial evaluation by an audiologist and otolaryngologist;
        - Physician and Hospital services;
            - Surgical placement of the device is covered under the Surgical Services section of this Certificate, including any applicable limitations or exclusions.
        - Replacement parts or upgrades necessary due to inadequate or non-functioning components.
            - Any replacement parts or upgrades to existing Bone-Anchored Hearing Aid components are covered under this Hearing Services and Hearing Aids section of this Certificate.
- Hearing Aids, as described below:
    - A Physician or licensed audiologist must certify you as deaf or hearing impaired.
    - Covered devices and services:
        - For children under the age of 18, one Hearing Aid per ear in each three-year period.
        - For adults, one Hearing Aid per ear per lifetime.
        - Examinations, tests or services for prescribing and fitting a Hearing Aid or device.

Not Covered

- Batteries and cords

Home Health Care

Covered

- The evaluation of the need for home health care services and development of a home care plan by a registered nurse or medical social worker.
    - The attending Physician must request or approve the home care plan and certify that:
        - Hospitalization or Confinement in a Skilled Nursing Facility would otherwise be required if home care was not provided.
        - Necessary care and treatment are not available from your Immediate Family Members, or other persons living with you, without causing undue hardship.
        - The home health care services will be provided or coordinated by a:
            - State-licensed or Medicare-certified home health care agency;
            - Certified rehabilitation agency; or
            - Home health care agency that meets our standards.
- The following services when provided during a Home Health Care Visit:
    - Part-time or intermittent Skilled Nursing Services provided or supervised by a registered nurse or licensed practical nurse.
        - The registered nurse or licensed practical nurse cannot:
            - Be the Subscriber or a Dependent covered under this policy; or
            - Ordinarily reside with you in your home.

- Part-time or intermittent Home Health Aide Services that are supervised by a registered nurse or medical social worker.
    - When provided by a home health aide, we cover help with the normal Activities of Daily Living that are connected with or incidental to covered medical services.
- Physical, respiratory, occupational or speech therapy.
- Prescribed medical supplies, drugs, medications, and laboratory services.
- Home infusion services.
- Prescribed intravenous (parenteral) or feeding tube (enteral) nutritional support systems.
    - We cover food substitutes for enteral nutrition when they provide at least 60% of the Member's nutrition, and the need is medically documented.
- Nutritional counseling provided or supervised by a certified or registered dietitian.

Not Covered

- Services provided by the Subscriber, covered Dependents, or others who ordinarily live with you.
- After learning about and demonstrating that you can do them, services that you or an Immediate Family member can reasonably and safely perform.

Hospice Care

Covered

- Medical support services provided to terminally ill individuals that are designed to provide pain relief and symptom management.
    - Care must be provided through a licensed hospice care provider, either at a hospice facility or at home.
    - The Member must have a life expectancy of six months or less, as confirmed by the attending Health Care Provider. However, coverage will continue if the Member lives longer than six months.
- Physician and nursing care.
- Room and board at a hospice facility, including services to alleviate physical symptoms.
- Home Health Care services.
- Prescription and non-prescription medications provided by the hospice agency, organization or facility.

Not Covered

- If you are receiving home hospice care:
    - Services provided by the Subscriber, covered Dependents, or others who ordinarily live with you.
    - After learning about and demonstrating that you can do them, services that you or an Immediate Family member can reasonably and safely perform
- Custodial or Long-Term Care

Hospital Services

Covered

- Room and board charges.
- Inpatient and outpatient services ordered by a Health Care Provider that are essential for diagnosis or treatment, including:
    - Services provided by the attending Health Care Provider; and
    - Services provided by an additional Health Care Provider that are necessary due to medical complexity.
- Diagnostic tests and services that are ordered by a Health Care Provider and expected to reveal new information that will be useful for diagnosis or treatment.
- Hospital or ambulatory surgery center services for dental care, including anesthesia when:
    - You have a chronic Disability; or

    - You have a medical condition that requires hospitalization or general anesthesia for dental care.
- Covered drugs and medications you take during your Hospital stay.
    - Coverage does not include take-home drugs, even if the Hospital pharmacy fills the prescription.
    - Take-home drugs are covered as described in the Prescription Drug section of this Certificate. To avoid high out-of-pocket costs, you should fill your prescription at a Network Pharmacy.

Not Covered

- Inpatient Hospital services provided after We determine that inpatient care is no longer Medically Necessary and, if needed, any further care can be safely provided in a less acute care setting.
- Inpatient admission for diagnostic tests that can be performed on an outpatient basis.
- Nursing services performed by nurses who are not employees of the Hospital.
- Take-home drugs or medications provided by the Hospital for use after discharge.
- Convenience items or services.

Kidney Disease Treatment

Covered

- Inpatient and outpatient services directly related to the treatment of kidney disease, including but not limited to:
    - Covered Services include, but are not limited to:
        - Dialysis services, including:
            - Inpatient Hospital dialysis services;
            - Inpatient, outpatient or self-dialysis services at a renal dialysis facility; and
            - Dialysis when performed at home by a trained End-Stage Renal Disease (ESRD) patient or helper, or both.
        - Hospital and Physician charges.
        - Kidney transplantation
            - For information about coverage for kidney transplantation, please see the Surgical Services section of this Certificate.
    - We are not required to duplicate coverage available to a Member under Medicare or any other insurance coverage the Member may have.
        - An individual can become eligible for Medicare due to ESRD. If or when that happens, we will coordinate benefits with Medicare at the time you become eligible for Medicare.
        - Please refer to Section 9, “Coordination of Benefits in Claims Payment” for more information about:
            - When you should enroll in Medicare Parts A and B;
            - The consequences of not enrolling in Medicare Parts A and B when you become eligible; and
            - When, and the circumstances under which, this group health plan is primary or secondary to Medicare.

Maternity and Newborn Care

Covered

- Maternity care, as described below:
    - Prenatal care, including:
        - Physical examination;
        - Pap test;
        - Laboratory tests; and
        - HIV antibody test.
    - Hospital care, including:

        - A minimum of 48 hours of inpatient care for the mother and the newborn following a vaginal delivery.
        - A minimum of 96 hours of inpatient care for the mother and the newborn following delivery by caesarean section.
    - Physician services related to labor, delivery and postpartum care.
    - Nurse-midwife services related to prenatal care, labor and delivery, and postpartum care:
        - Nurse-midwife care must be provided by:
            - A registered nurse certified to practice as a nurse-midwife by the American College of Nurse-Midwives and the State of Wisconsin; or
            - A licensed registered nurse certified as a nurse-midwife in the state in which he or she practices.
        - Except during an emergency, you must receive nurse-midwife services in a healthcare facility approved by the state in which it is located to offer nurse-midwife care.
- Newborn care, as described below:
    - Nursery room, board and care.
    - After birth and while the newborn is still in the Hospital:
        - A routine well-baby or Preventive exam; and
        - Other related routine or Preventive professional services.
    - Care and treatment a newborn may require immediately after birth for health concerns including but not limited to:
        - Pre-term or premature birth;
        - Low birth weight;
        - Respiratory Distress Syndrome (RDS);
        - Failure to thrive; or
        - Inadequate liver function.
    - Treatment of congenital defects and birth abnormalities, including functional repair which is needed to achieve normal bodily function.
        - Cosmetic Surgery only to improve a newborn's appearance is not covered.
        - See the "Surgical Services" section of this Certificate for more information regarding surgery to treat congenital heart conditions.

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

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by Cesarean section. However, we may pay for a shorter stay if the attending provider (e.g. your Physician, nurse-midwife, or Physician assistant), after consultation with you, discharges you or your newborn baby.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to you or your newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a Physician or other Health Care Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you must comply with Hospital admission notification requirements.

Not Covered

- Midwife labor and delivery outside of a Hospital unless:
    - The facility has met our requirements; and
    - The facility has been approved as a Qualified Provider under this Policy.

- Unless the mother requires and concurrently receives care for a medical condition, an extended Hospital stay beyond:
    - 48 hours following a vaginal delivery; or
    - 96 hours following a caesarean section.
- Amniocentesis or ultrasound performed to alleviate anxiety or to determine the gender of the fetus.
- Childbirth education or preparation courses (e.g. Lamaze).

Physical, Speech and Occupational Therapy

Covered

- Rehabilitative physical, speech and occupational therapy treatments, as described below:
    - Must be prescribed by a Physician in a treatment plan that identifies:
        - The specific goals the Physician has for treatment;
        - How often treatment is necessary (frequency); and
        - How long treatment should last (duration).
    - Therapy treatments must be:
        - Reasonably expected to promptly result in significant, meaningful progress toward treatment goals.
        - Provided according to the treatment plan; and
        - Provided by a therapist who is:
            - Licensed or certified by the state in which he or she is working; and
            - Practicing within the scope of his or her license or certification.
- Habilitative physical, speech and occupational therapy services, as described below:
    - Are covered when:
        - A functional ability has been delayed or impaired by congenital defect, birth abnormality, or early childhood Illness or Injury; and
        - Services are necessary to perform basic self-care activities.
    - Must be prescribed by a Physician in a treatment plan that identifies:
        - The delayed or impaired skill and/or functional ability;
        - The specific goals the Physician has for treatment;
        - How often treatment is necessary (frequency); and
        - How long treatment should last (duration).
    - Therapy treatments must be:
        - Reasonably expected to promptly result in significant, meaningful progress toward treatment goals.
        - Provided according to the treatment plan; and
        - Provided by a therapist who is:
            - Licensed or certified by the state in which he or she is working; and
            - Practicing within the scope of his or her license or certification.

Not Covered

- Any Rehabilitative Service that does not meet the coverage criteria described above, including:
    - According to our judgment, any services you receive after you have reached a point that it is unlikely you will make any further meaningful progress toward your treatment goals.
    - Any services you receive after your health condition has Stabilized and you have reached your expected level of improvement or resolution.
    - Any services you receive to prevent your health condition from worsening, relapsing or reversing.
    - Any services you routinely receive that do not meet the definition Rehabilitative Services. This exclusion applies even if these services are intended to help you maintain your body's highest level of functioning.
    - Group therapy.
    - Equipment or services to help prevent Injury or to help you participate in physical activity or sports.

- General observation of exercises you can perform at home or in a health club or similar setting.
- Services which help you perform actions or exercises that you have already learned and have shown you can adequately perform without help.
- Services and materials designed to help you make lifestyle changes, even if they will help enhance therapy. This includes, but is not limited to:
  - Chronic pain management classes;
  - Stress management classes
  - Behavior modification classes;
  - Family Member education;
  - Physical fitness lessons or guidance;
  - Nutritional counseling; and
  - Books and other materials related to health conditions.

- Any Habilitative Service that does not meet the coverage criteria described above, including:
  - Any services you receive after, in our opinion, you have reached a point that it is unlikely you will make any further meaningful progress toward your treatment goals.
  - Any services you receive after you have reached the level of functioning which is appropriate for your age and/or level of maturity.
  - Services which help you perform actions or exercises that you have already learned and have shown you can adequately perform without help.
  - Services that a school is legally obligated to provide. This exclusion applies whether the school actually provides these services, and whether you choose to use them.
  - Services to help develop or enhance a child's ability to perform school-related tasks. These include, but are not limited to:
    - Grasping a pencil;
    - Writing;
    - Using scissors;
    - Accessing playground equipment;
    - Developing play skills; or
    - Understanding reading materials.
  - Auditory processing evaluation and treatment.
    - This includes, but is not limited to:
      - Auditory integration training;
      - Aural rehabilitation; and auditory training.
    - This does not include an auditory processing evaluation and treatment related to and following placement of a Cochlear Implant.
  - Services designed to help with social awareness and social skills that do not help your Habilitative Services therapy goals.
  - Services that you can get from a governmental entity or another public or private organization.
  - Services that can be provided by Immediate Family Members without causing undue hardship.

Office Visits and Outpatient Care

Covered

- Services by qualified Health Care Providers in a Physician's office or other outpatient setting, including:
  - Examination, diagnosis and treatment of an Illness or Injury.
  - Routine physical examination.
    - We cover one each Benefit Period.
  - Preventive Services that we are required by law to cover.
    - Please see the "Preventive Care" subsection below for more information.
  - Medically Appropriate diagnostic services.
    - Diagnostic procedures are Medically Appropriate when they meet all of the following conditions:

- Contemporary medical consensus considers them reliable and effective;
- They are performed by Qualified Providers;
- They are safe and indicated for your individual medical history and risk group.
    - Your risk group is defined by your age, sex, and risk factors such as family history, lifestyle, and tobacco and alcohol use.
- They will provide new and relevant information about your health and will not duplicate information provided by other procedures that have been or are performed.

▪ Coverage includes, but is not limited to:
- Complete Blood Count;
- Total blood cholesterol count;
- Thyroid function test;
- HIV antibody test;
- Urinalysis;
- Colorectal cancer screening procedures;
- Mammogram;
- Clinical breast examination;
- Pap test; and
- Pelvic examination.

▪ We generally only cover one of each diagnostic service per Benefit Period. However, we may cover them in more frequent intervals if they are:
- Being performed to treat a diagnosed Illness;
- Warranted by Family history; or
- Medically Necessary due to other risk factors.

o Prenatal and maternity care.
▪ Please see the "Maternity and Newborn Care" subsection above for more information.

o Well baby and child care.
▪ Coverage includes, but is not limited to:
- Routine hearing screenings or tests;
- Vision tests;
- Hemoglobin and hematocrit tests; and
- Blood tests to detect lead exposure.

o Immunizations required by law or deemed appropriate by a Physician.
o Routine hearing screenings

Not Covered

- Diagnostic procedures that contemporary medical consensus considers, for an individual with your medical and other risk factors, to be:
    - Ineffective;
    - Unreliable;
    - Unproven; or
    - Of dubious value.
- Office visits and hearing examinations or tests performed when prescribing or fitting a Hearing Aid, except as described in the "Hearing Services and Hearing Aids" subsection above.
- Any immunizations you get for the sole purpose of traveling outside of the United States.

Preventive Care

Covered

- Preventive care services, as described below:
    - Coverage includes:

        - Preventive care services that have a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force (USPSTF).
        - Immunizations that are recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.
        - For infants, children and adolescents, evidence-informed preventive care and screenings recommended in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
        - For women, preventive care and screenings recommended in comprehensive guidelines by the Health Resources and Services Administration (HRSA). This includes, but is not limited to:
            - Well-woman visits.
            - Screening and counseling for gestational diabetes, HIV, and sexually transmitted infections.
            - Testing for human papillomavirus.
            - Contraceptive methods and counseling.
            - Breastfeeding support, supplies and counseling, including breast pumps.
            - Screening and counseling for interpersonal and domestic violence.
    - The preventive care services described above may change as USPSTF, CDC and HRSA guidelines are modified.
        - For more information, you can call us at (800) 279-4000 (TTY 711) or visit our website at www.weatrust.com
    - If a recommendation or guideline for a particular preventive care service does not specify the frequency, method, treatment or setting in which it must be provided, we may use reasonable medical management techniques to determine coverage.
    - Coverage of preventive care services provided during an office visit are covered as described below:
        - If your provider bills the office visit and the preventive care service separately, you may be asked to pay a cost-sharing amount for the office visit.
        - If your provider does not bill the office visit and the preventive care service separately, and the preventive care service IS the primary purpose of the office visit, you may not be asked to pay a cost-sharing amount for the office visit.
        - If your provider does not bill the office visit and the preventive care service separately, and the preventive service is NOT the primary purpose of the visit, then you may be asked to pay a cost-sharing amount for the office visit

Reproductive Health and Infertility Services

Covered

- Contraceptive methods, as described below:
    - Medical contraceptive methods, including but not limited to:
        - Diaphragm;
        - Cervical cap;
        - Intrauterine device (IUD);
        - Depo Provera shot;
        - Implantable birth control device;
        - Tubal ligation; and
        - Vasectomy;
    - Contractive methods available through the pharmacy, including birth control pills, are covered under the Prescription Drug Benefit. See the "Prescription Drugs" section of this Certificate for more information.
- Surgical sterilization methods, such as tubal ligation and vasectomy.
- Infertility services, as described below:
    - We cover only the following infertility-related services:

- Services performed exclusively to diagnose the cause of infertility.
    - Once a diagnosis has been found, we will not cover any further diagnostic tests, unless they are reasonably expected to reveal another clinical cause for infertility.
- To enable natural conception, surgical correction of a malformed or malfunctioning body part causing infertility.
    - This does not include reversal of a tubal ligation or vasectomy.

Not Covered

- Contraceptive drugs, devices or supplies that you can get without a prescription or intervention by a doctor or other health care professional. This includes, but is not limited to, condoms and contraceptive foam or gel.
- Services for or connected to the reversal of a tubal ligation or vasectomy.
- Diagnostic tests connected to the treatment of infertility, including but not limited to:
    - Diagnostic studies to determine when ovulation is occurring or will occur;
    - Abdominal ultrasounds to determine follicle growth; and
    - Diagnostic services that would not be performed outside of infertility treatment.
- Other than surgical repair, any Physician, Hospital or other service connected to infertility treatment, such as laparoscopic or transvaginal retrieval of an ovum.
- Services for, or connected to, any artificial, mechanical, or other alternative to natural conception. This includes, but is not limited to:
    - In vitro fertilization (IVF);
    - Gamete intrafallopian transfer (GIFT);
    - Zygote intrafallopian tube transfer (ZIFT);
    - Intracytoplasmic sperm injection (ICSI);
    - Embryo transplantation;
    - Artificial insemination;
    - Sperm and embryo storage; and
    - Other similar methods or procedures.
- Medication prescribed to treat infertility, including but not limited to:
    - Drugs for hyperstimulation of the ovaries (such as Clomiphene Citrate); and
    - Drugs for treating low sperm count or motility.

Skilled Nursing Care

Covered

- Skilled Nursing Facility care during a Confinement Period, as described below:
    - We only cover Skilled Nursing Facility care when:
        - You enter the Skilled Nursing Facility within 24 hours of being discharged from a general Hospital;
        - You are recuperating or rehabilitating from an Injury or Illness; and
        - You require daily Skilled Nursing or Skilled Rehabilitation Services.
    - Coverage includes, but is not limited to:
        - Room and board.
        - Physician services, Skilled Nursing Services, and Skilled Rehabilitation Services.
        - Prescription and non-prescription medications.
- Skilled Nursing Services, as described below:
    - Skilled Nursing Services can be provided either at home, or in a facility such as a Hospital or a Skilled Nursing Facility.
        - When Skilled Nursing Services are provided at home, they are covered under the “Home Health Care” section of this Certificate.
        - When Skilled Nursing Services are provided in a Hospital, they are covered under the “Hospital Services” section of this Certificate.

        - When Skilled Nursing Services are provided in a Skilled Nursing Facility, they are covered under the "Skilled Nursing Care" section, "Skilled Nursing Facility" subsection of this Certificate.
    - Coverage includes, but is not limited to:
        - Managing and evaluating a Physician-ordered care plan that requires skilled services.
        - Observing and assessing the patient's condition to evaluate whether the care plan needs modification.
        - Treating open wounds or ulcers that required skilled evaluation. This includes providing prescription medication and applying dressings using aseptic technique.
        - Intravenous, intramuscular, and subcutaneous injections.
        - Administering insulin when diabetes is newly diagnosed, or when the patient requires frequent dosage adjustments.
        - Nasogastric, gastrostomy and jejunostomy feedings when the patient is at risk for aspiration or complications.
        - Inserting, irrigating in a sterile manner, and replacing urinary catheters.
        - Assisting with a patient's initial phase of oxygen therapy;
        - Assisting with a patient's initial phase of intravenous chemotherapy, or other intravenous medications.
        - Instructing a patient on how to manage a self-care program.
        - Training a patient, Immediate Family, or other caregiver to perform any of the services described above.

Not Covered

- Skilled Nursing Facility Care that is primarily considered Custodial or Long-Term Care, even if provided by a registered nurse, a licensed practical nurse, or another trained medical professional.
- Unless they are incidental to covered Skilled Nursing Services, services that that do not need to be performed or supervised by skilled nursing personnel. These services included, but are not limited to:
    - Planning and managing a care plan that does not required Skilled Nursing Services.
    - Periodically turning and repositioning a non-ambulatory patient.
    - Prophylactic or palliative skin care, such as bathing and applying creams or lotions.
    - Administering routine medications, eye drops and ointments.
    - Wound care for:
        - Non-infected post-operative wounds; and
        - Non-infected wounds caused by a chronic medical condition.
    - General administration of oxygen and other inhalation therapy after the initial phase of treatment adjustments and caregiver graining are completed.
    - Services that you or your Family can reasonably and safely perform after you and/or you Immediate Family have learned them and shown that you/they can adequately perform them without help. This includes, but is not limited to:
        - Routine insulin injection;
        - Self-urinary catheterization; and
        - Long-term feeding by gastrostomy or jejunostomy tube.
    - General observation of exercises, including range-of-motion exercises.
    - General maintenance of ostomies or catheters.
    - Custodial or Long-Term Care.

Skilled Rehabilitation Care

Covered

- Skilled Rehabilitation Facility care, as described below:
    - We only cover Skilled Rehabilitation Facility care when:
        - You are rehabilitating from an Illness or Injury;

        - You require Skilled Rehabilitation Services for a minimum of three hours per day, for at least five days per week; and
        - Your condition requires that you see a Skilled Rehabilitation Physician or physiatrist at least three times per week.
    - Coverage includes, but is not limited to:
        - Room and board.
        - Physician, Skilled Nursing, and Skilled Rehabilitation Services.
        - Prescription and non-prescription medications.
- Skilled Rehabilitation Services, as described below:
    - Skilled Rehabilitation Services can be provided at home or in a facility such as a general Hospital, a freestanding special rehabilitation Hospital, or Skilled Nursing Facility.
        - When Skilled Rehabilitation Services are provided at home, they are covered under the "Home Health Care" section of this Certificate.
        - When Skilled Rehabilitation Services are provided in a Hospital, they are covered under the "Hospital Services" section of this Certificate.
        - When Skilled Rehabilitation Services are provided in a Skilled Rehabilitation Facility, they are covered under the "Skilled Rehabilitation Care" section, "Skilled Rehabilitation Facility" subsection of this Certificate.
    - We only cover Skilled Rehabilitation Services if:
        - Your prescribed care requires the services or supervision of skilled rehabilitation providers; and
        - The services are reasonably expected to promptly result in significant, meaningful progress toward treatment goals.
    - Coverage includes, but is not limited to:
        - Prescribed speech, physical or occupational therapy services to promptly restore a function the patient once had but lost due to Illness or Injury.
        - Physical therapy for specific neurological, muscular, or skeletal problems caused by Illness or Injury.
        - Teaching mobility or transfer skills.
        - Range-of-motion exercises when they are part of your prescribed treatment plan for a condition that caused mobility restriction or loss.
        - Design of a maintenance program for the patient to perform to prevent the patient's condition from getting worse.
        - Pulmonary rehabilitation therapy.
        - Cardiac rehabilitation therapy.
        - Post-Cochlear Implant aural therapy.

Not Covered

- Skilled Rehabilitation Facility Care that is primarily considered Custodial or Long-Term Care, even if provided a professional licensed to provide Skilled Rehabilitation Services or another trained medical professional.
- Any Skilled Rehabilitation Service that does not meet our Skilled Rehabilitation Services coverage criteria, including but not limited to:
    - Services that do not need to be supervised or provided by a professional licensed to provide Skilled Rehabilitation Services.
    - According to our judgment, any services you receive after you have reached a point that it is unlikely you will make any further meaningful progress toward your treatment goals.
    - General observation of exercises, including range-of-motion exercises.
    - Services which help you perform actions or exercises that you have already learned and have shown you can adequately perform without help.

Surgical Services

Covered

- Surgical services, as described below:
    - Surgical services are only covered if they are essential to accomplish one of the following:
        - Diagnose an Illness or Injury;
        - Cure an Illness; or
        - Repair an Injury.
    - Coverage includes, but is not limited to:
        - Surgical services performed by a Physician, Surgeon, or surgical assistant.
            - This includes oral surgery covered by this Policy that is performed by a Doctor of Dental Surgery (D.D.S) or a Doctor of Medical Dentistry (D.M.D.).
        - Anesthesia services, if they are not included in the global surgical fee.
        - Care provided by an anesthesiologist or nurse anesthetist to monitor vital signs.
        - Essential ancillary or supportive services, such as whole blood or blood plasma transfusion.
    - The following surgical services have additional, special coverage rules or requirements in addition to the ones stated above:
        - Coverage for reconstructive surgery following mastectomy includes:
            - All stages of reconstruction of the breast on which a mastectomy was performed;
            - Surgery and reconstruction of the other breast to produce a symmetrical appearance.
            - Prostheses; and
            - Physical complications of all stages of mastectomy, including lymphedemas.
        - Kidney transplant surgeries are covered as described below:
            - We only cover kidney transplant procedures if you receive your transplant evaluation and surgery at a facility that has been Medicare-certified to provide kidney transplants.
            - Covered Services include, but are not limited to:
                - Services for both the kidney transplant recipient and the living donor.
                    - Covered Services for the living donor include evaluation, hospitalization, surgical costs, and postoperative care.
                    - Living donor services are covered only if the transplant recipient is covered by this Policy.
                - Procurement, transportation, and preservation of the kidney from a deceased donor.
        - Transplant surgeries, other than kidney transplants, are covered as described below:
            - We only cover transplant procedures if you receive your transplant evaluation and surgery at a facility, approved in writing by us in advance of the surgery, that meets the following requirements:
                - For solid organs, the facility must be Medicare-certified to provide the particular type of surgery being performed.
                - For stem cell transplants, the facility must be certified to work with the National Marrow Donor Program.
            - Covered Services include, but are not limited to:
                - Transplant evaluation;
                - Hospital and Physician services;
                - Organ procurement; and
                - Tissue typing.
            - We only cover living donor services if the transplant recipient is covered by this Policy.
            - When the recipient and the donor are covered Members under the Policy, the donor's expenses shall be deemed to be the expenses of the recipient.

        - Except for corneal, bone marrow and kidney, transplants are limited to the initial transplant of the original organ per Member per Benefit Year for all transplants.
- Congenital heart disease (CHD) surgical procedures ordered by a Physician, as described below.
    - Coverage includes, but is not limited to, surgeries to treat the following conditions:
        - Coarctation of the aorta
        - Aortic stenosis
        - Tetralogy of fallot
        - Transposition of the great vessels
        - Hypoplastic left or right heart syndrome.
- Surgery may be performed as an open or closed surgical procedure, or through interventional cardiac catheterization.

Not Covered

- Services for or connected to surgeries that we consider unsafe, ineffective, or unproven.
- Services for or connected to surgical procedures:
    - That are primarily performed to improve appearance (e.g. Cosmetic Surgery); and
    - Will not likely restore a bodily function or result in meaningful improvement to the functionality of a malformed body part.
- Services for or connected to surgical weight management programs and surgical treatment for obesity, including but not limited to:
    - Roux-en-Y gastric bypass;
    - Sleeve gastrectomy;
    - Biliopancreatic diversion with duodenal switch;
    - Laparoscopic adjustable gastric banding;
    - Endoscopically placed gastric balloon; and
    - Other, similar types of bariatric surgery.
- Bariatric surgery, including gastric restrictive, bypass, and other similar surgeries, and treatment of any related complications.
    - This exclusion applies regardless of your diagnosis or the reason the surgery was performed.
- Services that are generally included in the global surgical fee.
- Services for or connected to a surgical procedure that is not covered under this Certificate.
- Costs for or connected to early admission before surgery, if pre-surgery services can be performed in an outpatient setting.
- Animal to human transplants.
- Artificial or mechanical devices designed to replace human organs.

Temporomandibular Disorder (TMD) Services

Covered

- Temporomandibular Disorder (TMD) Treatment:
    - Initial diagnostic evaluation, including:
        - Initial history and physical examination.
        - Panoramic or TMD tomography.
        - Magnetic Resonance Imaging (MRI) if there is evidence of joint disease.
        - Limited psychosocial assessment.
        - Blood testing and urinalysis.
        - Diagnostic injections, such as nerve blocks.
    - Surgical or nonsurgical treatment, including:
        - Reversible intraoral Prosthetic devices and appliances, such as removable splints.
        - Physical therapy.
        - Steroid joint injections.

- Open surgical procedures and surgical arthroscopy to rehabilitate a functional deficit or impairment cause by specific joint disease that has been resistant to other medical treatment.

Not Covered

- Any services related to the diagnosis of TMD which are considered by general medical consensus to be unproven or unconventional. This includes, but is not limited to, the following:
  - Electromyography (EMG) or muscle testing.
  - Electronic jaw-tracking systems.
  - Thermography and kinesiography.
  - Ultrasonography.
  - Radiography or regular dental X-rays.
- Any services related to the treatment of TMD which are considered by general medical consensus to be unproven or unconventional. This includes, but is not limited to, the following:
  - Orthodontic braces or orthognathic surgery to change the bite.
  - Occlusal adjustment or modification of a dental surface to change the bite.
  - Restorative therapy or prosthodontic treatment, such as the use of crowns and bridges to balance the bite.
  - Ultrasonic treatment, electrogalvanic stimulation, iontophoresis, and biofeedback.
  - Transcutaneous electrical nerve stimulation (TENS).
  - Nutritional counseling and home therapy programs.
  - Services which are not expected to lead to a prompt and predictable improvement in health status.
  - Services that continue after you reach the expected state of improvement, resolution, or stabilization of your health condition.

Telehealth

Covered

- Virtual Visit to address non-urgent, acute medical symptoms.
  - Can be used to address both physical and behavioral health symptoms.
  - In some instances, the Virtual Visit provider may recommend that you seek services in a clinic setting to receive the most appropriate treatment.

Not Covered

- Any other electronic communication between a provider and a Member, or a Member's Immediate Family, Authorized Representative, or other individual.
- Electronic communication between providers, including but not limited to email, text message, and communication through electronic health records.
- Any other Telehealth service that does not meet the definition of Virtual Visit.

Tobacco Cessation

Covered

- Tobacco use screening for all adults who are age 18 and over, and tobacco cessation interventions for identified tobacco users.
  - We will cover up to two cessation attempts every twelve months. During each cessation attempt you will get:
    - Up to four 10-minute tobacco cessation counseling sessions, including:
      - Telephone counseling;
      - Individual counseling; and
      - Group counseling; and
    - Up to 90 days of FDA-approved tobacco cessation medications.

- A Physician must prescribe this medication.
- You can only fill the prescription to receive a 30-day supply at a time. This gives you the opportunity to try different tobacco cessation aids to determine which one is most effective for you.

- Tobacco cessation aids, including both Prescription Drugs and over-the-counter aids.
    - Please visit our website, www.weatrust.com for a list of covered tobacco cessation aids, or you can call us at (800) 279-4000 (TTY 711)**.**

Urgent Care

Covered

- Urgent Care services
    - Examples of situations for which Urgent Care might be appropriate include, but are not limited to:
        - Sprains, strains and broken bones;
        - Cough, cold and sore throat;
        - Mild fever;
        - Earaches and infections;
        - Non-severe bleeding; and
        - Minor cuts and burns;

Vision Services

Covered

- Non-routine vision services, including:
    - Diagnosis and treatment of eye diseases and eye disorders.
    - Eye surgery to cure an Illness or treat an eye Injury.
    - An initial lens after cataract surgery.
    - Therapeutic contact lenses, including fitting, used to treat an Illness or Injury, such as keratoconus.
    - An initial artificial eye to replace an eye lost due to Illness or Injury.
    - After covering the initial artificial eye, any further expenses for or related to artificial eyes require Prior Authorization.

Not Covered

- Any vision services not described, above, as covered.
- Routine eye examinations.
- Refractions.
- Fitting of glasses or contact lenses.
- Prescription or nonprescription eyeglasses or contact lenses.
- Refractive eye surgery, including:
    - Radial keratotomy; or
    - Surgery to correct impaired vision that can be corrected with lenses.
- Vision training procedures and orthoptics.
- Low vision aids.

Walk-In Retail Clinic Services

Covered

- Services provided at a Walk-In Retail Clinic to diagnose or treat an Injury or Illness.
- Preventive services provided at a Walk-In Retail Clinic.

PRESCRIPTION DRUG BENEFITS

THREE TIER DRUG PLAN

Note: This Prescription Drug benefit section applies to your group's coverage only if your Benefit Summary indicates that it includes the "Three-Tier Drug Plan"

Important Notes

- We do not cover Prescription Drugs or medications, regardless of where they are purchased or received, for Members who are eligible to enroll in the Medicare Part D drug program, whether or not they enroll, except for the following:
    - Employees are actively-at-work and their covered Dependents;
    - Individuals who are covered by our standard Family Plan.
    - Individuals who are covered under state and federal continuation (COBRA) coverage, unless they choose to waive Prescription Drug coverage under this Certificate.
    - Any other individual for whom this plan is the primary insurer under Medicare Secondary Payer rules.
- We cover Prescription Drugs and medications that we are required by law to cover, including for those individuals eligible for Medicare Part D.
- Prescription drugs and medications are covered according to our drug Formulary.
    - Not all Prescription Drugs are in the Formulary.
    - Prescription drugs in the Formulary are categorized into three groups, or tiers, each with its own Cost Sharing Amount.
    - To find out if a drug is in our Formulary, or the tier in which it is placed, please visit our website at www.weatrust.com
- To get maximum reimbursement, you must choose the Tier 1 generic equivalent or therapeutically equivalent drug when one exists.
- Some drugs require Prior Authorization, and other drugs are subject to our medical review process and monitoring.
- For more information about your Prescription Drug coverage, please visit our website at www.weatrust.com or call our Customer Service Department at (800) 279-4000 (TTY 711).

How to Access

- To make the best and most knowledgeable use of your Prescription Drug benefits, always purchase your Prescription Drugs from an In-Network pharmacy.
    - In-Network pharmacies have up-to-date information about whether a specific drug is covered under the Formulary.
    - They can inform you about applicable Cost-Sharing Amounts, Prior Authorization requirements, and dispensing limitations. This helps you keep your out-of-pocket costs as low as possible.
    - To locate In-Network pharmacies, visit our website at www.weatrust.com or call our Customer Service department.
- Getting drugs at an Out-of-Network pharmacy will usually result in high out-of-pocket costs.

Formulary and Drug Tiers

- The Formulary includes the most current list of covered drugs, and indicates on which tier a specific drug has been placed.
    - You can find the Formulary on our website at www.weatrust.com.

- Share this information with your Health Care Providers so that you can make informed decisions about your treatment and how much it will cost you.

- The drug Formulary includes a comprehensive range of covered Prescription Drugs, but it does not include all Prescription Drugs.
  - We only cover a prescribed drug if it is:
    - Medically Necessary;
    - Medically Appropriate; and
    - Cost Effective.
  - We do not cover drugs that are not included on the Formulary, even if the drug may be beneficial and prescribed by a Health Care Provider.
  - We have the right to deny coverage for new drugs until we have investigated them and found them to be Medically Appropriate.
  - Coverage exceptions for drugs not included on the Formulary:
    - We will consider a coverage exception only if ALL of the following apply:
      - You have tried all the covered drugs in the appropriate therapeutic category.
      - Your Health Care Provider provides us with compelling, contemporaneous clinical evidence that either:
        - None of the covered drugs is effective for your; or
        - For a documented medical reason, you are unable to take any of the covered drugs.
      - The substitute drug you are requesting is the most Cost-Effective of the safe and effective alternative drugs in your specific medical circumstances.
    - Your Health Care Provider must submit an exception request to us, and we must approve it, before you fill your prescription.

- Three Drug Tiers
  - Prescription drugs on the Formulary are placed in one of three categories, or tiers. The tier in which we place a specific drug affects the amount we reimburse.
  - Tier 1:
    - Includes most, but not all, generic drugs.
    - It may also include some brand name drugs and a few over-the-counter drugs.
      - Tier 1 brand name drugs and over-the-counter drugs are therapeutically equivalent to drugs in Tier 2 or Tier 3.
  - Tiers 2 and 3:
    - Include all other generic and brand name drugs, based on cost, therapeutic efficacy, and the recommendations of our Pharmacy and Therapeutics Committee.

Coverage Limitations

- Dispensing Limitations
  - Dispensing is limited in quantity to a Medically Appropriate dosage, or what we have established as a 30-day supply. We reimburse only for the quantity that we consider a 30-day supply.
    - A 30-day supply may be either more or less than 30 unit dosages.
    - If your Health Care Provider prescribes a quantity that exceeds our established 30-day supply, the pharmacist at an In-Network pharmacy will inform you before filling the prescription.
    - Covered dispensing amounts may be different under the Home Delivery Program. See below for more information.
  - We will only consider an exception to the dispensing limitation when compelling clinical evidence indicates a larger dosage is Medically Necessary and Medically Appropriate for your specific medical circumstances.
  - IF your coverage will be terminating within 90 days, we have the right to limit dispensing to a 30-day supply.

- Home Delivery Program
    - Prescriptions and refills purchased through our specified Home Delivery Program are limited to a 90-day supply rather than a 30-day supply.
    - You will only be charged two Cost-Sharing Amounts for a 90-day supply, rather than three.
    - This arrangement will also be available to any pharmacy that agrees to accept the same reimbursement terms that apply to our Home Delivery Program.
    - Over-the-counter drugs are not available through the Home Delivery Program.
- Specialty Drugs
    - Specialty drugs are prescription medications that require special handling, administration or monitoring. They are used to treat complex, chronic conditions.
    - Specialty drugs are limited to a 30-day supply, even through our Home Delivery Program. You will be charged one Cost-Sharing Amount per 30-day supply.
    - We may require that you receive specialty drugs through our specialty drug program for maximum reimbursement.
- Prior Authorization and Medical Monitoring
    - We may require that you receive Prior Authorization, or undergo medical review and monitoring, for drugs:
        - With a high potential for drug-related toxicity;
        - For which a step-therapy approach is appropriate; or
        - With unique prescribing or monitoring indications.
    - The list of drugs that meet these criteria is small, but will change frequently with new developments. You can view the most current list on our website at www.weatrust.com.
        - If your Health Care Provider prescribes one of these drugs, the pharmacist at an In-Network pharmacy will inform you before filling the prescription. You can call us to initiate any required review.
        - If you present your prescription at an Out-of-Network pharmacy, you will need to pay for the prescription in advance.
            - You take the risk that we will not reimburse you for the drug because we would have denied a Prior Authorization request.
            - If we do reimburse you, your out-of-pocket costs will be high.
    - Penalties for failing to obtain Prior Authorization when required do not count toward your Maximum Out-of-Pocket Limit.

Cost Sharing and Reimbursement

- You may receive reimbursement of covered Prescription Drug expenses in either of the following ways:
    - You may present your insurance identification card to an In-Network pharmacy and pay the applicable Cost-Sharing Amount, plus any additional cost for brand name drugs. We will then reimburse the pharmacy directly.
    - You may pay the entire cost of a Prescription drug at any pharmacy and then submit a Prescription Drug Claim form with the required information. We will then reimbursement you for the appropriate amount.
        - You can get a Prescription Drug claim form by printing it from our website at www.weatrust.com, or by calling our Customer Service Department.
        - We will only reimburse the amount that is charged by an In-Network Pharmacy, minus the applicable Cost-Sharing Amount. If use an Out-of-Network pharmacy, our reimbursement may be much less than you were charged.
- The amount we reimburse and, thus, the amount you must pay for your covered Prescription Drugs depends on three factors:
    - The Cost-Sharing Amounts that apply to your Prescription Drugs. The amounts are different depending on whether you purchase a Prescription Drug from Tier 1, Tier 2, or Tier 3.

        - You can find the Cost-Sharing Amount for each tier in your Benefit Summary. The specified amount applies separately to each prescription or refill.
    - Whether you select an In-Network or an Out-of-Network pharmacy.
        - We limit reimbursement to the amount charged by an In-Network pharmacy that participates in our Prescription Drug program.
        - You can find the list of In-Network pharmacies in your area on our website at www.weatrust.com, or by calling our Customer Service department.
    - Whether you receive a Cost-Effective drug from among the viable alternatives.
        - This Plan limits reimbursement to the most Cost-Effective treatment from among viable alternatives.
        - If you purchase a brand name drug, we may limit reimbursement to the amount charged by an In-Network pharmacy for the FDA-approved generic equivalent drug.
            - If this occurs, you must pay the drug's applicable Cost-Sharing Amount, as well as the difference between the amount the pharmacy charged and the amount of our reimbursement. This usually results in a high out-of-pocket expense.
            - Without appropriate medical documentation, a note from your Health Care Provider on your prescription that a drug must be dispensed as written is not, itself, enough evidence for us to reimburse for that drug.
                - To receive reimbursement, your Health Care Provider must submit to us, and we must approve, an exception request before you fill your prescription.
- If you purchase Prescription Drugs from an Out-of-Network pharmacy, you will be required to pay the full cost of the drug and submit a claim form.
    - You can get a claim form by printing it from our website or by calling our Customer Service department.
    - We will reimburse the amount we would have paid an In-Network pharmacy, minus the applicable Cost-Sharing amount. Your out-of-pocket costs will usually be much higher when you use an Out-of-Network pharmacy.
        - Note: Most Hospital pharmacies are not In-Network pharmacies. If your Health Care Provider gives you a prescription when you leave the Hospital, you may want to go to an In-Network pharmacy to have it filled.

Benefits

Covered

- Drugs required to carry the legend, "Federal law prohibits dispensing without prescription."
- Drugs that may be dispensed only upon a Health Care Provider's written prescription as required by state law.
- Drugs for the treatment of HIV infection.
- Insulin and other Prescription Drugs and medications prescribed for the treatment of diabetes.
- Specified prescription and over-the-counter tobacco cessation aids, as described in the "Medical Benefits" section, "Tobacco Cessation" subsection of this Certificate.

Not Covered

- Drugs and medications that can lawfully be obtained without a prescription, even if your Health Care Provider prescribes them.
    - The only exception to this is an over-the-counter drug that we have determined to be a Cost-Effective, comparably equivalent alternative to a Prescription Drug, and have added it to the Formulary.
    - Such over-the-counter drugs require a prescription from your Health Care Provider.
- Drugs or medications that we deem to be ineffective or marginally effective.
- A drug or medication that has not been proven to be more effective than a less expensive, therapeutically equivalent drug.

- Any drug or medication labeled “Caution – limited by federal law to investigational use.”
    - This exclusion does not apply to drugs for the treatment of HIV infection that this Plan is required by law to cover.
- Any drug that has not been approved by the FDA for at least six months for the purpose that your Health Care Provider is prescribing it, or it is otherwise being used.
- Drugs or medications for the treatment of alopecia or hair loss.
    - Examples include, but are not limited to, minoxidil or Rogaine.
- Drugs or medications primarily to improve appearance.
    - This includes all dosage forms of tretinoin (for example, Retin-A) for individuals who are 36 years of age or older, except for the treatment of acute acne.
- Tobacco cessation aids, except for specified prescription and over-the-counter aids as described in this Certificate.
- Drugs or medications prescribed for, or in connection with, weight loss or weight control.
    - Examples include, but are not limited to, Dexedrine and Xenical.
- Drugs or medications prescribed for, or in connection with, infertility or conception.
    - Examples include, but are not limited to, Clomiphene Citrate, Pregnyl and Repronex.
- Drugs or medications for the treatment of impotence or erectile dysfunction.
- Early refills, refills in excess of the number of refills specified by the Health Care Provider, or any refill dispensed after one year from the date of the Health Care Provider’s original order.
    - We do not reimburse for early or additional refills if your medications are lost, stolen, damaged, expired, misplaced, missing, or otherwise compromised.
- Drugs or medications provided in connection with any medical service not covered by this Plan.

PRESCRIPTION DRUG BENEFITS

VALUE CHOICE DRUG PLAN

Note: This Prescription Drug benefit section applies to your group's coverage only if your Benefit Summary indicates that it includes the "Value Choice Drug Plan"

Important Notes

- We do not cover Prescription Drugs or medications, regardless of where they are purchased or received, for Members who are eligible to enroll in the Medicare Part D drug program, whether or not they enroll, except for the following:
    - Employees are actively-at-work and their covered Dependents;
    - Individuals who are covered by our standard Family Plan.
    - Individuals who are covered under state and federal continuation (COBRA) coverage, unless they choose to waive Prescription Drug coverage under this Certificate.
    - Any other individual for whom this plan is the primary insurer under Medicare Secondary Payer rules.
- We cover Prescription Drugs and medications that we are required by law to cover, including for those individuals eligible for Medicare Part D.
- Prescription drugs and medications are covered according to our drug Formulary.
    - Not all Prescription Drugs are in the Formulary.
    - Prescription drugs in the Formulary are categorized into groups, or tiers, each with its own Cost Sharing Amount.
    - To find out if a drug is in our Formulary, or the tier in which it is placed, please visit our website at www.weatrust.com
- Value Drugs
    - Value Drugs are a subgroup of Tier 1 drugs, consisting of selected over-the-counter, generic and brand name drugs.
        - A drug's designation as a Value Drug is based on the drug's clinical effectiveness, safety profile, and overall value. We reserve the right to determine which drugs will be Value Drugs.
    - The Cost-Sharing Amounts that apply to Value drugs are lower than the Cost-Sharing Amounts for other Tier 1 drugs.
    - Not every class will contain a Value Drug.
- To get maximum reimbursement, you must choose the Tier 1 generic equivalent or therapeutically equivalent drug when one exists.
- Some drugs require Prior Authorization, and other drugs are subject to our medical review process and monitoring. Some drugs require documentation of failed attempts to use more cost-effective clinical alternatives (as defined by us), or a contraindication, in order to be reimbursable by us.
- For more information about your Prescription Drug coverage, please visit our website at www.weatrust.com or call our Customer Service Department at (800) 279-4000 (TTY 711).

How to Access

- To make the best and most knowledgeable use of your Prescription Drug benefits, always purchase your Prescription Drugs from an In-Network pharmacy.
    - In-Network pharmacies have up-to-date information about whether a specific drug is covered under the Formulary.
    - They can inform you about applicable Cost-Sharing Amounts, Prior Authorization requirements, and dispensing limitations. This helps you keep your out-of-pocket costs as low as possible.

- To locate In-Network pharmacies, visit our website at www.weatrust.com or call our Customer Service department.
- Getting drugs at an Out-of-Network pharmacy will usually result in high out-of-pocket costs.

Formulary and Drug Tiers

- The Formulary includes the most current list of covered drugs, and indicates on which tier a specific drug has been placed.
  - You can find the Formulary on our website at www.weatrust.com.
  - Share this information with your Health Care Providers so that you can make informed decisions about your treatment and how much it will cost you.
- The drug Formulary includes a comprehensive range of covered Prescription Drugs, but it does not include all Prescription Drugs.
  - We only cover a prescribed drug if it is:
    - Medically Necessary;
    - Medically Appropriate; and
    - Cost Effective.
  - We do not cover drugs that are not included on the Formulary, even if the drug may be beneficial and prescribed by a Health Care Provider.
  - We have the right to deny coverage for new drugs until we have investigated them and found them to be Medically Appropriate.
  - Coverage exceptions for drugs not included on the Formulary:
    - We will consider a coverage exception only if ALL of the following apply:
      - You have tried all the covered drugs in the appropriate therapeutic category.
      - Your Health Care Provider provides us with compelling, contemporaneous clinical evidence that either:
        - None of the covered drugs is effective for your; or
        - For a documented medical reason, you are unable to take any of the covered drugs.
      - The substitute drug you are requesting is the most Cost-Effective of the safe and effective alternative drugs in your specific medical circumstances.
    - Your Health Care Provider must submit an exception request to us, and we must approve it, before you fill your prescription.
- Drug Tiers
  - Prescription drugs on the Formulary are placed into categories, or tiers. The tier in which we place a specific drug affects the amount we reimburse.
  - Tier 1:
    - Includes most, but not all, generic drugs.
    - It may also include some brand name drugs and a few over-the-counter drugs.
      - Tier 1 brand name drugs and over-the-counter drugs are therapeutically equivalent to drugs in Tier 2 or Tier 3.
    - Value Drugs are a subgroup of Tier 1 drugs specifically chose for their clinical effectiveness, safety profile, and overall value.
      - The Cost-Sharing Amount that applies to Value Drugs is lower than the Cost-Sharing Amount for other Tier 1 drugs.
      - Value Drugs provide you with the lowest out-of-pocket cost.
  - Tiers 2 and 3:
    - Include all other generic and brand name drugs, based on cost, therapeutic efficacy, and the recommendations of our Pharmacy and Therapeutics Committee.

Coverage Limitations

- Dispensing Limitations
    - Dispensing is limited in quantity to a Medically Appropriate dosage, or what we have established as a 30-day supply. We reimburse only for the quantity that we consider a 30-day supply.
        - A 30-day supply may be either more or less than 30 unit dosages.
        - If your Health Care Provider prescribes a quantity that exceeds our established 30-day supply, the pharmacist at an In-Network pharmacy will inform you before filling the prescription.
        - Covered dispensing amounts may be different under the Home Delivery Program, or at pharmacies participating in the 90-Day Retail Benefit. See below for more information.
    - We will only consider an exception to the dispensing limitation when compelling clinical evidence indicates a larger dosage is Medically Necessary and Medically Appropriate for your specific medical circumstances.
    - IF your coverage will be terminating within 90 days, we have the right to limit dispensing to a 30-day supply.
- Home Delivery Program
    - Prescriptions and refills purchased through our specified Home Delivery Program are limited to a 90-day supply rather than a 30-day supply.
    - You will only be charged two Cost-Sharing Amounts for a 90-day supply, rather than three.
    - This arrangement will also be available to any pharmacy that agrees to accept the same reimbursement terms that apply to our Home Delivery Program.
    - Over-the-counter drugs are not available through the Home Delivery Program.
- 90-Day Retail Benefit
    - This Plan offers a 90-day supply of some drugs from a specific subgroup of In-Network retail pharmacies.
        - You can get the names of these pharmacies in your area by visiting our website, www.weatrust.com, or by calling our Customer Service department.
    - A 90-day retail prescription is subject to a Cost-Sharing amount equal to what you would be for three separate 30-day refills of the prescription.
- Specialty Drugs
    - Specialty drugs are prescription medications that require special handling, administration or monitoring. They are used to treat complex, chronic conditions.
    - Some of our health plans have a Tier 4 for certain specialty drugs. With these plans, certain high cost specialty drugs are placed into Tier 4.
        - If this applies to your plan, your Benefit Summary will show cost-sharing information for Tier 4.
        - Our website includes the most current list of Value Drugs and other covered drugs, indicating the tier in which they have been placed. It also includes a separate list of the specialty drugs that are placed into Tier 4, if Tier 4 applies to your plan.
            - We encourage you to share this information with your Health Care Provider so that you can make informed decisions about your treatment and its cost to you.
            - These lists may change frequently, so if you have a question about reimbursement for a certain Prescription Drug, please visit our website at www.weatrust.com.
    - We may require that you receive specialty drugs through our specialty drug program for maximum reimbursement.
    - Specialty drugs are limited to a 30-day supply even through the Home Deliver Program. They are subject to one Cost-Sharing Amount per 30-day supply.
- Prior Authorization and Medical Monitoring
    - We may require that you receive Prior Authorization, or undergo medical review and monitoring, for drugs:
        - With a high potential for drug-related toxicity;
        - For which a step-therapy approach is appropriate; or

        - With unique prescribing or monitoring indications.
    - The list of drugs that meet these criteria is small, but will change frequently with new developments. You can view the most current list on our website at www.weatrust.com.
        - If your Health Care Provider prescribes one of these drugs, the pharmacist at an In-Network pharmacy will inform you before filling the prescription. You can call us to initiate any required review.
        - If you present your prescription at an Out-of-Network pharmacy, you will need to pay for the prescription in advance.
            - You take the risk that we will not reimburse you for the drug because we would have denied a Prior Authorization request.
            - If we do reimburse you, your out-of-pocket costs will be high.
    - Penalties for failing to obtain Prior Authorization when required do not count toward your Maximum Out-of-Pocket Limit.

Cost Sharing and Reimbursement

- You may receive reimbursement of covered Prescription Drug expenses in either of the following ways:
    - You may present your insurance identification card to an In-Network pharmacy and pay the applicable Cost-Sharing Amount, plus any additional cost for brand name drugs. We will then reimburse the pharmacy directly.
    - You may pay the entire cost of a Prescription drug any pharmacy and then submit a Prescription Drug Claim form with the required information. We will then reimbursement you for the appropriate amount.
        - You can get a Prescription Drug claim form by printing it from our website at www.weatrust.com, or by calling our Customer Service Department.
        - We will only reimburse the amount that is charged by an In-Network Pharmacy, minus the applicable Cost-Sharing Amount. If use an Out-of-Network pharmacy, our reimbursement may be much less than you were charged.
- The amount we reimburse and, thus, the amount you must pay for your covered Prescription Drugs depends on three factors:
    - The Cost-Sharing Amounts that apply to your Prescription Drugs. The amounts are different depending on whether you purchase a Value Drug or other drug from Tier 1, Tier 2, Tier 3, or Tier 4 if applicable.
        - You can find the Cost-Sharing Amount for each tier in your Benefit Summary. The specified amount applies separately to each prescription or refill.
    - Whether you select an In-Network or an Out-of-Network pharmacy.
        - We limit reimbursement to the amount charged by an In-Network pharmacy that participates in our Prescription Drug program.
        - You can find the list of In-Network pharmacies in your area on our website at www.weatrust.com, or by calling our Customer Service department.
    - Whether receive a Cost-Effective drug from among the viable alternatives.
        - This Plan limits reimbursement to the most Cost-Effective treatment from among viable alternatives.
        - If you purchase a brand name drug, we may limit reimbursement to the amount charged by an In-Network pharmacy for the FDA-approved generic equivalent drug.
            - If this occurs, you must pay the drug's applicable Cost-Sharing Amount, as well as the difference between the amount the pharmacy charged and the amount of our reimbursement. This usually results in a high out-of-pocket expense.
            - Without appropriate medical documentation, a note from your Health Care Provider on your prescription that a drug must be dispensed as written is not, itself, enough evidence for us to reimburse for that drug.

    - To receive reimbursement, your Health Care Provider must submit to us, and we must approve, an exception request before you fill your prescription.
- If you purchase Prescription Drugs from an Out-of-Network pharmacy, you will be required to pay the full cost of the drug and submit a claim form.
    - You can get a claim form by printing it from our website or by calling our Customer Service department.
    - We will reimburse the amount we would have paid an In-Network pharmacy, minus the applicable Cost-Sharing amount. Your out-of-pocket costs will usually be much higher when you use an Out-of-Network pharmacy.
        - Note: Most Hospital pharmacies are not In-Network pharmacies. If your Health Care Provider gives you a prescription when you leave the Hospital, you may want to go to an In-Network pharmacy to have it filled.

Benefits

Covered

- Drugs required to carry the legend, "Federal law prohibits dispensing without prescription."
- Drugs that may be dispensed only upon a Health Care Provider's written prescription as required by state law.
- Drugs for the treatment of HIV infection.
- Insulin and other Prescription Drugs and medications prescribed for the treatment of diabetes.
- Specified prescription and over-the-counter tobacco cessation aids, as described in the "Medical Benefits" section, "Tobacco Cessation" subsection of this Certificate.

Not Covered

- Drugs and medications that can lawfully be obtained without a prescription, even if your Health Care Provider prescribes them.
    - The only exception to this is an over-the-counter drug that we have determined to be a Cost-Effective, comparably equivalent alternative to a Prescription Drug, and have added it to the Formulary.
    - Such over-the-counter drugs require a prescription from your Health Care Provider.
- Drugs or medications that we deem to be ineffective or marginally effective.
- A drug or medication that has not been proven to be more effective than a less expensive, therapeutically equivalent drug.
- Any drug or medication labeled "Caution – limited by federal law to investigational use."
    - This exclusion does not apply to drugs for the treatment of HIV infection that this Plan is required by law to cover.
- Any drug that has not been approved by the FDA for at least six months for the purpose that your Health Care Provider is prescribing it, or it is otherwise being used.
- Drugs or medications for the treatment of alopecia or hair loss.
    - Examples include, but are not limited to, minoxidil or Rogaine.
- Drugs or medications primarily to improve appearance.
    - This includes all dosage forms of tretinoin (for example, Retin-A) for individuals who are 36 years of age or older, except for the treatment of acute acne.
- Tobacco cessation aids, except for specified prescription and over-the-counter aids as described in this Certificate.
- Drugs or medications prescribed for, or in connection with, weight loss or weight control.
    - Examples include, but are not limited to, Dexedrine and Xenical.
- Drugs or medications prescribed for, or in connection with, infertility or conception.
    - Examples include, but are not limited to, Clomiphene Citrate, Pregnyl and Repronex.
- Drugs or medications for the treatment of impotence or erectile dysfunction.

- Early refills, refills in excess of the number of refills specified by the Health Care Provider, or any refill dispensed after one year from the date of the Health Care Provider's original order.
    - We do not reimburse for early or additional refills if your medications are lost, stolen, damaged, expired, misplaced, missing, or otherwise compromised.
- Drugs or medications provided in connection with any medical service not covered by this Plan.

GENERAL EXCLUSIONS AND LIMITATIONS

We will not pay benefits for any of the following:

General Exclusions and Limitations: Medical

Testing, Services and Procedures

- Experimental/Investigational treatments and services
- Bariatric surgery, including gastric restrictive, bypass, and other similar surgeries, and treatment of any related complications.
    - This exclusion applies regardless of your diagnosis or the reason the surgery was performed.
- Weight loss or weight control programs, services and surgeries for the treatment of obesity, including bariatric surgery.
    - We also exclude coverage for complications that are related to any of these programs, services, treatments or surgeries.
    - This exclusion does not include any weight loss or weight control services that we are required by law to cover.
- Routine Foot Care
    - This exclusion does not apply to Routine Foot Care provided to Members with a confirmed diagnosis of:
        - Diabetes;
        - Peripheral neuropathies (as determined by Us);
        - Arteriosclerosis; or
        - Chronic Thrombophlebitis
- Private duty nursing services.
- Services or equipment to prevent Injury or to help or make physical activity or sports possible.
- Services to prevent Illness, except those services expressly listed in this "Specific Benefit Provisions" section of this Certificate, or that we are otherwise required by law to cover.
- Services or items for physical fitness, wellness, health education or personal hygiene.
- Services to educate you or help you adapt to a diagnosis or a chronic physical or mental condition. Examples include:
    - Stress management classes; and
    - Classes, education and awareness training for individuals suffering from chronic pain.
- In the absence of an Illness or Injury, services to help you improve your existing physical or mental health and sense of wellbeing.
- Services to treat impotence and erectile dysfunction.
- Removal and treatment of skin tags.
- Services for the sole purpose of improving appearance. Examples include, but are not limited to:
    - Services to improve skin appearance;
    - Cosmetic Surgery;
    - Services to treat and/or remove keloids;
    - Services to repair scarring or disfigurement caused by body piercing, tattooing, implants or other services or procedures which were:
        - Not Medically Necessary;
        - Not Medically Appropriate; or
        - Not performed by a licensed medical professional.
- Services for male or female baldness or hair loss regardless of the cause. This includes, but is not limited to:
    - Hair restoration;
    - Hair transplants; and

    - Hair implants.
- Services or supplies intended primarily for convenience or the personal preference of:
    - You;
    - Your Immediate Family;
    - The Health Care Provider; or
    - Any other person.
- Services or interventions that have not been documented as being safe and effective for a specific Illness or Injury.
    - This exclusion applies even if the service or intervention was potentially helpful.
    - Examples include, but are not limited to:
        - Acupuncture;
        - Acupressure;
        - Alternative nutritional therapy;
        - Aromatherapy;
        - Ayurvedic medicine;
        - Bioelectriomagnetic therapy;
        - Biofeedback, unless provided by a physical therapist or a certified mental health or substance use professional to treat headaches or spastic torticollis;
        - Energetic therapy;
        - Guided imagery;
        - Herbal medicine;
        - Hypnosis and hypnotherapy;
        - Homeopathy;
        - Iridology;
        - Light box therapy;
        - Macrobiotics;
        - Manual healing;
        - Meditation;
        - Mind/body control therapy;
        - Naturopathy;
        - Reflexology;
        - Relaxation techniques;
        - Rolfing;
        - Services provided by a massage therapist;
        - Traditional and/or ethnomedicine therapy; and
        - Yoga.
- A medical service that has not been proven to be both safe and effective through:
    - Randomized clinical trials; and
    - Recognition by a significant portion of the medical community that specializes in the relevant medical field.
- Custodial or Long-Term Care.
- Any services you receive after your health condition has Stabilized and you have reached your expected level of improvement or resolution.
- Holistic or homeopathic remedies and preparations.
- Any services you receive as a result or complications resulting from leaving a licensed medical facility against the advice of medical professionals.
- Any services you receive as a result of complications of a non-Covered Service.
- Any services which are not documented in the Provider's records.

Prescription Drugs and Other Equipment, Devices or Items

- Prescription drugs and other devices or items for the treatment of obesity.

- Replacement of Prescription Drugs or medications, orthotics, or equipment that are:
    - Lost;
    - Stolen;
    - Damaged;
    - Misplaced;
    - Missing; or
    - Otherwise compromised.
- Augmentative and/or alternative communicative devices and systems.
- Tobacco cessation aids, except for the specific prescription and over-the-counter aids described in the "Tobacco Cessation Benefits" subsection of this Certificate.
- Enuresis alarms.
- Appliances for snoring.
- Continuous passive motion (CPM) machine.
- Equipment or services to prevent Injury or to help or make physical activity or sports possible.
- Any immunizations you get for the sole purpose of traveling outside of the United States.
- Items or services for physical fitness, wellness, health education or personal hygiene.
- Vitamins.
- Nutritional or diet supplements, except for those we are required by law to cover.
- Prescription Drugs, equipment, devices or other items to treat impotence and erectile dysfunction.
- Drugs and injections for male or female baldness or hair loss regardless of the cause. This includes, but is not limited to:
    - Hair restoration;
    - Hair transplants; and
    - Hair implants.
- Holistic or homeopathic remedies and preparations.
- Any supplies or equipment you can purchase over-the-counter without a prescription. This includes, but is not limited to, items such as gauze, bandages and tape.

Therapies

- Vocational rehabilitation, including work-hardening programs.
- Gene therapies, treatments or enhancements.
    - While we never reimburse for gene therapies, treatments or enhancements, we reimburse for the Genetic Testing and/or genetic counseling described in the "Genetic Testing/Counseling" subsection of this Certificate.

General Exclusions and Limitations: Non-Medical

Appointments and Other Types of Visits

- Missed appointments.
- Office Visits, Physician charges, or any other service for or connected to a procedure or service that this Policy does not cover.
    - This exclusion applies even if you were not covered under this Policy when the noncovered procedure or service was performed.
    - This exclusion includes, but is not limited to:
        - Follow-up Physician and/or Surgeon visits;
        - Diagnostic tests which are primarily related to (or only necessary because) of a noncovered procedure or service;
        - Services to treat or resolve complications caused by a noncovered procedure or service;
        - Services or procedures to repair a failed noncovered procedure or service;
        - Services to repair scarring caused by a noncovered procedure, service or surgery;

        - Home health care required as a result of a noncovered procedure or service.
    - This exclusion does not apply when reimbursement is otherwise required by law.
- Charges related to the supervision of laboratory services that do not involve written consultation by a Health Care Practitioner including, but not limited to, laboratory interpretation.

Services, Treatments and/or Supplies

- Charges for which Our liability cannot be determined because a Covered Person, Health Care Practitioner, facility or other individual or entity within 30 days of Our request, failed to:
    - Authorize the release of all medical records to Us and other information We requested.
    - Provide Us with information We requested about pending Claims or other insurance coverage.
- Services that are for treatment of complications arising from non-Covered Services
- Legal Services
- Copying and providing medical or any other type of information in support of a Claim.
- Prescription Drugs and medications for Members who are eligible to enroll in the Medicare Part D program, regardless of whether they enroll. This exclusion does not apply to the following individuals, or in the following situations:
    - Employees who are covered Dependents.
    - Members who are covered by our standard Family plan.
    - Members who are covered under state or federal continuation (COBRA) coverage, unless they choose to waive Prescription Drug coverage under this Policy.
    - Any Member for whom we are the primary payer according to Medicare Secondary Payer rules.
    - Any Prescription Drugs or medications that we are required by law to cover for all Members, including Members who are eligible to enroll in the Medicare Part D program.
- Services or items that are provided for free or for which you are not legally obligated to pay if you don't have insurance.
- Services that a child's school is legally obligated to provide. This exclusion applies regardless of whether the school actually provides the, and whether you choose to use those services.
- Unless we are required by law to pay for them, services or items furnished or paid for by a governmental entity, facility, or program other than Medicaid.
- Services or items required by a third party. This includes, but is not limited to, services required for the purposes of insurance, employment or special licensing.
- Court-ordered treatment, unless:
    - It meets our criteria for Medical Necessity, Medical Appropriateness and Cost-Effectiveness;
    - It is otherwise covered under this Policy; or
    - We are required by law to cover it.
- Services or treatment for a medical condition that arose from, or originated during, service in the armed forces.
- Services or treatment for an Injury or Illness that resulted from participation in a crime.
- Non-emergency services you receive while you are outside the United States.
- Services ordered, directed, performed or provided to you by an Immediate Family member.
- Services or treatment eligible for worker's compensation benefits, or benefits from any other payment program established by a similar law.
    - This exclusion applies whether you apply for or receive worker's compensation or similar benefits.
    - This includes amounts received when a Claim under worker's compensation or similar law is settled by stipulation or compromise.

Charges and Expenses

- Travel and lodging.
- Charges or costs exceeding a benefit maximum or Maximum Allowable Fee, where applicable.
- Charges or costs for services you received while you were not covered under this Policy.

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

General

In this section, you will find information on who is eligible for coverage under this Plan, and when Members can be added to your coverage. Eligibility requirements are described in general terms below. Your Employer determines the class of Eligible Employees as well as any waiting period for coverage.

Employee Eligibility

An employee is eligible for Coverage if all the following apply:

- You are an employee;
- You are entitled to participate in the benefit Plan arranged by the Group;
- You have satisfied any probationary or waiting period; and
- You have submitted a completed enrollment form within 30 days of becoming eligible for coverage.

Dependent Eligibility

An employee eligible for and enrolled in this Plan may choose to enroll the following Dependents:

- The employee's legal spouse.
- The employee's or Dependent spouse's biological child, legally adopted child, or stepchild who is under the age of 26.
- A child for whom the employee or Dependent spouse is a legal guardian or as otherwise required by law.
- A child for whom the employee or Dependent spouse has a Qualified Medical Child Support Order (QMCSO).
- A Dependent child's child (ie. grandchild of employee or spouse) until the Dependent child turns 18 or marries, whichever occurs first.
- An unmarried disabled child age 26 or older whom meets all of the following circumstances:
    - S/He is permanently mentally or physically disabled.
    - S/He is incapable of self-sustaining employment.
    - S/He is chiefly Dependent on the employee or Dependent spouse for at least 50% of support.
        - You must provide written documentation that the above-listed criteria are met within 31 days of the date that your Dependent is initially eligible to enroll or within 31 days of that date s/he reaches the age of 26. We may request, and you must provide, documentation of continued disability at any time during the 2 years following the initial eligibility date. Thereafter, you may be required to provide proof of continued disability on an annual basis.
- A child who is age 26 or older, a full-time student and meets all of the following circumstances:
    - Was called to active duty in the National Guard or in a reserve component of the United States armed forces prior to age 27 while s/he was a full-time student.
    - Returns to full-time student status within 12 months of completing the active duty obligation.
    - Remains a full-time student.
        - We may require you to provide documentation of continued full-time student status for any enrolled child as frequently as every 6 months. Your failure to give this information could result in termination of a child's coverage.

Initial Enrollment and Effective Dates

Employees eligible for coverage must submit a completed enrollment form within 30 days of becoming eligible for coverage under this Plan. Failure to timely submit an enrollment form will result in your coverage and effective

date being covered by the Late Enrollees provisions below. When an enrollment form is received timely, the effective date of the Plan is as follows:

- Current Active Employees at Plan Effective Date
    - The effective date of coverage will be the date the Plan is effective for the employer.
- Newly Hired Employees
    - The date you complete any waiting period (not to exceed 90 days) specified by your employer.
    - If your employer has no waiting period for benefits, the date you begin the active performance of your regular job duties.

Late Enrollees

If the Employee waives or declines coverage or otherwise fails to enroll themselves and/or their Dependents when initially eligible or within the appropriate time period during a Special Enrollment period, they will not be eligible to enroll until the next Open Enrollment Period.

Open Enrollment Period

Open Enrollment refers to a period of time, usually 60 days, during which Eligible Employees and Dependents can apply for or change coverage. Open Enrollment occurs only once per year. The Group will notify you when Open Enrollment is available.

Special Enrollment Periods

If an Employee or Dependent does not enroll in coverage when initially eligible, they may be able to join the Plan prior to Open Enrollment if they qualify for Special Enrollment. Except as noted otherwise below, the Subscriber or Dependent must submit a completed enrollment form requesting Special Enrollment within 31 days of a qualifying event. The Effective Date of coverage when enrolling during a Special Enrollment Period will be the date of the event triggering the availability of Special Enrollment.

Special Enrollment is available for eligible individuals who:

- Lost eligibility under a prior health Plan for reasons other than non-payment of Premium or due to fraud or intentional misrepresentation of a material fact.
- Exhaustion of COBRA continuation coverage.
- Lost employer contributions towards the cost of the other coverage.
- Are now eligible for coverage due to marriage, birth, adoption, or placement for adoption.
- Loss of eligibility for coverage under Medicaid or BadgerCare.
    - Enrollment forms requesting Special Enrollment due to the above listed circumstance must be received within 60 days of the loss of coverage.
- Are newly eligible for Wisconsin's Premium assistance subsidy under Medicaid or BadgerCare.
    - Enrollment forms requesting Special Enrollment due to the above listed circumstance must be received within 60 days of the date you become eligible for Premium assistance.

Enrolling Dependent Children: Newborn Children

Newborn children are covered automatically from the moment of birth. Following the birth of a child, you should submit an enrollment form within 60 days to add the newborn to your Plan.

- Failure to enroll a newborn within 60 days as well as submit any additional Premium that may be due, if switching from single coverage to Family coverage, may result in a refusal to provide coverage, unless notification is later received within one year of birth along with payment of past due Premiums, plus interest as permitted by law.

Enrolling Dependent Children: Adopted Children

A newly adopted child is eligible for coverage on the earlier of these dates:

- The date that a court makes a final order granting adoption.
- The date that a child is legal placed with you for adoption.

The Effective Date for an adopted child will be the date of the adoption or placement for adoption if you send us the completed enrollment form within 60 days of the event.

Legal Custody or Guardianship

A child becomes eligible for coverage on the date an award of legal custody or guardianship for a child to a Subscriber or Dependent Spouse is issued. Coverage will be effective on the date the court granted legal custody or provided a completed enrollment is submitted within 31 days of the date legal custody or guardianship is awarded by the court.

Qualified Medical Child Support Order

In the event a Subscriber or Dependent Spouse is required by a Qualified Medical Child Support Order or other court order, as defined by ERISA and/or applicable state or federal law, to enroll a child in this Plan, we will permit the child to be enrolled at any time without regard to any Open Enrollment or Special Enrollment limits and will provide the benefits of this Plan according to the applicable requirements of such order.

- A completed enrollment form as well as a copy of the Order must be submitted.
- The Effective date of coverage will be the date specified in the court order.
- Coverage under this provision will be provided so long as:
  - The Employee or Dependent Spouse remain covered under the Plan;
  - The court order remains in effect;
  - The child is not covered under another group or individual policy that provides comparable coverage;
  - The child continues to meet the criteria as an eligible Dependent under the Plan

Duty to Provide Information

The Subscriber is required to provide the information we need to accurately determine eligibility and to notify the Plan of any changes that affect his/her eligibility or the eligibility of their Dependents for this Plan.

You must notify us immediately when one of your covered Dependents is no longer eligible for coverage.

When any of the following occurs, contact the Plan and complete the appropriate forms:

- Changes in address;
- Marriage or divorce;
- Death of an enrolled Family Member (a different type of coverage may be necessary);
- Enrollment in another health plan or in Medicare;

- Eligibility for Medicare;
- Dependent child reaching the Dependent Age Limit;
- Enrolled Dependent child either becomes totally or permanently Disabled, or is no longer Disabled.

Failure to notify us of individuals no longer eligible for services will not obligate us to cover such services, even if Premium is received for those individuals. All notifications must be in writing and on approved forms.

The Subscriber must provide evidence of eligibility of Dependents upon request by the Plan. Failure to provide such evidence either when your Dependent is no longer eligible or when requested is considered intentional material misrepresentation. Failure to provide evidence of eligibility may result in the termination of coverage for the Dependent. Such termination may be retroactive to the date the Dependent became ineligible for coverage under the Plan pursuant to applicable Department of Labor regulations, depending on the facts and circumstances. In the event your Dependent's coverage is terminated retroactive to the date of ineligibility, you have the right to submit a Grievance under the Grievance provisions of this Certificate below. Per the Grievance provisions, the Committee will review the facts and circumstances surrounding the ineligibility and the information that you were required to provide.

Termination of Coverage

Coverage for the Subscriber and any Dependents will end at 11:59 p.m. on the earliest of the following dates:

- The date this Plan terminates for the Employer for any reason.

- The end of the period for which the last Premium was paid in full..

- When Subscriber or any Dependent enters the military forces of any state or country, including the United States, on active duty or as a Member of a reserve unit of the armed forces for at least 30 consecutive days, coverage will end on the last day of the month.

- The last day of the month in which Subscriber ceases to be a Member of the class of Eligible Employees specified by Employer on the Agreement for coverage under this Plan. For example, a change in job duties or in the number of hours worked that renders Subscriber ineligible for coverage.

- The last day of the month in which Subscriber's occupational group ceases to be part of the class of Eligible Employees specified by Employer on the Agreement as being part of an insured group.

- The last day of the month in which Subscriber becomes ineligible because of the termination of employment, whether voluntary or involuntary.

- The date on which Subscriber fails to comply with any provision of this Certificate.

- The date of Subscriber's death.

- In the event of the death of Subscriber, coverage for Dependents will end on the last day of the month of Subscriber's death.

- In the case that divorce or annulment of marriage terminates the spousal relationship, coverage for the Dependent Spouse will terminate on the last day of the month in which the divorce or annulment is final.

- The last day of the month in which a Dependent child no longer meets the criteria to be covered under this Plan.

- Coverage will terminate for any Dependent as of the date of their death.

- When the Subscriber provides written notice requesting termination of coverage, the coverage will end on the last day of the month notice was received or the last day of the month in which Subscriber requests coverage to terminate, whichever is later.

Coverage Ending Due to Fraud or Intentional Misrepresentation

If we find that Subscriber or Employer, as it pertains to Subscriber or any Dependents, has performed an act, practice, or omission that constitutes fraud or intentional misrepresentation of fact, we have the right to terminate coverage and the termination may be retroactive. This includes knowingly providing incorrect information regarding the Subscriber or Dependents eligibility for coverage. When this happens, we will provide you with a 30-day advance written notice of the termination. Coverage will end on the date we specify in the notice, which may be retroactive pursuant to Department of Labor regulations and in accordance with other provisions in this Certificate.

Continuation of Coverage

When coverage ends, Subscriber and covered Dependents, may be eligible to continue coverage under the employer sponsored Plan under Federal COBRA or USERRA laws and/or Wisconsin continuation law. These laws provide the option to extend coverage under the Employer's Plan, at your own expense, after your eligibility ends. Contact the Employer if you have questions related to state and federal continuation coverage, and/or eligibility for such coverage.

You may also be able to get less expensive coverage through the Federally-Facilitated Marketplace (FFM), or any entity that replaces the FFM. For more information on the FFM, visit www.HealthCare.gov or call 1-800-318-2596 (TTY 711).

COBRA Continuation

If the Employer is subject to the requirements of COBRA, continuation coverage may be available to Employee and/or Dependents if a designated "qualifying event" has occurred. The duration of COBRA coverage is governed by Federal Law and will vary based upon your coverage class and the "qualifying event" leading to the loss of coverage. Individuals electing coverage under COBRA are responsible for payment of the Premium associated with this coverage.

For additional information about your rights, eligibility and responsibilities related to continuation coverage under COBRA contact the Employer.

Wisconsin Continuation

Wisconsin Law provides continuation rights, of up to 18 months, to Subscriber and/or covered Dependents if the individual was covered under the Plan for a period of at least three months and coverage is terminated due to one of the below listed circumstances.

- Termination of employment other than gross misconduct.
- Reduction in work hours.
- Death of Employee.
- Divorce or Annulment of marriage.

Employer must provide written notice of the right to continuation within five days of the termination of coverage. Subscriber and/or Dependents must elect continuation of coverage within 30 days of receiving this notice. Subscriber and/or Dependent is responsible for payment of the Premium associated with this coverage.

For more information regarding this Wisconsin law, please see www.oci.wi.gov/pub_list/pi-023.pdf.

USERRA Continuation

USERRA grants rights to individuals who take a leave of absence for service in the armed forces of the United States, including Reserve services. USERRA provides a Subscriber the right to elect to continue employer sponsored coverage for up to 24 months during a period of an armed forces leave of absence. A Subscriber's electing coverage under USERRA is responsible for payment of the Premium associated with this coverage.

****UNDER CIRCUMSTANCES IN WHICH MORE THAN ONE CONTINUATION PROVISION (COBRA/WISCONSIN CONTINUATION/USERRA) APPLY, AN ELECTION FOR CONTINUATION COVERAGE WILL BE TREATED AS AN ELECTION TO TAKE CONCURRENT COVERAGE (to the extent possible).**

CLAIMS PROCEDURES

To receive reimbursement, you must send us within 90 days a written Claim and proof that you have incurred a covered loss. Wisconsin law extends this period to 12 months beyond the 90 days required by this Certificate, but only if we are not prejudiced by the delay and it was not reasonably possible for you to meet our 90-day limit. You can get Claim forms from your employer or from us. The identification card we issue you after enrollment gives the address to which Claims must be submitted.

Most Health Care Providers submit Claims as a service to their patients. We are happy to accept Network provider-submitted Claims that meet industry-accepted standards, and this will fulfill your obligation if the Claim contains all the information, we need to evaluate it. We reserve the right to require that you submit Claims for services from Out-of-Network Providers that satisfy our requirement to prove that you have incurred a covered loss. We also may, at our discretion, pay you for Covered Services rendered by Out-of-Network Providers, and you must in turn pay the Out-of-Network Provider.

Claim for Health Care Services

Your Claim must include this information:

- The name and address of the covered employee.
- The employer's group number (this is listed on your insurance identification card).
- The patient's name, address, date of birth, and Subscriber number. The Subscriber number is listed on your insurance identification card.
- The name of the primary insurer, if other than the WEA Trust Health Plan.
- Information regarding any other group insurance coverage.
- The Health Care Provider's name, complete address, telephone number, federal tax identification number, and national provider identifier.
- The name and telephone number of the individual practitioner who performed the service(s).
- The place and date of service or, for Hospital Claims, admission and discharge dates.
- The patient's diagnosis and the appropriate procedure or billing code for each service received by the patient, with an itemization of charges for each service.

We rely on medical documentation to determine if procedure or billing codes for services reported and billed by a Health Care Provider are appropriate. If the documentation indicates another code is more appropriate, we have the right to base our reimbursement on the service(s) supported by the documentation. We also have the right to deny charges for services that are billed inconsistently with industry-accepted coding standards.

Claim for Prescription Drugs

If your health plan includes Prescription Drug coverage, you may receive reimbursement of covered Prescription Drug expenses in either of two ways:

1. You may present your insurance identification card to an In-Network pharmacy and pay the applicable Coinsurance or Copayment amount plus any additional cost for brand name drugs. We will then reimburse the pharmacy directly.

2. You may pay the entire cost of a Prescription Drug at any pharmacy and then submit a Prescription Drug Claim form with the required information. We will then reimburse you for the appropriate amount. You can obtain Prescription Drug Claim forms from your employer or from us. Remember, we reimburse only the amount that is charged us by an In-Network pharmacy, less the applicable Coinsurance or Copayment amount. If you use an Out-of-Network pharmacy, our reimbursement to you may be significantly less than you were charged. **Note:** Most Hospital pharmacies are not In-Network pharmacies. If your Physician gives you a prescription when you leave the Hospital, you may want to go to an In-Network pharmacy to have it filled.

Proof of Loss

You must provide both satisfactory proof that you have incurred a covered loss and the information that we need to calculate your benefits. In many cases, your Claim form provides that proof. In other cases, we require additional medical documentation that any services you received fulfill our criteria for coverage. Whenever we have questions about whether a Claim meets our criteria for coverage and whether reimbursement limits apply, we rely on objective, contemporaneous medical documentation and records and the advice of our medical consultants. When your Claim involves services to treat an Injury, we require documentation about the details of your Injury. We assist you in any way we can, but you are responsible for obtaining and providing this information.

Some medical providers charge for copying and/or submitting medical documentation. We do not pay or reimburse any fees charged for providing information, so you must pay any costs incurred.

We have the right to require that you be examined by a health care professional of our choice whenever it is necessary to establish proof of loss and evaluate a Claim. When we do so, we pay the cost of the examination.

How and When Claims Will Be Paid

We pay benefits within 30 days after we receive a Claim and the required proof of loss. We reimburse the Network Health Care Providers from whom you received the services. We also may, at our discretion, pay you for Covered Services rendered by Out-of-Network Providers, and you must in turn pay the Out-of-Network Provider.

If a benefit is payable to your estate or to a beneficiary not competent to give a valid release, we may pay the benefit to whomever we consider to be legally entitled.

Our Right of Review and Recoupment

We review Claims both before and after payment. Whenever we find that any information is fraudulent, misleading, inaccurate, or incomplete, we have the right to reevaluate and retroactively modify our Claim payment. We have this right regardless of whether we have paid some or all of the Claim.

If we pay benefits that exceed those you're entitled to, you must repay the excess as soon as we notify you of the overpayment. We may, at our option, recover some or all of the overpayment by reducing subsequent benefits payable or by applying Premium refunds due you. We have the right to charge reasonable interest on the delinquent amount.

If and when the Plan determines that benefit payments under the Plan have been made erroneously but in good faith, the Plan reserves the right to seek recovery of such benefit payments from the Provider of services to whom such payments were made. The Plan reserves the right to offset subsequent benefit payments otherwise available to the Provider by the amount of any such overpayments.

If benefits are paid under this Certificate and you or your covered Dependent receives worker's compensation benefits through settlement, compromise, judgment, award, or other arrangement, you must repay us promptly. If you do not, we may recover some or all of the amount owed us by reducing subsequent benefits payable, by filing suit against you, or by taking lesser legal action.

This Certificate also obligates you to cooperate with us in our attempts to recover payments we have made on your behalf when we determine that you are eligible for, or have received, worker's compensation benefits. This means that you will make no settlement or agreement with any party that prejudices our right to recovery.

If we pay benefits that exceed those you're entitled to under this Certificate, we have the right to recover some or all of the overpayment, regardless of whether you have made a Claim for worker's compensation benefits (provided we have a reasonable basis for our determination that you are eligible for worker's compensation benefits), whether the worker's compensation insurer disputes your Claim for benefits, and regardless of how the settlement or agreement characterizes your compensation from the worker's compensation insurer.

COORDINATION OF BENEFITS

Applicability

The provisions of this section apply when the Member has healthcare coverage under more than one Benefit Plan.

- A Member is considered to have healthcare coverage from another Benefit Plan if coverage is available from any of the following:
    - Group insurance or group-type coverage, whether insured or uninsured, that provides continuous 24-hour coverage. This includes any type of health maintenance organization, individual practice association, prepaid group practice, preferred provider organizations, or other prepayment, group practice, or individual practice plans.
    - Labor-management trusteed plans, union welfare plans, employer organization plans, and employee benefit plans.
    - Medical benefits coverage in group, group-type, and individual automobile "no-fault" contracts and in group or group-type automobile "fault" contracts.
    - Coverage under any governmental plan or program, including Medicare, and any coverage that is required or provided by law, including coverage provided under no-fault and uninsured motorist statutes. This does not include a plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act) or a law or plan whose benefits, by law, are excess to any private insurance plan or other nongovernment plan.
    - Eligibility for coverage under Medicare, whether or not you apply for or receive Medicare benefits.
        - If you are eligible for Medicare Parts A and B and Medicare would be your primary insurer, but you have not enrolled, we will estimate what Medicare would have paid and coordinate benefits available under this Plan accordingly.
        - If Medicare is primary and you seek care from a provider who does not accept Medicare, we will estimate what Medicare would have paid an In-Network Provider and coordinate benefits available under this Plan accordingly.
        - When we coordinate benefits with Medicare, we follow all Medicare rules, including the adoption of Medicare's maximum charge as to the allowable expense.
- When a Member is covered by more than one Benefit Plan the rules noted in the Order of Benefit Determination Rules section below, will establish which plan is considered primary and will pay benefits first.
    - When this Benefit Plan is considered secondary, the benefits under this Certificate are determined after those of the other Plan and may be reduced because of the primary plan's benefits.
    - When this Benefit Plan is considered primary, the benefits available under this Certificate are determined before those of any other Benefit Plan and without considering the other plan's benefits.

Order of Benefit Determination Rules

This section outlines the Order of Benefit Determination Rules that will be followed.

General Rules

- In the event the other Plan does not have a coordination of benefits provision, it will be primary and the benefits available under this Certificate will be secondary.

- The Plan that covers an individual as an employee, Member, or Subscriber is primary.

    - If a Member is covered by more than one Plan as an employee, Member or Subscriber than the Plan with the earlier effective date is primary.

    - The Plan that covers an individual as a Dependent is secondary.

- The Plan that covers an individual as an employee who is neither laid off nor retired or as that employee's Dependent are primary to a Plan that covers a person as a laid-off or retired employee or as that employee's Dependent.

    - If the other Plan in question does not have this rule so that the Plans order of benefit determinations do not agree, this rule will be ignored.

- If an individual has continuation coverage provided pursuant to federal or state law and is also covered by another Plan, the Plan that covers the individual as an employee, Member, or Subscriber or as the Dependent of such individual will be primary.

- If none of the above rules determines the order of benefits, the Plan that covered the individual for the longer period of time will be primary.

Dependent Child/Parents Married, Not Separated or Divorced

- When a Dependent child is covered as a Dependent of both married persons who are parents of the Dependent which Plan is determined to be primary is as follows:

    - The Plan of the parent whose birthday falls earlier in the Calendar Year is primary.

    - In the event both parents have the same birthday, the Plan that covered a parent for the longer period of time is primary.

    - In the event the other Plan does not follow the above noted birthday rule, and instead uses a rule based on gender of the parent, the rule based on gender will determine the order of benefits.

Dependent Child/Non-Married, Separated or Divorced Parents

- When two or more Plans cover a child of divorced or legally separated parents, benefits for the child will be determined in this order:

    - First, the Plan of the custodial parent.

    - Then, the Plan of the Spouse of the parent with the custody of the child; and

- Finally, the Plan of the noncustodial parent.

- In the event a court decree states that parents share joint custody but does not identify which parent is responsible for healthcare coverage, the order of benefits will be determined as if the parents were married utilizing the birthday rule stated above.

- If the specific terms of a court decree state which parent is responsible to provide healthcare coverage, the Plan of the specified parent will be primary.

Coordinating Benefits with Medicare

This Plan will coordinate benefits with Medicare when a Member becomes eligible for Medicare benefits, including benefits under Medicare Part D, as required by Medicare Secondary Payer regulations. Payment under this Benefit Plan and the payment made by Medicare will never be more than the Maximum Allowable Amount. All Cost Sharing Amounts and exclusions apply to all benefits paid under this Benefit Plan.

If you are eligible for Medicare Part A and B but have not enrolled in that coverage, this Plan will estimate what Medicare would have paid an In-Network Provider and coordinate benefits available under this Plan accordingly.

When this Plan is Primary to Medicare

- The Employer has 20 or more employees
- The covered individual has End Stage Renal Disease and is in the first 30 months of treatment
- The covered individual is Disabled and the Employer has more than 100 employees

When Medicare is Primary

- The Employer has less than 20 employees
- You are retired
- A covered individual with End Stage Renal Disease and has more than 30 months of treatment
- A covered individual is Disabled and the Employer has less than 100 employees

Effect on Benefits when this Plan is Secondary

If this Plan is the Primary Plan, according to the Order of Benefit Determination provision, this Plan will pay benefits that would have been paid under this Plan without regard to this Coordination of Benefits provision.

If this Plan is the Secondary Plan, according to the Order of Benefit Determination provision, this Plan will pay the lesser of:

- The difference between the Maximum Allowable Fee and the amount paid by the Primary Plan; or

- Benefits that would have been paid under this Plan without regard to this Coordination of Benefits section.

When this Plan is the Secondary Plan, the benefits payable under this Plan will be reduced to the extent necessary so that when those benefit payments are added to the benefits payable under all other Plans, they do not exceed the total Maximum Allowable Fee for any services or equipment.

Rights Under this Section

This Plan has the right to:

- Release or obtain Claim information from any Benefit Plan, individual or entity.

- Pay benefits to any other Benefit Plan or entity which has paid benefits which should have been paid by this Plan.

- Recover any overpayment made by this Plan from the person or entity to whom the payment was made.

We may obtain or release any information needed to carry out the intent of this section. You must inform us if you or your covered Dependents have coverage under any other Benefit Plan(s) when the covered individual makes a Claim.

COMPLAINTS, GRIEVANCES, AND APPEALS PROCEDURES

Complaint and Grievance Procedures

You have the right to a full and fair review of any Complaints you may have about your Claims or how we administer your benefits.

This section explains your rights to ask us to explain our decisions regarding your Claims, as well as make Complaints and appeal adverse determinations.

Right to Information and an Explanation of Benefits

If you have questions about your benefits or how to get maximum reimbursement for your health care services, you may call and/or visit with a customer service representative. A customer service representative can provide you with additional information and answer any questions you may have.

After you receive health care services, your provider will submit a Claim for benefits. After we process that Claim, we will send you an Explanation of Benefits (EOB) form. The EOB form will contain the following information:

- How much the provider charged.
- How much we paid.
- Any amount that you are responsible for paying.
- The reason for any amount you have to pay.

If you have questions about your EOB form or how we determined your benefits, or if you have a Complaint, you may call us and talk with one of our customer service representatives.

Questions or Complaints

Many questions or Complaints about benefits and Claims payments can be resolved informally by contacting our customer service department.

If you are still dissatisfied after raising your question or Complaint with our customer service department, we encourage you to call our Grievance/Appeal Manager. You can reach the Grievance Appeal Manager at (800) 279-4000 (TTY 711).

He or she will promptly investigate your Complaint and keep you informed about the progress of the investigation. If we are unable to resolve your Complaint informally, you have the right to file a formal Grievance.

Filing a Grievance

If our dispute resolution specialist cannot resolve your Complaint to your satisfaction, you have the right to file a Grievance.

We have two Grievance procedures, one for standard Grievances and one for Expedited Grievances. Both generally follow the same steps and afford you the same rights. The main difference between them is the timeline within which we reach a decision. Both procedures are summarized below. If you would like more information about either Grievance procedure, you may request a copy of our detailed description.

Note: In certain limited circumstances, you can request an External Review before you have exhausted the internal Grievance process. When necessary due to an urgent medical condition, you can file an Expedited Grievance and request an Expedited External Review at the same time. For more information, please see the Expedited External Review Procedure section below.

Standard Grievance Procedure

Filing a Grievance: You or your Authorized Representative can file a Grievance in any written format, such as a signed form or letter, that includes the following information:

- The Member's name, Member number and contact information;
- A description of why you are dissatisfied;
- Any information you think is relevant, such as:
    - Provider names;
    - Dates of service; and
    - A chronological description of events.
- What you believe to be a fair resolution of your Grievance.
- Copies of any documents related to your Grievance.

Send your signed Grievance and any supporting documents to the following address:

Grievance/Appeal Manager
WEA Trust Health Plan
P.O. Box 21538
Eagan, MN 55121

We will mail you an acknowledgement letter within five (5) business days of receiving your Grievance.

Initial Review: As soon as is reasonably possible, our Grievance/Appeal Manager will review your Grievance. He or she will investigate any new information you have provided, and will consider your proposed resolution in the context of the Plan's applicable terms, conditions and provisions. If the Grievance/Appeal Manager agrees with your proposed resolution, he or she will notify you by phone and then mail you a confirmation letter.

Grievance Committee: If the Grievance/Appeal Manager is unable to resolve your Grievance, it will go to the Grievance Committee for review. While not required, you have the right to attend the Grievance Committee meeting in person or via telephone. You can also have someone else represent you in the meeting. If necessary, we will make reasonable accommodations to allow you and/or your representative to participate.
At least seven (7) calendar days in advance, we will notify you in writing of the Grievance Committee meeting date, time and location. Before or during the Grievance Committee meeting, you have the right to present any of the following for the committee to consider:

- Written comments or questions;
- Documents;
- Records;
- Evidence;
- Testimony; and
- Other information related to your Grievance.

The Grievance Committee will review all of the information and documentation you have provided and inform you in writing of its decision. If the Committee believes that WEA Trust Health Plan did not reasonably handle your Complaint according to the Plan's terms and the known facts, it will issue instructions for corrective action.

Decision Timeframe: We will make every effort to resolve your Grievance and notify you in writing within thirty (30) calendar days from the date we receive your Grievance. However, if we are unable resolve your Grievance within thirty (30) calendar days, we may extend the decision timeframe for up to another thirty (30) calendar days. If that happens, we will notify you in writing of the reason we need an extension and the date by which we will make a decision.

Expedited Grievance Procedure

Expedited Grievance Criteria: There may be times, when necessary due to an urgent medical need, you may need a faster response to your Grievance. When that happens, you can file a Grievance and request that it be expedited.

You can request an Expedited Grievance when any of the following are true:

- The length of time it normally takes to resolve a Grievance would result in serious jeopardy to your life or health, or would limit your ability to regain maximum function.
- Your Physician requests the expedited process because your pain is too severe to be adequately managed without the care or treatment you are requesting.
- Your Physician determines the Grievance should be treated as an Expedited Grievance.

When we, or someone on our behalf, are deciding whether a Grievance should be expedited, the decision is made by someone who is applying the judgment of a prudent layperson who possess an average knowledge of health and medicine.

If your Grievance is urgent and meets the criteria to be treated as an Expedited Grievance, we will investigate it as quickly as your health condition requires. See the "Definitions" section of this Certificate for more information about what qualifies as an Expedited Grievance.

Filing an Expedited Grievance: You, your Authorized Representative or Physician can file an Expedited Grievance orally by calling us at (800) 279-4000 (TTY 711). You can also file it in writing but calling us will ensure a faster investigation and resolution.

Decision Timeframe: We will investigate, review and resolve your Expedited Grievance within 72 hours of receiving it. Our Grievance/Appeal Manager will then call to inform you of our decision and also mail you a written copy of our decision letter.

Adverse Benefit Determination

A Grievance that involves an Adverse Benefit Determination is also known as an Appeal. The Standard and Expedited Grievance procedures described above apply to Appeals, as well as the following additional rules.

- After you have received an Adverse Benefit Determination, you have 180 days to submit an Appeal.

- You can to request access to, and copies of, all documents, records, and other information relevant to your Appeal. We must provide these copies to you free of charge.

- You can ask us to identify any medical or vocational expert that we consulted when making our initial Adverse Benefit Determination, regardless of whether we relied upon the advice when we made our decision.

- If your Appeal is wholly or partially based on medical judgment, the Grievance Committee will consult with a health care professional who has appropriate training and experience in the medical field involved in the medical judgment.
    - The health care professional will not be someone consulted while we were making our initial decision, nor the subordinate of such a person.
    - Decisions based on medical judgment include, but are not limited to, whether a particular treatment, drug or other item is Experimental, Investigational, Medically Necessary or Appropriate.

- The Grievance Committee reviewing your Appeal will not include anyone who:
    - Made the initial Adverse Benefit Determination; or

- Is a subordinate of any person who made the initial Adverse Benefit Determination.

- The Grievance Committee will take into account all comments, documents, records and other information you submit with your Appeal. We will do this regardless of whether we considered this information when we made our initial decision.

- Your Appeal will be decided in a way that is designed to ensure the independence and impartiality of the people making the decision.
  - This means that we cannot make employment-related decisions for the people on the Grievance Committee based on the likelihood that they will support benefit denials.
    - Employment-related decisions include hiring, compensation, termination, promotion, or other similar matters.

- Before we resolve your Appeal and make a Final Adverse Benefit Determination based on new or additional rationale, we will, free of charge, inform you of that rationale.
  - We will send you this rationale as soon as possible, with enough time to give you a reasonable opportunity to respond before we must make a decision.
  - After you have had the opportunity to respond, we must notify you of our decision as quickly as is reasonable for your health condition.

- We will notify you of our decision as soon as possible, but no later than the following timeframes:
  - For a Pre-Service Claim, we will notify you in writing within thirty (30) calendar days after the date we receive your Appeal.
  - For a Post-Service Claim, we will make every effort to resolve your Appeal and notify you in writing within thirty (30) calendar days after the date we receive your Appeal.
    - However, if we are unable to resolve your Appeal within thirty (30) calendar days, we may extend the decision timeframe for up to another thirty (30) calendar days.
    - If that happens, we will notify you in writing of the reason we need an extension and the date by which we will make a decision.

For an Urgent Care Claim, we will notify you via telephone no later than 72 hours after we receive your Appeal. We will then mail you a written copy of our decision letter

Requesting an Independent External Review

If you are not satisfied with how your Grievance or Appeal was resolved, you may have the right to seek an independent External Review. There are two types of decisions that can be eligible for External Review, an initial Adverse Benefit Determination and a Final Adverse Benefit Determination.

There are two External Review procedures, one for standard External Review and one for Expedited External Review. Both procedures are summarized below. If you would like more information about either External Review procedure, you may request a copy of our detailed description.

Note: In certain limited circumstances, you can request an External Review before you have exhausted the internal Grievance process. When necessary due to an urgent medical condition, you can file an Expedited Grievance and request an Expedited External Review at the same time. For more information, please see the Expedited External Review Procedure section below.

External Review Criteria: You or your Authorized Representative can request an External Review when:

- The benefit at issue is otherwise covered under the Plan;
  -AND-
- The Adverse Benefit Determination or Final Adverse Benefit Determination was based on either of the following:

- The use of medical judgment, including, but is not limited, to decisions about:
  - Medical Necessity and Medical Appropriateness;
  - Health care setting;
  - Level of care;
  - Effectiveness of a covered benefit;
  - A determination that a treatment is Experimental or Investigational;
  - A determination of whether a Member is entitled to a reasonable alternative standard for a reward under a wellness program; or
  - A determination of whether the Plan is complying with the nonquantitative treatment limitation requirements under federal mental health parity rules that require parity in the application of medical management techniques;
- A Rescission of coverage, regardless of whether the Rescission had any effect on a particular benefit at the time the Rescission occurred.

-AND-

- You have exhausted the Plan's internal Grievance and Appeal process.
  - However, you may be able to proceed directly to External Review in the following limited circumstances:
    - We agree to proceed directly to External Review.
    - Due an urgent health condition, you need a fast response to your External Review request.
      - Please see the Expedited External Review procedure discussed below for more information.
    - If we do not comply with the requirements of our internal Grievance procedures.
      - This does not apply when the failure does not cause you prejudice or harm.

You cannot request an External Review if the Adverse Benefit Determination or Final Adverse Benefit Determination was based on a denial, reduction or failure to pay for a benefit because you were determined ineligible for coverage under this Plan.

The IRO decides whether the External Review process applies to a particular Adverse Benefit Determination or Final Adverse Benefit Determination.

Standard External Review Procedure

Requesting an External Review: You or your Authorized Representative must submit the request in writing. You can use any written format, such as a signed form or letter. You have four (4) months after the date you receive an Adverse Benefit Determination or Final Adverse Benefit Determination to request an independent External Review.

Initial Plan Review: When we receive your written request for an Independent External Review, we will review it to determine whether:

- You were covered under the Plan at the time you requested or received the benefit which is the subject of your request;
- The Adverse Benefit Determination or Final Adverse Benefit Determination is related to a failure to meet Plan eligibility requirements;
- You have exhausted the internal Grievance and Appeals process, unless you are not required to exhaust the internal Grievance and Appeals process; and
- You have provided all the information and forms necessary to complete the External Review process.

Within one (1) business day of completing our initial Plan review, we will send to you written notification of the status of your request.

- If your request is incomplete, we will tell you what information or materials are needed to complete your request, and by when you need to send them to us.

- If your request is complete but ineligible for External Review, we will tell you why it is ineligible.
- If your request is complete and eligible for External Review, we will forward your request to the IRO.

If we determine that your request is eligible for External Review, we will randomly assign an IRO from a list of IROs approved by the Wisconsin Office of the Commissioner of Insurance (OCI) with whom we have contracted. Within five (5) business days of receiving your External Review request, we will send to the IRO:

- Your written request;
- All supporting information you submitted to support your request; and
- Any other relevant documents or information we used when deciding your Grievance or Appeal.

IRO Review: When the IRO has received your External Review request it will perform its own initial review. It will timely notify you of the results of its initial review, including the following information:

- Whether your request is eligible for External Review; and
- If eligible, that you may submit to the IRO, in writing, any additional information you would like the IRO to consider during its review.
    - You or your Authorized Representative must send such additional information to the IRO within ten (10) business days of the date you received the IRO's notice.

The IRO will review all of the provided information and documentation and inform both you and us, in writing, of its decision.

Decision Timeframe: The IRO must provide written notice of its decision within 45 days of the date it receives the External Review request. If it chooses to reverse our decision, we will immediately provide coverage for the requested benefit (such as immediately authorizing care) or pay the disputed Claim.

Expedited Independent External Review Procedure

There may be times when, due an urgent health condition, you may need a faster response to your External Review request. When that happens, you or your Authorized Representative can request an Expedited External Review.

Criteria for Expedited External Review: When you receive an initial Adverse Benefit Determination, generally you must exhaust the internal Grievance process before you can request External Review. However, when necessary due to an urgent medical condition, you can file an Expedited Grievance to seek review of an initial Adverse Benefit Determination and also request an Expedited External Review at the same time.

To be eligible for an Expedited External Review of an initial Adverse Benefit Determination:

- The initial Adverse Benefit Determination must have been based on the use of medical judgment, as described in the External Review Criteria section above; and
- The length of time it normally takes to resolve an Expedited Grievance would result in serious jeopardy to your life or health, or would limit your ability to regain maximum function.

You can also request an Expedited External Review after you have exhausted the internal Grievance process and received a Final Adverse Benefit Determination.

To be eligible for an Expedited External Review of a Final Adverse Benefit Determination:

- The Final Adverse Benefit Determination:
    - Must have been based on the use of medical judgment, as described in the External Review Criteria describe above; and
    - The length of time it normally takes to resolve an Expedited Grievance would result in serious jeopardy to your life or health, or would limit your ability to regain maximum function.

    -OR-

- The Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received Emergency services, but have not been discharged from the facility.

Requesting an Expedited External Review: To request an Expedited External Review of an Initial Benefit Determination, follow the process for filing an Expedited Grievance described above. In your communication, tell us that you want to proceed directly to External Review.

To request an Expedited External Review of a Final Benefit Determination, you must submit it to us in writing. You can use any written format, such as a signed form or letter.

Initial Plan Review: When we receive your request, we will immediately review it to determine whether it meets the External Review criteria. See the standard External Review Initial Plan Review section for above for more information.

If we determine that your request is eligible for External Review, we will randomly assign an IRO, as described above in the standard External Review Procedures section. Using the fastest available communication method, we will immediately forward to the assigned IRO your request for an Expedited External Review. We will include all information and documentation we used to make our initial decision, as well as any documentation or information your provided with your request.

IRO Review: Immediately upon receiving your request for an Expedited External Review, the IRO will review it to determine whether it meets the criteria for Expedited External Review.

If the IRO determines that your request does not meet the criteria for Expedited External Review, it will return your request to us. We will notify you if this occurs, and proceed to review it using our standard Grievance procedures. See the Standard Grievance Procedures section above for more information about this process.

If the IRO determines that your request meets the criteria for Expedited External Review, it will review all of the provided information and documentation and inform both you and us, in writing, of its decision.

Decision Timeframe: The IRO must provide written notice of its decision as quickly as your medical condition or circumstances require, but no later 72 hours of receiving your External Review request. If the IRO chooses to reverse our decision, we will immediately provide coverage for the requested benefit (such as immediately authorizing care), or pay the disputed Claim.

Right to File a Complaint With OCI

You also have the right to file a Complaint with the Wisconsin Office of the Commissioner of Insurance (OCI). It is a state agency that enforces Wisconsin's insurance laws. You can contact the **Office of the Commissioner of Insurance** by writing to:

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

You can contact them to request a Complaint form by calling (800) 236-8517 outside of Madison, or (608) 266-0103 in Madison.

Legal Actions

You may not file a lawsuit or bring an action in equity to recover benefits under this Certificate unless **all** of the following apply:

- You have exhausted the Grievance procedures allowed by law and described above.
- You file a legal action within 3 years of the date this Certificate requires you to provide proof of loss.
- You have chosen NOT to use the independent External Review process. If you choose to use the independent External Review process, the decision of the IRO is binding and you cannot later file a legal action.

GENERAL PROVISIONS

Premiums

Premiums for each Member are paid by both the employer and the insured employee. The employer determines the amount employees contribute toward the total Premium amount.

Benefit Changes or Plan Termination

The employer may change or terminate this Plan at any time. The employer will immediately communicate to all Members any Plan changes that are made.

However, when termination is due to nonpayment by the Employer, notice will also be given to the Subscriber; this shall be deemed notice to all affected Members.

Statements by Our Employees or Agents

No statement or representation made by any of our employees or agents can:

- Change or waive any requirement of this Policy;
- Change or otherwise affect the benefits, limitations, exclusions or conditions of this Policy;
- Increase or reduce the benefits described within this Certificate or other Policy documents; or
- Be used in the challenge or defense of a Claim under this Policy.

No statement, representation, or change to the Policy will be binding unless or until it is made, in writing, by an officer of our company.

The employer will never be considered our agent without our written approval or permission.

Entire Contract and Changes

The following documents, combined, make up the entire Policy and contract of insurance:

- This Certificate;
- Any Amendments;
- Benefit Summary;
- The Group Health Insurance Agreement between the employer and us.
- The employer's application form; and
- The employees' (and Dependents) enrollment and Member change forms.

If there are any differences between the official Policy documents and any summaries your employer gave you, the Policy documents will control.

No changes to the Certificate or any other Policy documents are valid unless they are written and signed by an Officer of our company.

If we make any changes to the Certificate or other Policy documents while your coverage is active and in force, the change will only apply to any Covered Services, equipment or supplies you get after the change's effective date.

Conformity with State Statutes

This Certificate is designed to comply with applicable state and federal laws. Any Certificate provision that conflicts with applicable Wisconsin state or federal statutes or regulations is hereby amended to conform to the minimum requirements of those statutes and regulations. The effective date of any required revision will be the latest date permitted by law.

APPENDIX: OPTIONAL ELIGIBILITY PROVISIONS

These eligibility provisions do not apply to your coverage unless they are listed on your Benefit Summary. Contact your employer to determine if any of the Optional Eligibility Provisions apply to your coverage.

Note: Whenever the terms “you” or “your” appear in these provisions, they refer only to an employee of the employer who purchased this group health insurance plan.

Domestic Partner Coverage

This eligibility provision applies to your coverage only if your Benefit Summary indicates "Domestic Partner Coverage."

This Domestic Partner Coverage, Optional Eligibility Provision, modifies the WEA Essential Health Certificate of Coverage to provide for the following: Coverage for the Employee's Domestic Partner as well as his or her biological or legally adopted children who otherwise meet all the Certificate's requirements for eligibility.

Definitions

The following definition is *added* to the definitions section.

Domestic Partner: A Domestic Partner is an individual with whom the Employee has agreed to live as sole Domestic Partners in a relationship and for at least the past 6 months have:

(a) Shared the same regular and permanent residence; and
(b) been jointly responsible for basic living expenses; and
(c) each been 18 years of age or older; and
(d) not been married to anyone else; and
(e) not been party to an action for divorce or annulment; and
(f) not been in another Domestic Partnership relationship; and
(g) been considered mentally competent to consent to a contract.

Eligibility and Enrollment

In the entirety of the **Dependent Eligibility** portion of the Eligibility, Enrollment and Effective Date of Coverage section of this Certificate the language that currently refers to Employee or Spouse is revised to **include** "Employee, Spouse or Domestic Partner."

In the **Eligibility, Enrollment and Effective Date of Coverage** section of this Certificate, the following section is *added*:

Enrolling Domestic Partners
An Employee may enroll his/her Domestic Partner by completing the *Designation of Domestic Partner* form and attesting to the information contained therein. The signed *Designation of Domestic Partner* form is part of the contract of insurance. We reserve the right to verify the information at any time.

Your Domestic Partner is eligible for coverage on the later of these two dates:

- The date you are eligible for coverage.
- The earliest date on which your Domestic Partnership fulfilled all of the conditions we have described above. Subject to the terms of the Special Enrollment Periods provision of the Certificate.

In the **Eligibility, Enrollment and Effective Date of Coverage** section, **Termination of Coverage** subsection of this Certificate, the following provision is *added*:

- In the case a Domestic Partnership ends due to a change in the parties' relationship resulting in a failure to meet the definition of a Domestic Partner, coverage for the Domestic Partner and his/her children will terminate on the last day of the month in which the Domestic Partnership ends.

Surviving Dependent Continuation

If your Plan includes the "Surviving Dependent Continuation" or the "Surviving Dependent Continuation—Limited Duration" Optional Eligibility Provision, the following exception applies:

The coverage continuation rights of survivors of covered Employees will be provided to covered Domestic Partners and their covered Dependents if **both** of the following apply:

- The Domestic Partnership has been in existence for at least 3 years at the time of the covered Employee's death.
- The covered Employee has attained the minimum age required for Dependents to be eligible for continued coverage, prior to death.

The 3-year existence of the Domestic Partnership must be documentable as having continuously met all of the requirements on our *Designation of Domestic Partner* form during the 3 years preceding the covered Employee's death.

Expanded Eligibility Options

The following provisions extend coverage for you and/or your covered Dependents beyond the date coverage would otherwise end, as described below. A provision applies to your Plan only if it is listed on your Benefit Summary.

Under these provisions, you and/or your Dependents are eligible for the same health plan(s) available to active employees in the occupational group within the class of Eligible Employees to which you belonged while you were actively working.

The Premium rate will be the same as the rate in effect, on each date that Premium is due, for the class of Eligible Employees to which you belonged while you were actively working. You and/or your Dependents may be responsible for paying all or part of the required Premiums for coverage.

If, while you and/or your Dependents continue coverage provided for in any of these provisions, you and/or your Dependents become eligible for Medicare Parts A and B, that individual should enroll for those benefits because we will coordinate the benefits of this Certificate with the benefits payable by Medicare, whether or not the individual enrolls. See the "Coordination of Benefits" section of this Certificate for information about how we calculate benefits when this Plan is secondary.

Retired Employee Continuation

This eligibility provision applies to your coverage only if your Benefit Summary indicates "Retired Employee Continuation."

If you retire at age 55 or older while you are covered by this Certificate as an Active employee, your coverage will continue under this provision as long as all of the following apply:

- We receive your election to continue coverage under this option within 60 days of the date you retire.
- We receive the required Premiums on time.
- We continue to insure the Active employees in the occupational group within the class of Eligible Employees from which you retired.
- Your employer permits all retired employees within your class of Eligible Employees to continue coverage under this provision.

If you do not choose to continue coverage under this option at the time you retire or you voluntarily terminate coverage under this provision at any time, you cannot re-enroll later, even during an open enrollment period.

- If, however, you are enrolled as a Dependent of another Active Employee with Employer, you will be considered to have had continuous coverage and be eligible to elect coverage under this Retired Employee Continuation period at such point you are no longer covered as a Dependent under another Employee and we receive your election to continue coverage within 60 days of that date.

- If your Retired Employee Continuation is subject to a Limited Duration provision, the duration of your eligibility for Retired Employee Continuation will be calculated from the date of your retirement, not the date of your Election of Retired Employee Continuation.

If you continue coverage under this provision, the following rules will apply to your Dependents:

- Your Dependents are eligible to continue coverage as long as you remain covered and they continue to qualify as Dependents under the Certificate.
- If you acquire an eligible Dependent through marriage, birth of a child, or adoption or placement for adoption of a child, you may enroll your new eligible Dependents if we receive the required enrollment form within 30 days of the date of the event.
- You may enroll your eligible Dependents during your employer's annual open enrollment period or any group open enrollment that applies to the class of Eligible Employees to which you belonged while you were working.

Retired Employee Continuation—Limited Duration

This eligibility provision applies to your coverage if your Benefit Summary indicates "Retired Employee Continuation—Limited Duration."

This provision is the same as the "Retired Employee Continuation" provision, with two exceptions:

- Coverage will continue only for a limited period of time if specified by your employer for your class of Eligible Employees; and
- The minimum age you must attain prior to retirement to be eligible for coverage under this provision may be an age other than 55, if specified by your employer for your class of Eligible Employees.

Retired Employee Continuation – Consecutive COBRA

This eligibility provision applies to your coverage if your Benefit Summary indicates "Retired Employee Continuation – Consecutive COBRA"

This provision provides that an employee who elects Retired Employee Continuation coverage upon retirement rather than COBRA coverage, may elect COBRA at the end of the Limited Duration period of Retired Employee Continuation.

- Eligibility to elect COBRA coverage is limited to those retired employees under the age of 65.
- COBRA eligibility will only extend until your reach the age of 65, regardless of whether the eligibility period under COBRA has been exhausted.

Disabled Employee Continuation

This eligibility provision applies to your coverage only if your Benefit Summary indicates "Disabled Employee Continuation."

If you become Disabled while covered under this Certificate as an Active employee, your coverage will continue for as long as you are Disabled and all of the following apply:

- We receive your election to continue coverage under this option within 60 days of the date you become Disabled.
- We receive the required Premiums on time.
- We continue to insure the Active employees in the occupational group within the class of Eligible Employees to which you belonged before becoming Disabled.

- Your employer permits all Disabled employees from your class of Eligible Employees to continue coverage under this provision.

If you do not choose to continue coverage under this option at the time you become Disabled or you voluntarily terminate coverage under this option at any time, you cannot re-enroll later, even during an open enrollment period.

If you continue coverage under this provision, the following rules will apply to your Dependents:

- Your Dependents are eligible to continue coverage as long as they continue to qualify as Dependents under this Certificate.

Disabled Employee Continuation—Limited Duration

This eligibility provision applies to your coverage only if your Benefit Summary indicates "Disabled Employee Continuation—Limited Duration."

This provision is the same as the "Disabled Employee Continuation" provision, with one exception. Coverage will continue only for a limited period of time if specified by your employer for your class of Eligible Employees.

Surviving Dependent Continuation

This eligibility provision applies to your coverage only if your Benefit Summary indicates "Surviving Dependent Continuation."

If you are covered by this Certificate and are age 55 or older at the time of your death, coverage for your Dependents will continue under this provision as described below.

Your spouse may continue coverage for as long as desired if all of the following apply:

- We receive your spouse's election to continue coverage under this option within 60 days of your date of death.
- We receive the required Premiums on time.
- We continue to insure the active employees in the occupational group within the class of Eligible Employees to which you belonged at the time of your death.
- Your employer permits all surviving Dependents from your class of Eligible Employees to continue coverage under this provision.

Your Dependent children are eligible to continue coverage if all of the following apply:

- Your surviving spouse continues family coverage.
- Your Dependent children continue to qualify as Dependents under this Certificate.
- We receive your Dependent children's election to continue coverage under this option within 60 days of your date of death.

If your Dependents do not choose to continue coverage under this option at the time of your death or they voluntarily terminate coverage under this provision at any time after your death, they cannot re-enroll later, even during an open enrollment period.

If your surviving spouse obtains a new spouse or children while covered under this provision, the new Dependents will have no rights to coverage under this provision unless the child/children otherwise qualify as your Dependents.

Surviving Dependent Continuation—Limited Duration

This eligibility provision applies to your coverage only if your Benefit Summary indicates "Surviving Dependent Continuation—Limited Duration."

This provision is the same as the "Surviving Dependent Continuation" provision, with two exceptions:

- Coverage will continue only for a limited period of time if specified by your employer for survivors of your class of Eligible Employees; and
- The minimum age you must attain prior to your death for your Dependents to be eligible for coverage under this provision may be an age other than 55, if specified by your employer for your class of Eligible Employees.

APPENDIX: OPTIONAL BENEFIT PROVISONS

These Optional Benefit Provisions do not apply to your coverage unless they are listed on your Benefit Summary.

Remember that we cover some health care services only if you receive Prior Authorization in advance of obtaining the service. See our website, www.weatrust.com, for a list of services that require Prior Authorization.

Also, see your Benefit Summary for the Cost-Sharing Amounts and Maximum Benefit limits that apply to certain health care services.

Extraction/Replacement of Natural Teeth

This benefit provision applies to your coverage only if your Benefit Summary indicates "Extraction/Replacement of Natural Teeth."

In addition to the dental services described in the "Medical Benefits" section of this Certificate, this Plan covers the extraction of natural teeth.

This Plan also covers the following services if received within 18 months of the date of the extraction of natural teeth:

- The initial replacement of the extracted natural teeth.

- The replacement of previously existing fixed bridgework if replacement is required due to the extraction of one or more natural teeth that are:
    - Adjacent to the fixed bridgework, or
    - Abutment teeth supporting the existing bridgework.

- The replacement of previously existing partial removable dentures:
    - If replacement is required due to the extraction of one or more natural teeth, and
    - The existing partial denture is no longer serviceable and cannot be made serviceable.

The exclusion in Medical Benefits Section of the Certificate under "Dental Services" for the "Extraction or replacement of natural teeth required because of disease or decay" does not apply to you.

Vision Examination Benefit

Vision Examination Benefit

This benefit provision applies to your coverage only if your Benefit Summary indicates "Vision Examination Benefit."

In addition to the vision services described in the Medical Benefits Section, this Certificate covers one complete examination of your eyes and related structures during each Benefit Period.

The examination, to evaluate a new or existing visual condition, must be performed by a licensed optometrist. The examination may include a patient history, an internal ophthalmoscopic examination, biomicroscopy, tonometry, and a determination of refractive status, unless otherwise contraindicated.

Determination of refractive status means the quantitative procedure that yields the refractive data needed to determine your best visual acuity with lenses and to prescribe lenses.

Vision correction materials such as eyeglasses and contact lenses and the fitting of eyeglasses or contact lenses are not covered under this optional benefit provision.

Enhanced Vision Examination Benefit

This benefit provision applies to your coverage only if your Benefit Summary indicates "Enhanced Vision Examination Benefit."

This provision is the same as the "Vision Examination Benefit" provision, with two exceptions:

- The examination to evaluate a new or existing visual condition may also be performed by an ophthalmologist; and

- Deductible, coinsurance, and copayment amounts do not apply to this benefit.

Erectile Dysfunction Benefit

This benefit provision applies to your coverage only if your Benefit Summary indicates "Erectile Dysfunction Benefit."

This benefit provision provides coverage for treatment of impotence and erectile dysfunction, by removing all exclusions for such services.

Drug Plan Amendment for Medicare Part D Eligible Individuals

This benefit provision applies to your group's coverage only if your Benefit Summary indicates "Drug Plan Amendment for Medicare Part D Eligible Individuals."

This benefit provision provides Prescription Drug coverage for individuals eligible to enroll in the Medicare Part D drug program, if they are covered under any of the Expanded Eligibility Options.

The Certificate is revised in three places to support this benefit.

In the "General Exclusions and Limitations" section, "General Exclusions and Limitations: Non-Medical" subsection, under "Services, Treatments and Supplies," the exclusion regarding Prescription Drugs covered under Medicare Part D is deleted and replaced with the following:

- Prescription drugs and medications for individuals who are eligible to enroll in the Medicare Part D drug program, whether or not they enroll, except for:
    - Employees who are Actively at Work and their covered Dependents.
    - Individuals who are covered by our standard Family Plan.
    - Individuals who continue coverage under any of the Expanded Eligibility Options.
    - Individuals who are covered under state and federal continuation (COBRA) coverage, unless they choose to waive Prescription Drug coverage under this plan.
    - Any individual for whom this plan is primary under Medicare Secondary Payer rules.

Prescription drugs and medications that we are required by law to cover are covered for all individuals, including those eligible to enroll in the Medicare Part D program.

. . .

The "Three-Tier Drug Plan" and "Value Choice Drug Plan" are amended.

The first bullet point under "Important Notes" is deleted and replaced with the following:

- This Certificate does not cover Prescription Drugs and medications, regardless of where they are purchased or received, for individuals who are eligible to enroll in the Medicare Part D drug program, whether or not they enroll, except:
    - Employees who are Actively at Work and their covered Dependents.
    - Individuals who are covered by our standard Family Plan.
    - Individuals who continue coverage under any of the Expanded Eligibility Options.
    - Individuals who are covered under state and federal continuation (COBRA) coverage, unless they choose to waive Prescription Drug coverage under this plan.
    - Any other individual for whom this plan is the primary insurer under Medicare Secondary Payer rules.

Prescription drugs and medications that we are required by law to cover are covered for all individuals, including those eligible for Medicare Part D.

