AMENDMENT
to the WEA Trust Essential Health Plan

This amendment modifies various provisions of your WEA Trust Essential Health Plan Certificate of Coverage.

The address on the face page of the Certificate of Coverage (Certificate) is deleted and replaced with the following:

45 Nob Hill Road
Madison, Wisconsin 53713-3959

The first box under "Important Notices" on the first page of the Certificate is deleted and replaced with the following:

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE—If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

WEA Insurance Corporation
P.O. Box 21538
Eagan, MN 55121
Voice/TTY: (800) 279-4000 or (608) 276-4000

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can file a complaint electronically with the **OFFICE OF THE COMMISSIONER OF INSURANCE** at its website at http://oci.wi.gov/, or by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517
608-266-0103

Three modifications are made to Section 3, "Eligibility and Coverage of Employees and Their Dependents." Under "Your Duty to Provide Information," the first bullet is deleted and replaced with the following:

- **You must let us know when one of your covered dependents is no longer eligible for coverage and, upon our request, you must provide us with evidence of eligibility for your dependents.** When we enroll your dependents, we accept your representation of their eligibility. You must notify us when a covered dependent is no longer eligible. You must also provide us with evidence of eligibility for your dependents, upon our request. Your failure to provide such evidence, upon request, is considered evidence of fraud and intentional material misrepresentation**.** If you do not provide the requested evidence of eligibility, we have the right to terminate coverage for the dependent. The termination may be retroactive to the date the dependent became ineligible for coverage under the plan.

Under "When Coverage Ends," the seventh bullet stating, "The date on which you fail to comply with any provision of this Certificate" is deleted.

The following new provision entitled "Coverage Ending Due to Fraud" is inserted between "When Coverage Ends" and "Rules for Late Enrollments." The "Table of Contents" is also updated accordingly.

Coverage Ending Due to Fraud

If we find that you, or your employer as it pertains to you and/or your dependents, have performed an act, practice, or omission that constitutes fraud, or intentional misrepresentation of material fact, we have the right to terminate coverage and the termination may be retroactive. This includes knowingly providing incorrect information regarding your or your dependents' eligibility for coverage. When the termination is retroactive, 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.

In Section 4, "General Provisions That Apply to All Benefits," the following new provision entitled "Calculation of Deductibles, Coinsurance, Copayments and Maximums" is inserted between "Maximum Out-of-Pocket Limit" and "Maximum Befit Amount" under "Factors that Affect the Reimbursement Amount." The introductory box at the beginning of Section 4 is also updated to reflect this addition.

Calculation of Deductibles, Coinsurance, Copayments and Maximums

Some of our contracts with providers (health care providers and pharmaceutical companies) may entitle the WEA Insurance Corporation to discounts, allowances, adjustments, rebates and/or settlements. In some situations, we may enter into risk-sharing arrangements with the provider, where there is a reconciliation and settlement of the parties' respective risks after the end of the contract year. In other situations, we may contract to pay providers on a basis that is not tied to the services that the provider actually renders to our members. For example, some providers may be paid based on the number of our members that select or are assigned to the provider. When one of our members receives services from any such provider, the coinsurance, copay, deductible and out-of-pocket maximum limits owed by you and any maximum benefit amount may be calculated by us based on the provider's billed charges without regard to our discounts, allowances, adjustment and/or settlements. Any discounts, allowances, rebates, adjustments, settlements, refunds and other savings that are realized by us will be for the sole benefit of WEA Insurance Corporation.

Section 10, "Your Right to a Resolution of Complaints," is deleted and replaced with the following:

Section 10
Your Right to a Resolution of Complaints

You have the right to a full and fair review of any complaints you may have about your claims or our administration of this Certificate. This section explains the rights you have under this Certificate and by law to receive explanations of what your plan covers and our decisions concerning your claims. It also explains your rights to seek resolution of complaints and adverse determinations.

Right to Information and Explanation

If you have questions about your benefits under this Certificate or how to receive maximum reimbursement for your health care services, you may call and visit with a customer service representative who can provide the information you need.

After we receive and process a claim for benefits, you will receive an Explanation of Benefits (EOB) form showing, among other things:

- The provider's charges.
- How much we reimbursed.
- Any amount that is your responsibility to pay.
- The reason for any amount you have to pay.

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

Right to an Investigation of Any Complaint

Most questions about benefits and claims payments can be resolved on an informal basis. Therefore, if you are dissatisfied after you have raised your question or complaint with our customer service representative, we encourage you to call our dispute resolution specialist at (800) 279-4000 or (608) 276-4000 (Voice/TTY). Our dispute resolution specialist will promptly investigate your complaint and keep you informed about the progress of the investigation.

Right to Submit a Grievance

If our dispute resolution specialist is unable to resolve your complaint to your satisfaction, you may pursue your complaint through our grievance procedure.

What a Grievance Is—A grievance is any written dissatisfaction with our services, our claims practices, or our administration of your health plan. For example:

- You believe you have not received the reimbursement the Certificate promises.
- You believe you have been denied coverage promised by the Certificate.
- You are dissatisfied with covered services you received from one of our providers.
- You believe the termination of your coverage, including a retroactive termination, is not supported by the Certificate.

How to Activate the Grievance Process—We have two grievance procedures: a standard grievance procedure and an expedited grievance procedure that includes a process for urgent care claims. Both are summarized below. If you would like more information about either grievance procedure, you may request a copy of our detailed description, which includes all legal requirements.

Procedure for a Standard Grievance—To file a formal grievance, you or your authorized representative must submit it to us in writing at this address:

Ombudsperson
WEA Insurance Corporation
P.O. Box 21538
Eagan, MN 55121

Your written grievance may be submitted in any form but should include the following information:

- The employee's name and subscriber number.
- Why you are dissatisfied.
- Any information you think is relevant, such as dates and events in chronological order and names of any providers involved.
- Copies of any documents that relate to your grievance.
- What you believe to be a fair resolution of your grievance.

We will acknowledge receipt of your grievance within 5 business days after we receive it. Your grievance will be considered by our Grievance Committee within 30 calendar days of its receipt. If we are unable to make a decision about your grievance within the 30-day time limit, we may extend the limit an additional 30 calendar days by informing you in writing of the reason for the extension and the date by which the decision will be made.

Our Grievance Committee is composed of three or more members. At least one Committee member will be a Trust plan member who is not a company employee, if one is available to serve on the Committee. Another Committee member will be a WEA Insurance Corporation employee who is authorized to take any corrective action the Committee deems appropriate.

We will notify you of the time and place of the Grievance Committee meeting at least 7 days in advance. You or your authorized representative has the right to appear in person or by telephone to present information, ask questions, or submit written questions.

We will provide you, free of charge, with copies of any new or additional evidence considered and relied upon in connection with your claim or the subject of your grievance. We will provide you with this information as soon as possible in advance of the meeting.

The Committee will review your grievance, make a decision, and inform you in writing of its decision. If the Committee believes that the WEA Insurance Corporation has not reasonably handled your dissatisfaction in light of the Certificate and the known facts, it will issue instructions for corrective action.

Procedure for an Expedited Grievance—An expedited grievance is one where any of the following applies:

- The duration of the standard grievance resolution process will result in serious jeopardy to your life or health or to your ability to regain maximum function.

- In the opinion of a Physician with knowledge of your medical condition, the standard grievance process would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance.

- A Physician with knowledge of your medical condition determines that the coverage determination shall be treated as an expedited benefit determination.

If you have an expedited grievance, you, your authorized representative, or your Physician should report it immediately to our ombudsperson by calling (800) 279-4000 or (608) 276-4000 (Voice/TTY). The ombudsperson will investigate the grievance as expeditiously as your condition requires and call you with our decision no more than 72 hours after we receive the grievance. You will then receive a written confirmation of the decision.

Right to an Independent External Review

If, after exhausting your grievance rights, you are not satisfied with the determination made by the Committee, or if we fail to respond to your grievance in accordance with the timing requirements outlined in this section and applicable regulations, you may be entitled to request an independent external review of our determination.

You have the right to an independent external review of a final adverse determination that is based on this Certificate's requirements. An adverse determination is our determination, after

reviewing the medical information you or your provider supply to us, that health care services do not meet the Certificate's criteria for medical necessity, medical appropriateness, or cost-effectiveness, or if we determine that services are Experimental/Investigative. These terms are explained in detail in Section 4 of this Certificate. Adverse determinations also include retroactive terminations of coverage.

How the Independent External Review Process Works—An independent external review is performed by an independent review organization (IRO) that we randomly select from a list of organizations certified by the Office of the Commissioner of Insurance.

To qualify for this review, you must first exhaust our grievance procedure unless **either** of the following applies:

1. You and we agree to waive the grievance procedure and proceed directly to an independent review.
2. An IRO we have randomly selected determines that exhausting the standard grievance procedure would jeopardize your health or your ability to regain maximum function.

You or your authorized representative may initiate an independent external review by sending your written request to us. We must receive your written request within four months from the date of our final coverage denial determination or the date of the Grievance Committee's decision letter, whichever is later.

Within 5 business days after we receive your written request, we submit to the IRO all of the information you provided in support of your position, the relevant Certificate provisions on which we based our decision, and any other relevant documents or information used in our grievance determination. The review organization has 45 days from the date it receives the required information to notify you and us in writing of its decision. The decision is binding on both of us.

For further information about this or any of these procedures, call our ombudsperson.

Right to File a Complaint With the Office of the Commissioner of Insurance

Another legal right you have is the right to file a complaint with the **Office of the Commissioner of Insurance**, a state agency that enforces Wisconsin's insurance laws. You can file a complaint electronically with the **Office of the Commissioner of Insurance** at its website at http://oci.wi.gov/, or by contacting:

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

Alternatively, you can call (800) 236-8517 outside of Madison, or (608) 266-0103 in Madison, and request a complaint form.

Legal Actions

You may not bring an action at law or in equity to recover on this Certificate unless **all** of the following apply:

- You have exhausted the grievance procedures provided by law and outlined above. **Note:** If we fail to respond to your grievance in accordance with the timing requirements outlined in this section and applicable regulations, you are deemed to have exhausted the grievance procedures.

- You file a legal action within 3 years of the date you were required by this Certificate to provide proof of loss.

- You have not chosen to use the independent external review process. If you choose to use the independent external review process, the decision of the IRO is binding.

Amendment Effective Date—This amendment is effective May 1, 2018.