Essential Qualified Health Plan

A WEA Insurance Corporation Group Health Policy

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Voice/TTY:
(800) 279-4000
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IC OGC 4032-0616

Important Notices

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 7338
Madison, WI 53707-7338
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 contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** 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

Pediatric Dental

This policy does not include pediatric dental services as required under the federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, agent, or the Federally Facilitated Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

You may view all of the WEA Insurance Corporation insurance policies on our website, weatrust.com. If we amend your policy, we add the amendment to our online policies. If you prefer to receive a paper policy, please call our customer service department.

WEA Trust Essential Qualified Health Plan

A WEA Insurance Corporation Group Health Policy

This is a high deductible preferred provider health insurance policy intended for use with a tax-qualified health savings account. This document is a description of group health insurance benefits. If you are a covered employee, then this insurance policy entitles you to reimbursement of the covered health care costs incurred by you and your covered dependents, subject to the reimbursement limits defined in Section 4.

We do not cover all health care services. We reimburse only for those services that are explicitly defined in this policy. Except for those preventive services expressly listed, or that we are required by law to cover, we cover services only when we find them to be medically necessary and medically appropriate for the diagnosis or treatment of an Illness or Injury. These concepts are defined and clarified in Section 4. Please see our website, weatrust.com, for the most current list of covered preventive services. You may also obtain a paper copy of the current list by calling our customer service department.

Your choice of provider (Network or non-network provider) determines how much we will reimburse for covered services and, consequently, how much you must pay for your health care. When you use a Network provider, we will pay the amount we have contracted to pay for each covered service, subject to applicable deductible, coinsurance, and copayment amounts. Other than deductible, coinsurance, and copayment, Network providers will not bill you for amounts that exceed our payment for covered charges.

We limit reimbursement to the maximum allowable fee for cost-effective covered services, subject to applicable deductible, coinsurance, and copayment amounts. If a charge exceeds our maximum allowable fee, we may reimburse less than the billed charge. You are responsible for any amount charged in excess of our maximum allowable fees, as well as applicable deductible, coinsurance, and copayment amounts.

We cover some services only if you receive our written authorization before purchasing the service. When we preauthorize services based on a specified expenditure, the specified expenditure is the reimbursement limit. For more information, see "Preauthorization Requirements" in Section 7. If you do not receive our advance authorization of expenditures for services that require preauthorization, we have no obligation to reimburse you.

This policy excludes coverage for prescription drugs and medications (except as required by law) for individuals who are eligible to enroll in the Medicare Part D drug program, whether or not they enroll, except those in specified categories. See the Prescription Drug Plan provision for these exceptions.

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The eligibility criteria for coverage described in this policy may be changed by one or more of the Optional Eligibility Provisions that are located in the Appendix at the back of this document. Your Benefit Summary indicates which Optional Eligibility Provisions, if any, apply to your coverage.

The benefits described in this policy may be changed by one or more of the Optional Benefit Provisions that are located in the Appendix at the back of this document. Your Benefit Summary also indicates which Optional Benefit Provisions, if any, apply to your coverage.

Premiums are to be paid monthly on or before the 20th day of the month preceding the month of coverage.

If you have any questions about the benefits or requirements of this policy, call us at (800) 279-4000 or (608) 276-4000 (Voice/TTY).

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Section 1
General Provisions

General Information About This Policy

This is a high deductible preferred provider health insurance policy intended for use with a tax-qualified health savings account. In accordance with its terms, we will reimburse for covered health care services incurred by covered employees and their covered dependents, subject to the applicable deductible, coinsurance, and copayment amounts defined in Section 4 of the policy.

This policy does not provide reimbursement for all health care services even when those services are recommended by Physicians. We will reimburse only for those services explicitly defined in, and not excluded by, the provisions of this policy. Covered services are reimbursed if we find them to be medically necessary and medically appropriate for the diagnosis and treatment of an Illness or Injury. Further clarification of these criteria is presented in Section 4 of the policy.

Some of the services covered by this policy require preauthorization. We require preauthorization when the specific facts of the patient's medical condition determine whether that service is appropriate and cost-effective.

Our reimbursement for covered services and how much you must pay for your health care is determined by your choice of Network or non-network provider. When you use a Network provider, we will pay the amount we have contracted to pay for each covered service, subject to applicable deductible, coinsurance, and copayment amounts, and our cost-effectiveness criteria. Other than deductible, coinsurance, and copayment amounts, Network providers will not bill you for amounts that exceed our payment for covered charges.

All reimbursements are limited to the maximum allowable fee for cost-effective covered services. If a health care charge exceeds our maximum allowable fee, reimbursement may be less than the billed charge. The covered individual is responsible for the amount in excess of the maximum allowable fee as well as the applicable deductible, coinsurance, and copayment amounts. More information about factors that affect reimbursement is included in Section 4 of the policy.

When we preauthorize services based on a specified expenditure, the specified expenditure is the reimbursement limit.

If you have any questions about the benefits or requirements of this policy, or if you would like further information about our maximum allowable fee, call us at (800) 279-4000 or (608) 276-4000 (Voice/TTY).

Premiums
The premiums are paid by the employer and their insured employees. The employer determines the amount of the employee contributions. All employee contributions are determined on a non-discriminatory basis.

Benefit Changes or Policy Termination
The employer may change or terminate the policy at any time. Any changes to the policy will be communicated immediately by the employer to the individuals covered under the policy.

Statements by Our Employees or Agents
No statement or representation by any of our employees or agents can alter or waive any requirement or provision of this policy. No statement or representation relating to the interpretation or application of any provision of this policy will be binding unless an officer of our company issues it in writing.

Under no circumstances will the employer be deemed our agent without our written authorization.

Entire Contract and Changes
The entire contract of insurance consists of:

1. This policy and any Optional Eligibility and Optional Benefit Provisions.

2. The Benefit Summary.

3. The Group Health Insurance Agreement (Agreement) between the employer and us.

4. The employer's application form.

5. The employees' enrollment forms.

If there is a conflict between the contract and any summaries provided to you by your employer, the contract will control.

No change in this policy will be valid unless written and signed by an officer of our company.

If any policy provision is changed while coverage is in force, the change will apply only to those covered services that are received after the effective date of the change.

Conformity With State Statutes
Any provision of this policy that conflicts with the applicable statutes of Wisconsin, or with any applicable federal law, is hereby revised to conform to the minimum requirements of those statutes. The effective date of any such required revision will be the latest date permitted by those statutes.

Section 2
Definitions That Apply to All Provisions

The terms defined below appear throughout this policy. When these terms are capitalized in the text of the policy, they have the meaning that is defined below.

Benefit Period means 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.

Disability or **Disabled** means 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.

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.

Hospital means 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 means 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.

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

Physician or **Surgeon** means 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 policy when performed by a Physician or Surgeon.

Primary Care means 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, weatrust.com, for a list of medical services providers that we consider Primary Care Providers.

Specialty Care means 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.

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

- Any time the word **"services"** appears in this policy, 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 policy, they refer to the WEA Insurance Corporation.

- Any time the words **"you"** or **"your"** appear in this policy, they refer to any individual who is covered by the policy. 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 policy.

- Any time the word **"covered"** appears in the benefit provisions of this policy, 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 policy's cost-effectiveness limits; and our preauthorization requirements. See Sections 4 and 7 for a discussion of these concepts.

Section 3
Eligibility and Coverage of Employees and Their Dependents

This section describes the individuals who are eligible for coverage under this policy. It explains when those individuals become eligible for coverage, when their coverage begins, and when coverage ends. It also describes their rights with respect to group continuation coverage and conversion coverage.

The date you become eligible for coverage is subject to any applicable waiting period. The waiting period is the length of time you must be continually at work for your employer before you are eligible for coverage under this policy. The waiting period, if any, is established by your employer and is specified in the Agreement between your employer and us.

Note: Whenever the terms "you" or "your" appear in this section, they refer only to an employee of the employer who purchased this group health insurance policy. Whenever the term "class of eligible employees" is used, it refers to the occupational group(s) of employees specified by the employer as being eligible for coverage as part of an insured group.

How to Obtain Coverage

In order to obtain coverage you must provide an enrollment form to us, listing all individuals for whom you wish coverage, within 30 days of the date you become eligible. This 30-day period is an initial enrollment period during which you and your dependents will be enrolled if eligible. If we receive your enrollment form after the 30-day period, you may have to exhaust a 12-month waiting period before your coverage becomes effective, unless you meet the requirements described later in this section under "Special Late Enrollment Circumstances."

After you are enrolled, you will receive an insurance identification card. You must present this card each time you receive services from any provider. You may also use this card to obtain covered prescription drugs at any participating pharmacy.

Even if you do not wish coverage at the time you are initially eligible, you should submit an enrollment form. If you are waiving coverage because you have other health insurance coverage, you must clearly state that fact and identify your other health insurance coverage. Doing so will be necessary to preserve your rights to coverage at a later date should you lose your other coverage as described under "Special Late Enrollment Circumstances."

Eligibility and When Coverage Begins

Current Active Employees

You are eligible for coverage on the date this policy takes effect only if **both** of the following apply:

- You are engaged in the active performance of your regular job duties on that date. To determine eligibility for coverage, you are considered engaged in the active performance of your regular job duties each day of a regular paid vacation, any regular nonworking day or holiday, or if you are not working due to your own illness, medical condition, or disability as determined by your employer.

- You belong to the class of eligible employees specified by your employer on the Agreement.

Your coverage will begin on the date this policy takes effect if we receive your enrollment form within 30 days of that date.

New Employees

If you belong to the class of eligible employees specified by your employer on the Agreement, you are eligible for coverage on the later of the following dates:

- The date you complete any waiting period specified by your employer.

- The date you begin the active performance of your regular job duties. You are considered engaged in the active performance of your regular job duties each day of a regular paid vacation, any regular nonworking day or holiday, or if you are not working due to your own illness, medical condition, or disability as determined by your employer.

Your coverage will begin on the date you become eligible if we receive your enrollment form within 30 days of that date.

Your Dependents

If you are covered by this policy, the following dependents are eligible for coverage:

1. Your legal spouse.

2. Your biological child, legally adopted child, stepchild, or legal ward* who is under the age of 26.

   ***Note:** To be initially eligible for coverage, your legal ward must be under the age of 18 or must be a ward who was covered by the previous employer-sponsored group health plan that this policy replaced. In addition, you must have sole and permanent guardianship of both the individual and the individual's estate.

3. Your biological child, legally adopted child, stepchild, or legal ward of any age who is a full-time student **and** meets **both** of the following requirements:

- Was initially called to federal active duty for the National Guard or a reserve unit of the United States armed forces before age 27, while attending an institution of higher education as a full-time student.

- Within 12 months of the date of fulfilling his or her active duty obligation, applied to an institution of higher education as a full-time student.

4. A biological child of your covered dependent child or legal ward (i.e., your grandchild), but only until your child or legal ward becomes 18 years old or marries, whichever occurs first.

5. Your unmarried biological child, legally adopted child, stepchild, or legal ward who has attained the limiting age for coverage under this plan, but who meets **all** of the following:

   - He or she is permanently mentally disabled or permanently physically disabled.

   - He or she is incapable of self-sustaining employment.

   - He or she is chiefly dependent on you for at least 50% of his or her support.

   - He or she was continuously covered by the previous employer-sponsored group health plan that this policy replaced.

   You must provide us with proof 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 the date he or she reaches the limiting age, and at any time we request it during the 2-year period that follows. After the 2-year period, we may request proof of ongoing eligibility on an annual basis.

Your dependents are eligible for coverage on the date your coverage takes effect. Their coverage will begin on the date your coverage takes effect if we have received your application for their coverage within the first 30 days of their eligibility.

Children Who Become Re-eligible for Coverage—If your covered dependent child becomes ineligible for coverage because he or she no longer meets the criteria to qualify as an eligible dependent, that child will lose coverage under this policy. However, the child may once more become eligible if the criteria are again met. If this happens, we must receive the application for your dependent child's coverage within 30 days of the event that gave rise to that dependent's re-eligibility. Coverage for that child will resume on the first of the month following the event that gave rise to the re-eligibility if you notify us promptly of the child's re-eligible status. If we do not receive the application within the 30-day time limit, your dependent child will be subject to the "Rules for Late Enrollments" described later in this section.

Note: If you have **single** coverage and want to add a dependent child who becomes re-eligible, you must change to family coverage. We must receive the application for your dependent child's coverage within 30 days of the event that gave rise to that dependent's re-eligibility. If we do not receive the application within the 30-day time limit, your dependent child will be subject to the "Rules for Late Enrollments" described later in this section.

Adding Dependents Through Marriage—If you marry, you may obtain coverage for any new eligible dependents and you may change from single to family coverage if we receive the required enrollment form within 30 days after the date of your marriage. In this case, coverage for these new dependents begins on the date of your marriage. If we receive your application for their coverage after the 30-day period, their enrollment will be subject to the "Rules for Late Enrollments" described later in this section.

Newborn Child—A newborn's coverage begins at birth if you have family coverage. If you have single coverage, you must notify us of the birth and your desire to obtain family coverage within 60 days of the birth date. If we are not notified and the required premiums are not paid within 60 days of the birth date, we may refuse coverage for the newborn unless, within one year of the birth date, we receive all required premiums, plus interest as permitted by law, from the date of birth. If we do not receive the required premiums within one year of the birth date, you will be able to obtain coverage for the child only through the "Rules for Late Enrollments" described later in this section.

Newly Adopted Child—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 the child is legally placed with you for adoption.

Coverage for the adopted child will begin on the date he or she first becomes eligible if we receive your application for the child's coverage, or written notification of the adoption, within 60 days after that date. If we do not receive an application for the child's coverage within 60 days after he or she becomes eligible, you will be able to obtain coverage for the child only through the "Rules for Late Enrollments" described later in this section.

Legal Wards—A legal ward is eligible for coverage on the date established by the court order as the date on which you began guardianship. Coverage for your legal ward will begin on the date he or she became eligible if both of the following apply:

- You have family coverage.
- We receive your application for your legal ward's enrollment within 30 days after he or she first became eligible for coverage.

Your Duty to Provide Information

If you are covered by this policy, you must provide the information we need to accurately determine whether your dependents are eligible for coverage and to pay benefits. Examples include but are not limited to:

- **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 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.

- **You must notify us when you or a dependent becomes covered by another group health plan or by Medicare.** The State of Wisconsin has adopted rules that must be followed by all insurers who coordinate benefits. These rules, included in Section 9, specify which insurer pays first, which pays second, etc.

- **You must respond to our requests for information.** For example, periodically we will send you a questionnaire asking if you or any of your dependents are covered by any other health plan. You must either complete and return the questionnaire or call one of our customer service representatives and provide the information. Because we rely on this information to coordinate benefits, we suspend claims processing until we receive the requested information.

- **You must provide, at your own expense, the medical documentation we need to determine if services are covered.** We will tell you what we need to make a determination.

- **You must inform us when you or your covered dependent receives medical services as a result of a work-related Illness or Injury, and you must notify us of any worker's compensation claim you make.** You must also notify us of any worker's compensation benefits you receive as a result of an award, compromise, or settlement. Because we will use this information to determine whether any benefits are owed to you under this policy, you must promptly provide us with any related information or documentation that we require. This policy excludes services that are eligible for worker's compensation benefits whether or not you apply for or receive them.

If you fail to timely provide us with the information described above, and we pay claims in error as a result, we have the right to recover the overpayment. You will be responsible for the cost of any claims paid in error, together with all costs and legal fees we incur in recovering those claims payments. See also "Our Right of Review and Recoupment" in Section 8.

When Coverage Ends

Your coverage will end on the earliest of the following dates:

- The date this policy terminates for any reason.

- The end of the period for which the last premium was paid for you.

- The last day of the month in which you enter the military forces of any state or country, including the United States, or the last day of the month after you have served on active duty as a member of a reserve unit of the armed forces for at least 30 consecutive days.

- The last day of the month in which you cease to be a member of the class of eligible employees specified by your employer on the Agreement for coverage under this policy. For example, you have a change in your job duties or in the number of hours worked that renders you ineligible for coverage.

- The last day of the month in which your occupational group ceases to be part of the class of eligible employees specified by your employer on the Agreement as being part of an insured group.

- The last day of the month in which you become ineligible because of the termination of your employment, whether voluntary or involuntary.

- The date on which you fail to comply with any provision of this policy.

- The date of your death.

Coverage for any dependent will end on the earliest of the following dates:

- The date this policy terminates for any reason.

- The end of the period for which the last premium was paid for your dependent.

- The last day of the month of the divorce or annulment of your marriage is the date that coverage terminates for your spouse.

- The last day of the month in which your dependent enters the military forces of any state or country, including the United States, or the last day of the month after your dependent has served on active duty as a member of a reserve unit of the armed forces for at least 30 consecutive days.

- The last day of the month in which your dependent child no longer meets the criteria to be covered as your dependent under your coverage.

- The date of your dependent's death.

- The date your coverage ends for any reason, except for your death. If you die, coverage for your dependents will end on the last day of the month of your death.

Rules for Late Enrollments

Late Enrollment

It is important that you apply for coverage by submitting an enrollment form, listing all individuals for whom you wish coverage, within 30 days of becoming eligible. If you waive or

decline coverage when you are initially eligible, your ability to enroll later will be seriously affected. Unless your late enrollment satisfies the conditions described under "Special Late Enrollment Circumstances" or you are eligible to enroll under an "Annual Open Enrollment" as stated below, you and your dependents will be required to exhaust a 12-month waiting period. The 12-month waiting period will begin on the date we receive your late application, which must be in writing. During those 12 months, no benefits will be paid. Your coverage will be effective on the first day of the first month that begins at least 12 months after the date we receive your application, but only if **both** of the following apply:

- You and any dependents you seek to enroll remain eligible for coverage under this policy on that date.

- You were continuously employed by your employer during the 12-month waiting period.

Special Late Enrollment Circumstances

These are circumstances under which we will approve a late enrollment without requiring a 12-month waiting period.

Late Enrollment Arising From Loss of Other Coverage

If you and your dependents are not enrolled but are otherwise eligible for coverage, you may enroll yourself and your eligible dependents if **all** of the following apply:

- You had submitted an enrollment form within 30 days of your initial date of eligibility and waived the benefits of this policy for yourself and your eligible dependents for the express reason that you had other health coverage.

- You and your dependents were either eligible for coverage or were covered by this policy when you initially waived the benefits of this policy.

- You lost coverage for yourself and your dependents under the other group health plan or qualifying health insurance coverage that you had when you waived the benefits of this policy.

- We receive your application for enrollment for yourself and your eligible dependents within 30 days after your other health coverage ends.

Under these circumstances, coverage for you and/or your dependents will begin on the date your other health coverage ended.

Other Special Late Enrollment Circumstances

If you are an active member of the class of eligible employees and have completed any waiting period required by your employer, you may enroll yourself and your eligible dependents under the circumstances listed below.

1. You acquire an eligible dependent through marriage, birth of a child, or adoption or placement for adoption of a child.

2. Your spouse's employer terminates its contribution for your health plan coverage.

3. The amount of premium you are required to contribute for coverage under this policy decreases by at least 10% of the total premium in any 12-month period.

Note: In the above circumstances, we must receive an enrollment form from you, listing all individuals for whom you wish coverage, within 30 days of the date you experience the special late enrollment circumstance. If we do, coverage for you and/or your eligible dependents will begin on the date you experience the special late enrollment circumstance. If we receive your enrollment form after the 30-day period, you and/or your eligible dependents will have to exhaust a 12-month waiting period before coverage becomes effective.

4. You and/or your dependents become ineligible for Medicaid or BadgerCare or you and/or your dependents become eligible for Wisconsin's premium assistance subsidy under Medicaid or BadgerCare.

   Note: In either of these circumstances, we must receive an enrollment form from you, listing all individuals for whom you wish coverage, within 60 days of the date you experience the special late enrollment circumstance. If we do, coverage for you and/or your eligible dependents will begin on the date you experience the special late enrollment circumstance. If we receive your enrollment form after the 60-day period, you and/or your eligible dependents will have to exhaust a 12-month waiting period before coverage becomes effective.

Note: These provisions regarding "Special Late Enrollment Circumstances" do not apply to you or your dependents if you are on an unpaid leave (except if you have continued your coverage under this policy pursuant to "Your Legal Rights to Continuation and Conversion Coverage," described later in this section, or are on leave under the Family and Medical Leave Act).

Annual Open Enrollment

If your employer is required to provide an annual open enrollment under the federal Patient Protection and Affordable Care Act, you and/or your eligible dependents may enroll during your employer's annual open enrollment period.

Your coverage will begin on the effective date specified by your employer for the annual open enrollment, but only if **both** of the following apply:

- You complete an enrollment form, listing all individuals for whom you wish coverage.

- We receive your completed enrollment form within the annual open enrollment period specified by your employer.

If you do not meet both of these criteria, then you and/or your eligible dependents will have to exhaust the 12-month waiting period under "Rules for Late Enrollments" before coverage becomes effective unless you satisfy the conditions described under "Special Late Enrollment Circumstances," or you and/or your eligible dependents are eligible to enroll under an "Annual Open Enrollment" sooner.

Your Legal Rights to Continuation and Conversion Coverage

In certain cases, you and/or your eligible dependents may be eligible to continue coverage under your employer's group health plan in accordance with state continuation and conversion law and/or the Federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), if coverage is lost due to specific qualifying events. Continuation coverage is offered by the employer or the "plan administrator" designated by the employer to administer continuation coverage under state continuation law and COBRA.

Please contact your employer or their "plan administrator" if you have questions related to state and federal continuation coverage, and/or eligibility for such coverage.

Wisconsin Continuation and Conversion Law – General Rule

You and/or your eligible dependents may elect continuation or conversion coverage if you were continuously covered under the policy for a period of at least three months and coverage is terminated due to one of the events listed below:

1. The termination of your employment for reasons other than gross misconduct.

2. A reduction in the number of your work hours.

3. Your death.

4. Your divorce or the annulment of your marriage.

Your employer must provide you with written notice of the right to continuation and conversion coverage within five days of receiving notice to terminate coverage. You must elect continuation coverage within 30 days of receiving this notice. If you choose continuation coverage, your coverage is identical to the coverage provided to other active employees under the policy.

Continuation coverage may continue under the policy until the earliest of the following dates:

1. The date on which you or your covered dependents become eligible for any other group health coverage.

2. The date on which the 18-month period of continuation coverage ends.

3. The end of the period for which the last premium was paid in full and on time.

4. The date this policy terminates for any reason.

5. For your former spouse, the date your coverage under this policy ends.

6. The date you or your dependent establishes residence outside of Wisconsin.

7. The date this policy ends for any reason.

You may enroll in our conversion policy when you have exhausted the maximum period of continuation coverage. You must notify us of your choice to enroll in the conversion policy and pay the required premium within 30 days after continuation coverage ends. If you do so, coverage under the conversion policy will begin on the day after continuation coverage under this policy ends.

The coverage provided by our conversion policy is similar but not identical to the coverage provided by this policy. The premium for conversion policy coverage for each individual will be based on the rate for coverage under this policy, but will contain actuarial modifications for several factors. Those factors include the individual's age and geographic location and our additional cost of providing personalized administration of the policy. These modifications may increase the conversion policy premium above the rate for coverage under this policy. Call us if you are interested in information about the conversion policy.

Section 4
General Provisions That Apply to All Benefits

This policy covers a comprehensive range of health care services including benefits required by state and federal law. However, not all health care services are covered even when they are beneficial and recommended by a Physician. This section details the three criteria by which we determine whether your services are covered:

1. Illness and Injury.

2. Medical necessity.

3. Medical appropriateness.

This high deductible health policy will not pay for any covered service, including prescription drugs, until the plan deductible has been satisfied. There is an exception to this rule: If you go to Network providers, we will pay for preventive health care services as described in Section 6 before the deductible is satisfied. Please see your Benefit Summary for the deductible amount that applies. Some services require our advance authorization. Those services are specified on our website, weatrust.com, or you may obtain the information by calling our customer service department. Some services are explicitly excluded in Section 5 or in Section 6 under the specific benefit provision to which they pertain.

This section also explains the factors that affect the amount of reimbursement for covered services:

1. Your choice of health care provider (Network or non-network provider).

2. Maximum allowable fee.

3. Coding and billing standards.

4. Reimbursement limit on services that require preauthorization.

5. Cost-effectiveness limit.

6. Deductibles.

7. Coinsurance.

8. Copayments.

9. Maximum out-of-pocket limit.

10. Maximum benefit amount.

How We Determine if a Service Is Covered

We cover services when we find them to be medically necessary and medically appropriate for diagnosing or treating Illnesses and Injuries. You must prove to our satisfaction that the services you receive fulfill these criteria.

Whenever we have questions about whether claims meet these criteria, we rely on objective, contemporaneous, clearly documented medical records and the advice of our medical consultants. To provide the information we need to determine whether services meet our criteria for coverage, medical records should meet the documentation standards of the relevant medical and/or professional organization. If we are unable to establish the medical necessity and medical appropriateness from the medical documentation we receive, we will not authorize or reimburse for the services.

Some providers charge for copying and/or submitting medical records and 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 provider of our choice whenever it is necessary to evaluate a claim. When we do so, we pay the cost.

We evaluate claims by three tests. A claim must pass each test to qualify for reimbursement.

1. We determine whether there is an Illness or Injury.

We cover only services to diagnose or treat Illnesses or Injuries, except for the specified routine services listed throughout Section 6 and those preventive services that we are required by law to cover.

When we use the term Illness, we mean 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.

When we use the term Injury, we mean an occurrence or event that hurts, damages, or wounds the body to the extent that it impairs the soundness of health or bodily functions.

2. Then, we determine whether the service is medically necessary.

A diagnostic service is medically necessary if we find it meets **all** of these conditions:

- It is responsive to symptoms actually experienced or other manifest indications of Illness or Injury.
- It is likely to yield additional information that is useful for healing, curing, or planning medical treatment.
- It is not redundant when performed with other procedures that have been or are performed.

Equipment, facilities, and supplies are medically necessary if they are required for the safe and effective delivery of covered health care services. Any exceptions to this criterion are specifically listed in Section 6.

Other health care services are medically necessary if they are **required** to accomplish one of the following:

- Heal, cure, or alleviate either the symptoms or the underlying cause of an Illness or Injury.
- Promptly rehabilitate a functional deficit or impairment caused by an Illness or Injury.
- Promptly restore a specific bodily function or condition to its status prior to an Illness or Injury.
- Significantly improve the functioning of a malformed body part.

Services that are redundant when performed with other procedures that have been or are performed will not be considered medically necessary.

Note: Many beneficial health care services are recommended by Physicians but are not medically necessary as we use the term.

Medically necessary services exclude services performed in the absence of a diagnosed Illness or Injury and, thus, are not covered by this policy. There is an exception: We cover those preventive services required by law or as explicitly listed in the "Maternity and Newborn Benefits," "Reproductive Health Benefits," and "Routine Physical and Preventive Care Benefits" provisions in Section 6. This policy does not cover other preventive services or treatments.

Medically necessary services also exclude treatments aimed at the development or acquisition of a functional ability that has not previously been achieved and, thus, are not covered by this policy.

3. Finally, we determine whether the service is medically appropriate.

A service is medically appropriate if we find it to be both a safe and an effective response to the medical circumstances, as described below. We base our decisions about safety and effectiveness on contemporary medical consensus, which is also described below.

Contemporary medical consensus is demonstrated by general agreement among a significant portion of the medical community that specializes in the relevant field. In determining contemporary medical consensus, we consider one or more of the following:

- Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.

- Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline and MEDLARS database Health Services Technology Assessment Research (HSTAR).

- Medical journals recognized by the Secretary of Health and Human Services under the Social Security Act.

- These standard reference compendia: The American Hospital Formulary Service—Drug Information, The ADA/PDR Guide to Dental Therapeutics, current edition, and The United States Pharmacopoeia—National Formulary.

- Findings, studies, or research conducted by, or under the auspices of, federal governmental agencies and nationally recognized federal research institutes.

- Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services.

Contemporary medical consensus is **not** demonstrated by sources such as the following:

- Results of studies sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer.

- Anecdotal evidence of patients or Physicians.

- Studies published in other than peer-reviewed resources such as those listed above.

- Internet articles that do not have their foundation in one of the sources listed above.

A service is safe if we find that it meets both of these conditions:

- Contemporary medical consensus considers the risk of negative health effects acceptable in the patient's specific medical circumstances.

- Qualified providers perform the services within the scope of their license and/or certification. Qualifications include such education, training, state licensure, and professional certification as is legally required or recommended by credible professional societies.

  Qualified providers include those who are specified in this policy, those whose services we are required by law to cover, and others whom we determine, in our sole discretion, to be qualified to provide reimbursable services.

A service is effective if we find that it meets both of these conditions:

- Contemporary medical consensus predicts the service will diagnose or correct the patient's

Illness or Injury either in whole or significant measure. For example, services that have not been demonstrated in randomized clinical trials to have long-term efficacy or services we deem to be marginally effective will not be considered medically appropriate.

- Contemporary medical consensus considers the service, method of delivery, duration, frequency, and intensity of the service to be responsive to and commensurate with the patient's diagnosis, symptoms, and specific medical circumstances. For example, services that we deem inconsistent with current medical standards of practice for the patient's specific condition will not be considered medically appropriate.

We consider medical devices, drugs, and biologicals safe if they have been accepted for marketing by the FDA and they are being used in accordance with the specifications in the FDA-approved label. However, FDA approval does not guarantee we will find the device, drug, or service to be effective.

We consider a treatment of unproven safety and effectiveness to be an Experimental/Investigative service if it is the subject of 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. See Section 2 for our criteria defining Experimental/Investigative services.

Our medical review unit will determine if the service in question is an Experimental/Investigative service.

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

Factors That Affect the Reimbursement Amount

Your Choice of Health Care Provider (Network or Non-network Providers)

Your choice of health care provider determines how much we will reimburse for covered services and, consequently, how much you must pay for your health care. Specifically, deductible, coinsurance, copayment, and maximum out-of-pocket amounts vary depending on whether you choose to receive your health care services from a Network or non-network provider. Copayment amounts you must pay out-of-pocket are generally less for Network providers than for non-network providers, and may be different for primary care providers than specialty care providers.

When you use a Network provider, we will pay the amount we have contracted to pay for each covered service, subject to applicable deductible, coinsurance, and copayment amounts, and our cost-effectiveness criteria. When you use a non-network provider and the provider's charge exceeds the amount we pay for the most cost-effective service, you are responsible for the remainder of the amount charged, as well as applicable deductible, coinsurance, and copayment amounts.

When we use the term provider, we mean the following:

- Physicians and other qualified providers.

- Hospitals, clinics, skilled nursing facilities, and other health care facilities.

- Other providers of medical services, equipment, and supplies.

The term **Network provider** refers to any provider in the Preferred Provider Network listed on your health insurance identification card. The term **non-network provider** refers to all other providers.

Provider Directory

You can access our provider directory online at weatrust.com or request a paper copy by calling our customer service department. The directory contains a listing of the Physicians, clinics, Hospitals, durable medical equipment providers, and transplantation centers in the Network that services your plan.

Provider information changes constantly. Therefore, if using a Network provider is an important part of your health care decision, visit our website, weatrust.com, to view our most current provider information or call us toll-free at (800) 279-4000 to confirm Network membership before you receive care.

You Will Save Money When You Use Network Providers

You receive the most reimbursement your health plan provides only when you obtain covered services from Network providers. The amount you must pay out-of-pocket for your health care will be significantly more when you receive services from non-network providers. Out-of-pocket expenses may include deductible, coinsurance, and copayment amounts, as well as reimbursement reductions based on the reimbursement rules described in this policy. The deductible, coinsurance, and copayment amounts that apply to Network and non-network provider services are specified on your Benefit Summary.

We will apply the Network deductibles, coinsurance, copayments, and maximum out-of-pocket limits shown on your Benefit Summary to covered services that you receive from this plan's Network providers. We will apply the non-network deductibles, coinsurance, copayments, and maximum out-of-pocket limits shown on your Benefit Summary to covered services that you receive from non-network providers. There is one exception: Deductible, coinsurance, and copayment amounts you pay for prescription drugs, whether you obtain the drugs from a participating or non-participating pharmacy, are applied to the Network deductible and maximum out-of-pocket limit.

> **Note**: Except for prescription drugs, the amounts we apply to your non-network deductible are not transferable, and do not apply to your Network deductible. You must meet each deductible separately, if you seek services from both Network and non-network providers.

Reimbursement for Emergency Services from Non-Network Providers

We recognize that there may be times when you need medical emergency services and it is not reasonably possible for you to reach a Network provider. If you receive such medical emergency services from a non-network provider, or are admitted to a non-network Hospital under these circumstances, we will reimburse for covered services at the deductible, coinsurance, and

copayment amounts that apply to Network providers. Our reimbursement will be subject to our maximum allowable fee and all policy provisions, including Hospital admission notification and preauthorization requirements, if applicable. Read about "Emergency Services By Non-Network Providers" below, "Emergency Services" in Section 6 and "Hospital Notification Requirements" in Section 7.

Reimbursement for Urgent Care from Non-Network Providers

We realize that there may be times when you need urgent care outside of your provider's normal office hours. Or, on occasion you may need urgent care when it is not possible for you to reach a Network provider. If you receive such urgent care services under these circumstances, we will reimburse for covered services at the deductible and coinsurance amounts that apply to Network providers. Our reimbursement will be subject to your copayment requirements, our maximum allowable fee, and all policy provisions. Read about "Urgent Care" services in Section 6.

Identification Card

After you enroll, you will receive an insurance identification card. You must present this card each time you receive services from any provider. You may also use this card to obtain covered prescription drugs at any participating pharmacy. You may get the names of participating pharmacies in your area by visiting our website or by calling us.

Maximum Allowable Fee

We reimburse charges in accordance with our maximum allowable fee schedule. If a charge for a service or group of services exceeds this amount, we will reimburse less than the billed charge. You are responsible for any amount that exceeds our maximum allowable fee, and that excess amount does not apply to your deductible or maximum out-of-pocket limit.

Network Providers—For Network providers, our maximum allowable fee is the lesser of the following:

- The fee we have contracted to pay your Network providers for the most cost-effective covered service.

- The fee charged by the provider.

To determine if your provider is in the Network, please visit our website, weatrust.com, and click on the online provider directory. You can also contact our customer service department at (800) 279-4000.

Non-Network Providers—Unless the non-network provider's billed charge is less than any of the following maximum allowable reimbursement amounts, our reimbursement will be less than the provider's billed charge. You are responsible for any amount that exceeds our maximum allowable fee and that excess amount does not apply to your maximum out-of-pocket limit.

The maximum allowable fee for emergency services and for services for which we have contracted with specialty Network providers is described later in this section. For all other

services, the first of the following options that applies to the provider from whom you seek care will determine our reimbursement:

1. The fee that we have negotiated with the provider who is billing you for this service.

2. The fee that entities we are affiliated with have negotiated with the provider who is billing you for this service.

3. A percentage, determined by us, of the Medicare-allowable amount for the same or similar service provided in the same geographic area. Please see your Benefit Summary for the percentage of the Medicare-allowable fee we currently use.

4. A percentage, determined by us, of the fee we have contracted to pay Network providers. Please see your Benefit Summary for the percentage of the contracted Network provider fee we currently use.

5. For providers of residential mental health or substance abuse treatment in the state of Wisconsin, the daily rate will be the fee paid to residential care centers as determined by the State of Wisconsin Department of Children and Families.

6. For providers of residential mental health or substance abuse treatment outside of Wisconsin, the daily rate will be the lowest fee payable to residential care centers as determined by the State of Wisconsin Department of Children and Families.

Emergency Services by Non-Network Providers—The maximum allowable fee for emergency care services from a non-network provider will be the greatest of the following:

1. The amount negotiated with Network Providers for the emergency service furnished.

2. The amount for the emergency service calculated using the same method we generally use to determine payments for non-network services but substituting the Network cost-sharing provisions for the non-network cost-sharing provisions.

3. The amount that would be paid under Medicare for the emergency service.

Services by Specialty Network Providers—You may receive services from any qualified provider. However, we have contracted with providers in specialty Networks because of their outcomes and survival rates, credentialing and experience of staff, volume of procedures performed for each service, or overall cost-effectiveness.

If the covered service is one for which we have contracted with a specialty Network, as described in the preceding paragraph, our reimbursement limit is the contracted amount. Therefore, if you choose to receive the service from our specialty Network, we reimburse the full cost of the service, less applicable deductible, coinsurance, and copayment amounts that apply to our specialty Network. If you choose to receive the service from another provider, you will be responsible for the difference between that provider's charge and our contracted amount, in addition to applicable deductible, coinsurance, and copayment amounts, charges that do not

comply with industry-accepted coding and billing standards, and the policy's reimbursement rules.

If you have questions about how we determine our maximum allowable fee, or if you would like to know whether your health care provider's charge will be within our maximum allowable fee, call our customer service department. When you call, we will need this information to answer your question:

- The procedure or billing code for the service or services that will be performed. Your Physician can provide this to you.
- The estimated charges for each procedure or billing code.
- Your Physician's name and zip code.
- The approximate date you will receive the service.

Coding and Billing Standards

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 claims for services that are billed inconsistently with industry-accepted coding standards.

Reimbursement Limit on Services That Require Preauthorization

It is important that you obtain our advance approval before receiving any of the services that require preauthorization. Services that require preauthorization are listed on our website, weatrust.com. If you do not receive our advance authorization of expenditures for these services, we have no obligation to reimburse you.

Cost-Effectiveness Limit

When more than one viable alternative service or treatment protocol is available for diagnosis or treatment, we evaluate the predicted health benefits, risks, and costs of services that are comparable in safety and effectiveness for your medical circumstances. When we deem benefit/risk relationships to be comparable, you may choose the treatment you wish, but we reimburse no more than the maximum allowable fee for the most cost-effective service. The most cost-effective alternative is one 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.
- The service is received in the least costly setting required for safe delivery of those services. Examples: An inpatient Hospital stay is cost-effective only if you cannot be safely treated as an outpatient. Use of an ambulatory (outpatient) surgical center is cost-effective only if the surgery cannot be safely performed in a Physician's office or clinic setting.

If we find that a more costly service is reasonably expected to produce a more beneficial outcome, we may determine it to be the cost-effective alternative because the predicted improved outcome justifies additional expenditure.

Deductibles

Except for preventive services, reimbursement for covered services may be subject to a deductible. The deductible is the amount that you must pay in a Benefit Period for covered services before we will reimburse you for any covered costs you incur during the remainder of that Benefit Period. The deductible must be satisfied in each Benefit Period. Deductible amounts you must pay out-of-pocket are generally less for Network providers than for non-network providers. Any amounts you pay for charges in excess of our maximum allowable fees do not count toward your deductible.

> **Note**: Except for prescription drugs, the amounts we apply to your non-network deductible are not transferable, and do not apply to your Network deductible. You must meet each deductible separately, if you seek services from both Network and non-network providers.

To qualify as a health savings account-qualified high deductible health plan, the deductible amounts must be equal to or greater than the lowest amounts allowed by the Internal Revenue Service (IRS). This means that each year, at the beginning of the Benefit Period, we will adjust your deductibles to reflect the updates published by the IRS. We will notify you at least 60 days in advance of the annual change in your deductible amount.

How we calculate and apply the deductible(s) depends on whether your plan has an aggregate or embedded deductible. Your Benefit Summary specifies which type of deductible applies to your plan.

Aggregate Deductible—The deductible that applies to your plan depends on whether you have single or family coverage. If you have single coverage, you must pay for all covered services until you satisfy the individual deductible. If you have family coverage, the individual deductible does not apply. You and your covered family members must pay for all covered services until your combined covered expenses satisfy the family deductible. Once the family deductible is met, no further deductible applies to any family member for the remainder of the Benefit Period. It is possible that the family deductible can be met by only one covered family member on behalf of the entire family. The individual and the family deductible amounts, for both Network and non-network services, are specified on your Benefit Summary.

Embedded Deductible—Once an individual satisfies the individual deductible, no further deductible applies to him or her for the remainder of that Benefit Period. If you have family coverage, amounts applied to the individual deductible for each covered family member are also applied to the family deductible. Once the family deductible is met, no further deductible applies to any family member for the remainder of that Benefit Period. The individual and the family deductible amounts, for both Network and non-network services, are specified on your Benefit Summary.

Coinsurance

Reimbursement for covered services may be subject to a coinsurance payment. This means we pay only a specified percentage of the maximum allowable fee for covered services, and you are responsible for paying the remainder. Coinsurance amounts you must pay out-of-pocket are generally less for Network providers than for non-network providers. Your Benefit Summary specifies the coinsurance percentages you must pay, for both Network and non-network services, and the services to which they apply.

Copayments

Reimbursement for covered services may be subject to a copayment. A copayment is a fixed amount you must pay out-of-pocket each time you receive certain services. For example, Physician office visits, urgent care visits, emergency room visits, and the prescription drug benefit of this policy may be subject to copayments. Copayments do not apply to all services, and the amount may vary for different services. Copayments you must pay out-of-pocket are generally less for Network providers than for non-network providers. Copayments for primary care providers may also be different than copayments for specialty care providers, with one exception. The copayment you must pay for a psychiatrist will always be the same as the copayment you must pay for a primary care provider. Your Benefit Summary specifies copayments you must pay, for both Network and non-network services, and the services to which they apply.

Maximum Out-of-Pocket Limit

The maximum out-of-pocket limit is the most that you must pay for deductible, coinsurance, and copayment amounts during any Benefit Period. Maximum out-of-pocket limits are higher for non-network providers than for Network providers.

> **Note**: Except for prescription drugs, the amounts we apply to your non-network maximum out-of-pocket limit are not transferable, and do not apply to your Network maximum out-of-pocket limit. You must meet each maximum out-of-pocket limit separately, if you seek services from both Network and non-network providers.

Your Benefit Summary specifies which of the following apply toward your maximum out-of-pocket limit:

- Deductible.
- Coinsurance.
- Copayments.

The following **never** apply to the maximum out-of-pocket limit:

- Amounts you pay that exceed the maximum benefit amount specified on 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 preauthorized services.
- Penalty amount for failure to obtain a required preauthorization.
- Penalty amount for failure to comply with our Hospital admission notification requirements.
- Amounts you pay for charges that do not comply with the policy's reimbursement rules.

How we calculate and apply the maximum out-of-pocket limit(s) depends on whether your plan has an aggregate or embedded maximum out-of-pocket limit. Your Benefit Summary specifies which type of maximum out-of-pocket limit applies to your plan.

Aggregate Maximum Out-of-Pocket Limit—The maximum out-of-pocket limit that applies to your plan depends on whether you have single or family coverage. If you have single coverage, once the individual maximum out-of-pocket limit is met we will reimburse 100% of the maximum allowable fee for covered services during the remainder of the Benefit Period, except for amounts that do not apply to the maximum out-of-pocket limit. If you have family coverage, the individual limit does not apply to your coverage. Out-of-pocket amounts for all individuals are instead applied toward the family maximum out-of-pocket limit. Once the family limit is met, we reimburse 100% of the maximum allowable fee for covered services incurred by any covered family member during the remainder of that Benefit Period, except for amounts that do not apply to the maximum out-of-pocket limit.

Your Benefit Summary specifies the individual and family maximum out-of-pocket limits that apply to your coverage, for both Network and non-network providers, and the out-of-pocket costs that apply toward those limits.

Embedded Maximum Out-of-Pocket Limit— The individual maximum out-of-pocket limit applies to each covered individual. Once an individual meets the individual limit, we reimburse 100% of the maximum allowable fee for covered services for that individual during the remainder of that Benefit Period, except for amounts that do not apply to the maximum out-of-pocket limit. If you have family coverage, out-of-pocket amounts applied to the individual maximum out-of-pocket limit for each covered family member are also applied toward the family maximum out-of-pocket limit. Once the family limit is met, we reimburse 100% of the maximum allowable fee for covered services incurred by any covered family member during the remainder of that Benefit Period, except for amounts that do not apply to the maximum out-of-pocket limit.

Your Benefit Summary specifies the individual and family maximum out-of-pocket limits that apply to your coverage, for both Network and non-network providers, and the out-of-pocket costs that apply toward those limits.

Maximum Benefit Amount

This amount, which is specified on your Benefit Summary, is the total amount this policy will reimburse for certain types of treatment or services for each covered individual during the

"Benefit Period" specified on the Benefit Summary. 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.

Policy Changes

If any policy 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 Policy Requirements

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

Section 5
General Exclusions

All benefits are subject to the general exclusions listed in this section. Other exclusions appear in Section 6 under the specific benefit to which they apply. Limitations that affect reimbursement for covered services are discussed under "Factors That Affect the Reimbursement Amount" in Section 4.

We do not reimburse expenses for, or in connection with, the following:

- Legal services.
- Missed appointments.
- Copying and providing medical or any other type of information in support of a claim.
- Travel and lodging.
- Experimental/Investigative treatments and services.
- Services rendered by a massage therapist.
- Weight control, weight loss, or the treatment of obesity, including, but not limited to, prescriptions, programs, and surgeries.

  Note: While we never reimburse for weight control, weight loss, or the treatment of obesity, we reimburse the following services, as required by law: Comprehensive, intensive nutritional counseling by qualified providers for obese adults and adults at higher risk for diet-related chronic disease, and comprehensive, intensive nutritional counseling and behavioral interventions for obese children.

- Replacement of prescription drugs or medications, orthotics, prosthetics, or equipment that are lost, stolen, damaged, misplaced, missing, or otherwise compromised.
- Vocational rehabilitation, including work-hardening programs.
- Augmentative and/or alternative communicative devices and systems.
- Bariatric surgery, gastric restrictive or bypass procedures, or similar surgeries.
- Services for, or in connection with, or leading to, gender reassignment.
- Routine foot care except in cases where such foot care may pose a hazard for a patient with a recognized medical diagnosis, such as diabetes, peripheral neuropathies (as determined by

us), arteriosclerosis, or chronic thrombophlebitis. Routine foot care includes, but is not limited to, the treatment of corns, calluses, plantar keratosis, and nail trimming.

- Foot orthotics.
- Compression stockings.
- Tobacco cessation aids, except for specified prescription and over-the-counter aids as described in Section 6, "Tobacco Cessation Benefits."
- Blood pressure cuffs.
- Non-wearable automated external defibrillator (AED).
- Cranial banding.
- Enuresis alarms.
- Appliances for snoring.
- Ultrasonic nebulizers.
- Private duty nursing services.
- Gene therapies, treatments, or enhancements.

  Note: While we never reimburse for gene therapies, treatments, or enhancements, we reimburse for genetic testing and/or genetic counseling as specifically provided under "Maternity and Newborn Benefits" in Section 6.

- Office visits, Physician charges, or any other service for, or in connection with, a procedure or service that this policy does not cover. This includes, but is not limited to, follow-up Physician and/or Surgeon visits, diagnostic tests necessary only or primarily because of the noncovered procedure, services to repair a failed procedure or service, services to repair scarring from services or surgery that this policy does not cover, and home health care required as a result of a noncovered procedure or service. This exclusion applies except where reimbursement is otherwise required by law.
- Equipment or services to prevent Injury or to facilitate participation in physical activity or sports.
- Services to prevent Illness, except for those expressly listed in Section 6 or that we are required by law to cover.
- Immunizations obtained solely for the purpose of traveling outside of the United States.

- Services or items for physical fitness, wellness, health education, vitamins, or personal hygiene.

- Nutritional or diet supplements, except for those that we are required by law to cover.

- Services to educate or help adapt to a diagnosis or a chronic physical or mental condition. Examples are stress management classes and education and awareness training for those suffering from chronic pain.

- Services to improve an existing physical or mental state in the absence of an Illness or Injury.

- Services to treat impotence and erectile dysfunction.

- Services to improve appearance. Examples are services to improve skin appearance, cosmetic surgery, and services to remove keloids or repair scarring or disfigurement resulting from body piercing, tattooing, implants, or other services or procedures that are not medically necessary or medically appropriate and/or were not performed by a licensed medical professional.

  Cosmetic surgery is elective surgery performed primarily to improve appearance. The procedure would provide little or no accompanying meaningful improvement in the functioning of a malformed body part or restoration of a bodily function.

- Services, drugs, and injections for male or female baldness or hair loss regardless of the cause, including hair restoration, hair transplants or hair implants.

- Services or supplies provided primarily for the convenience or personal preference of the patient, the Physician, the patient's family, or any other person.

- Custodial or long term care. By this, we mean services that can generally be provided by persons without professional medical training or skills and that are primarily for one or more of the following purposes:

  - Maintaining an individual's existing physical or mental condition of health.

  - Preserving an individual's condition from further decline.

  - Assisting an individual in performing the activities of daily living, such as bathing, eating, dressing, toileting, and transferring.

  - Protecting an individual from threats to health and safety due to cognitive impairment.

  - Meeting an individual's personal needs.

  We consider such services to be custodial even if provided by registered nurses, licensed practical nurses, or other trained medical personnel.

- Services that continue after the patient reaches the expected state of improvement, resolution, or stabilization of a health condition.

- Holistic or homeopathic remedies and preparations.

- Services or interventions that, while they may be beneficial, have not been scientifically documented as safe and effective for a specific Illness or Injury. Examples include, but are not limited to, acupuncture, acupressure, guided imagery, meditation, Rolfing, reflexology, yoga, hypnosis, aromatherapy, relaxation techniques, herbal medicine, naturopathy, iridology, Ayurvedic medicine, and massage.

- Medical services that have not been proven in randomized clinical trials and recognized by contemporary medical consensus as being both safe and effective.

- 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:

  1. Employees who are actively at work and their covered dependents.

  2. Individuals who are covered by our standard family plan.

  3. Individuals who are covered under state and federal continuation (COBRA) coverage, unless they choose to waive prescription drug coverage under this plan.

  4. 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.

- Services or items furnished free of charge or for which you are not legally obligated to pay in the absence of insurance.

- Services that a child's school is legally obligated to provide, whether or not the school actually provides them and whether or not you choose to use those services.

- Services or items furnished or paid for by a governmental entity, facility, or program other than Medicaid, unless we are required to do so by specific law.

- Services or items required by a third party. Examples are services required for insurance, employment, or special licensing purposes.

- Court-ordered treatment unless it meets our criteria for medical necessity, medical appropriateness, and cost-effectiveness, or is otherwise covered under the policy.

- Costs incurred while you are not covered by this policy.

- Care for a medical condition that arises from, or originates during, service in the armed forces.

- Non-emergency services you receive outside of the United States.
- Care for a medical condition resulting from participation in a crime.
- Services provided to you by a covered member of your family.
- Services eligible for worker's compensation benefits, or benefits from any other payment program established by similar law, whether or not you apply for or receive them. This includes amounts received when a claim under worker's compensation or similar law is settled by stipulation or compromise.

Section 6
Specific Benefit Provisions

This section provides additional details about how the "General Provisions" of this policy (Section 4) apply to specific health care services. It also describes special provisions that apply to these benefits. Any service that is covered under this section is also covered when provided in connection with a clinical trial if required by state or federal law.

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

Also see your Benefit Summary for the coinsurance, copayment amounts, and maximum benefit limits that apply to specific health care services.

Reminder: The "Definitions" (Section 2), "General Provisions" (Section 4), and the "General Exclusions" (Section 5) also govern the actual benefits in every case. Reimbursement for covered services is subject to the "Factors That Affect the Reimbursement Amount," also in Section 4.

Advanced Imaging
Advanced imaging is provided in a Hospital or a free-standing facility, and consists of tests performed using magnetic resonance imaging (MRI), computerized axial tomography (CT) scans, or positron emission tomography (PET) scans. We reimburse for services by qualified providers, but only if the services are medically necessary and medically appropriate to diagnose Illnesses or Injuries.

Allergy Treatment
We reimburse only for those allergy tests and treatments that contemporary medical consensus considers safe and effective. We do not cover unproven or unconventional services even when prescribed by a Physician. In determining whether allergy services are covered, we rely on the standards of the American Academy of Allergy, Asthma, and Immunology (AAAAI). Thus, we cover only services that meet AAAAI's standards. We encourage you to share this information with your Physician when you decide on a treatment plan. If you wish, you may submit a written plan to us, and we will let you know whether we will cover the proposed treatment.

Covered Services
These are examples of services we cover if they are performed according to the standards of the AAAAI:

- Initial diagnostic evaluation. This includes the initial history, physical examination, relevant laboratory services, and the following diagnostic tests to determine the cause of an allergy:

1. Scratch tests or specific intradermal tests, if warranted by the patient's history and physical examination.

2. Specific laboratory tests to determine respiratory function and blood levels of the immune system.

3. In vitro (via a blood sample) allergy tests if skin testing is not conclusive, if the patient has a condition that precludes the use of scratch testing or intradermal tests, or if these tests are used in lieu of scratch or intradermal testing.

- Injections of antigens (immunotherapy) to build up immunities, if warranted by the diagnosis.

Services Not Covered

We do not cover testing or treatment that the AAAAI considers unproven or unconventional. These are examples of such services:

- Sublingual antigen drops, a technique in which antigens are administered sublingually (under the tongue) to provoke or treat allergic reactions.

- Provocative and neutralization testing and treatment, which involves placing allergy-producing substances under either the skin or the tongue and then "neutralizing" the symptoms with a weaker solution of the same substance.

- Repeated intradermal testing. Repeated testing is not covered unless information is provided that substantiates the need for continued intradermal testing according to AAAAI guidelines.

- Skin-test end-point titration for evaluating the effectiveness of immunotherapy.

- Food allergy desensitization therapy. Although testing for food allergies is covered under the policy if it is warranted by the history and physical examination, food allergy therapy is not. The AAAAI maintains that the only proven therapy in treating food allergies is the strict elimination of the offending food.

Ambulance Services

We reimburse for licensed ambulance transport if your condition requires rapid transport and the attendance of skilled medical professionals. You will be responsible for any deductible, coinsurance, and copayment amounts that apply to ambulance services for Network providers. We will pay 100% of the remaining charges.

Covered Services

- Licensed ground ambulance transportation to the nearest facility equipped to handle your Illness or Injury.

- Licensed air ambulance transportation to the nearest facility equipped to handle your Illness or Injury, but only if such swift transport is essential for your safe and effective treatment.

- Licensed ambulance transport between medical facilities, but only if you cannot be treated safely and effectively in the facility where you are confined and your condition requires the attendance of medical professionals during transport. In this case, reimbursement is limited to the cost of transportation to the nearest facility equipped to treat your medical condition.

We never cover ambulance transport that is primarily for the convenience of a patient, a family member, or a provider of services.

Autism Spectrum Disorder Treatment

We reimburse for evidence-based Intensive-Level and Nonintensive-Level services that qualify for coverage under state law, when you have a primary, verified diagnosis of an autism spectrum disorder. An autism spectrum disorder includes autism, Asperger's syndrome, and pervasive developmental disorder, not otherwise specified. For information about benefits for diagnostic testing for autism spectrum disorder, please see "Outpatient Treatment" under the "Mental Health and Substance Abuse Benefits" provision in this section of the policy.

We may require that you obtain a second opinion, at our expense, to confirm a diagnosis of autism spectrum disorder. If we require a second opinion, the provider will be one that is mutually agreeable to you and to us.

We cover Intensive-Level and Nonintensive-Level services prescribed by a Physician and provided by someone who is qualified, as defined by state law. For the majority of the services provided, the child's parent or legal guardian must be present and engaged in the intervention. Progress must be assessed and documented throughout the course of treatment. We may periodically request and review the treatment plan and summary of progress.

Covered Services

Intensive-Level Services

Intensive-Level services mean evidence-based behavioral therapies that help a child with autism spectrum disorder overcome the cognitive, social, and behavioral deficits associated with the disorder. Intensive-Level services may be provided for up to 35 hours per week, but must be provided on average for at least 20 hours per week, over a six-month period of time.

We reimburse for Intensive-Level services, for up to four, consecutive, cumulative years. This four-year period includes any time your child received Intensive-Level services prior to the effective date of coverage under this plan. Services must begin between the ages of two and nine.

If your child requires and qualifies for Intensive-Level services but is unable to receive them for an extended period of time, you or your authorized representative must promptly notify us. If you do not, your child may no longer qualify for Intensive-Level services. We will not deny reimbursement for covered Intensive-Level services if:

- You timely provide a reasonable explanation that we find acceptable; or,

- You send us documentation that your child was waiting for Wisconsin Medicaid Waiver program services.

Nonintensive-Level Services
Nonintensive-Level services are evidence-based therapies designed to sustain and maximize gains made during Intensive-Level services. For a child who has not and will not receive Intensive-Level services, Nonintensive-Level services mean evidence-based therapies that will improve the child's condition.

Transition from Intensive to Nonintensive-Level Services
Our reimbursement for Intensive-Level services will end on the earliest of the following dates:

- The date your child receives four consecutive, cumulative years of Intensive-Level services.

- The date your child no longer requires Intensive-Level services as supported by documentation from a provider.

- The date your child no longer receives evidence-based behavioral therapy for at least 20 hours per week, on average, over a six-month period of time and you fail to promptly notify us, or the reason for this interruption is not acceptable to us.

We will send you a written notice to explain why your child no longer qualifies for reimbursement for Intensive-Level services.

If your child is no longer eligible for reimbursement for Intensive-Level services, your child may qualify for Nonintensive-Level services. Once your child begins receiving Nonintensive-Level services, your child can never receive reimbursement for Intensive-Level services.

Services Not Covered
These are examples of services that are 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 an insured'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.

Chiropractic Treatment

In accordance with state law, we reimburse for chiropractic services on the same terms as medical services. Accordingly, we cover only chiropractic treatment that is reasonably expected to cure or alleviate your Illness or Injury or to restore a functional ability to its status prior to Illness or Injury. Treatment ceases to be covered when you have recovered from the acute stage of an Illness or Injury and further meaningful progress is expected to be minimal or difficult to measure. We decide whether further progress can be reasonably expected. When we make this decision, we consider your diagnosis, prognosis, medical and chiropractic records, progress notes related to prior treatment, contemporary medical consensus, and the advice of our chiropractic consultants. If you wish, you may submit your proposed treatment plan to us for preauthorization.

Covered Services

We cover only chiropractic treatment, X rays, and diagnostic services that meet all of these conditions:

- A Doctor of Chiropractic renders the services within the scope of his or her license.
- The need for services results from Illness or Injury.
- The International Chiropractic Association (ICA) and the American Chiropractic Association (ACA) consider the services to be an appropriate and effective response to the diagnosis or symptoms, or the therapy or procedure is taught in the core curriculum of the majority of accredited chiropractic colleges.
- The services are expected to promptly and significantly heal or cure an acute health condition or an acute exacerbation of a chronic health condition and normalize body function.

Services Not Covered

We do not cover any chiropractic service that does not meet all of the conditions listed above. For example, none of the following is covered:

- Services that continue after you have recovered from the acute stage of your Illness or Injury and further meaningful progress will be minimal or difficult to measure.

- Services to treat a chronic condition or any condition if there is no reasonable expectation of prompt and significant improvement.

- Services that continue after you reach your expected state of improvement, resolution, or stabilization of a health condition.

- Services intended to prevent a relapse, reversal, or exacerbation of a health condition.

- Services provided on a routine or scheduled basis in the absence of functional impairment, even if intended to maintain optimal functioning.

- Supplies, or counseling in connection with any supplies, such as vitamins, herbs, nutritional supplements, cervical pillows, shoe and heel lifts, and lumbar rolls.

  Note: While we never reimburse for supplies, or counseling in connection with any supplies, we reimburse for certain limited nutritional or diet supplements that we are required by law to cover.

- Orthotic devices unless custom made and prescribed by a Physician.

Congenital Heart Disease Surgery

Congenital heart disease (CHD) surgical procedures include, but are not limited to, surgeries to treat congenital conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels, and hypoplastic left or right heart syndrome. Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

Convenient Care Clinic Services

We reimburse for services provided at Convenient Care Clinics if they are medically necessary and medically appropriate to diagnose or treat Illnesses or Injuries. There is an exception: We cover the specified routine services listed throughout Section 6, and those preventive services that we are required by law to cover, even when you have no symptoms of an Illness or Injury.

Convenient Care Clinics are low-cost clinics that have convenient hours and locations for members that need medical diagnosis or treatment of minor medical problems. Such clinics are frequently co-located with retail pharmacies or shopping centers. Typically no appointments are necessary. The types of services frequently offered at such clinics include: diagnosis and treatment for upper respiratory infections, including ear and sinus infections, sore throats, bladder infections, minor burns, bug bites, and other skin irritations. In addition, some clinics may offer immunizations. Some clinics may offer minor lab services, such as urinalysis, monospot, rapid strep tests, TB skin tests, and pregnancy tests.

Convenient Care Clinics are usually staffed by nurse practitioners or physician assistants and are not urgent care clinics or emergency rooms. If a member needs urgent or emergency care, the clinic staff will refer the member to the appropriate setting. Such clinics may sometimes be referred to as Fast Care, Quick Care, Express Care, or Take Care clinics. A list of Network Convenient Care Clinics can be found on our website, weatrust.com.

Dental Services

Covered Services

We cover only these dental services:

- The initial treatment required to repair and restore the functioning of sound, natural teeth that have been injured. The term injured, as used here, does not include dental conditions resulting from eating, biting, disease, or decay. A sound, natural tooth is one that is organic, not manufactured. Therefore, bridges, implants, crowns, and dentures are not natural teeth. Any service for, or in connection with, their restoration and repair is not covered under this policy.

- Oral surgery performed by a Doctor of Dental Surgery (D.D.S.) or a Doctor of Medical Dentistry (D.M.D.) in connection with a service that is covered by this policy; for example, removal of impacted wisdom teeth.

- Hospital and ambulatory surgery center charges, including anesthesia charges, if you must receive dental care in one of these settings because you meet one of these two conditions:

    1. You are less than 5 years old.

    2. You have a chronic disability or medical condition that requires hospitalization or general anesthesia for dental care.

Services Not Covered

We do not cover dental services other than those described above. For example, we do not cover:

- Subsequent treatment to an injured tooth after the initial treatment.

- Orthodontia, occlusal adjustment, or dental restorations unless required to repair and restore the functioning of a natural tooth that is injured.

- Replacement of bridges, implants, crowns, or partial or full dentures.

- Extraction or replacement of natural teeth required because of disease or decay.

- Implants or oral surgery for, or in connection with, implants unless needed to repair and restore the functioning of a sound, natural tooth that has been injured.

- Orthognathic surgery unless required for the correction of a handicapping skeletal malocclusion that causes significant functional impairment.

- Behavior modification therapy or symptomatic care such as nutritional counseling and home therapy programs.

- Any service that is directed at improving the appearance of a tooth and that does not meaningfully restore the function of an injured tooth or any tooth; for example, bleaching.

Diabetes Supplies and Equipment

In addition to medical services, we reimburse for supplies and equipment essential for diabetes treatment. Information about our coverage criteria is provided under "Durable Medical Equipment and Supplies" below.

Covered Services

Covered supplies and equipment for diabetes treatment include:

- Insulin and other prescription drugs and medications prescribed for the treatment of diabetes. If your health plan coverage includes a prescription drug plan, these drugs and medications are subject to the provisions and reimbursement rules that apply to your drug plan. If your health plan does not provide prescription drug coverage, these drugs and medications are subject to the provisions and reimbursement rules that apply to other medical services.

- Test strips, swabs and wipes, autolets or lancets, syringes, and hypodermic needles for administering insulin. If your health plan provides prescription drug coverage, you should purchase these supplies with your prescription drug card at a pharmacy that participates in our prescription drug program. If your health plan does not provide prescription drug coverage, submit a claim to us after you purchase the drugs and/or supplies.

- Durable medical equipment such as insulin infusion pumps and non-invasive continuous glucose monitors. We cover the purchase of no more than one insulin infusion pump during a Benefit Period, and we may require you to use it for 30 days at our expense before we authorize its purchase.

- Diabetes self-management education programs.

Services Not Covered

We do not cover travel, lodging, meals, or other incidental costs related to participation in a diabetic self-management program.

Durable Medical Equipment and Supplies

Durable medical equipment, as we use the term, is equipment that is primarily and customarily used for a medical purpose in connection with an Illness, Injury, or disability. It is usually designed for long-term or repeated use, and not useful in the absence of Illness, Injury, or disability.

Information About Our Coverage Criteria for Durable Medical Equipment

We base our coverage of expenditures for durable medical equipment on medical necessity, medical appropriateness, and cost-effectiveness criteria described in Section 4, and on the additional cost-effectiveness criteria described below.

Cost-effectiveness—In comparing equipment alternatives, we consider whether distinct medical advantages justify greater cost or more frequent replacement. Thus, we do not cover added costs for equipment that has no advantage over a suitable alternative other than convenience or personal preference. We also do not cover repair or replacement of equipment damaged because of negligent use or abuse. We reserve the right to determine whether to rent or purchase.

Covered Equipment

These are examples of items we may cover:

- Durable medical equipment for home use. Examples are morphine pumps, oxygen regulators, infusion pumps, and specialized feeding equipment.

- Prosthetic devices to replace a missing body part. Examples are artificial limbs, artificial eyes, and full cranial hair prostheses (wigs) in the case of sudden onset baldness that is the consequence of a covered disease, accident, or medical treatment and that is sufficiently extensive to significantly alter the patient's appearance.

- Durable mechanical equipment (which does not meet our definition of durable medical equipment), such as wheelchairs and Hospital beds.

- Functional repair of durable medical equipment.

Covered Supplies

These are covered supplies:

- Orthopedic appliances. Examples are custom made orthotics (excluding foot orthotics) prescribed by a Physician, casts, splints, trusses, braces, and crutches for short-term or long-term use.

- Supplies necessary for the proper mechanical operation of equipment that we cover.

- Ostomy care items and catheter maintenance supplies.

Equipment and Supplies Not Covered

These are examples of items that are not covered:

- Items that are useful in the absence of Illness, Injury, or disability. Examples are air conditioners, air cleaners and purifiers, humidifiers, whirlpools, dehumidifiers, shoe and heel lifts, lift chairs, stair lifts, van lifts, physical fitness items such as exercise cycles, and other similar items for an individual's comfort, personal hygiene, physical fitness, or convenience.

- Routine maintenance of equipment. This applies whether or not we have purchased the equipment.

- Repair or replacement of equipment damaged because of negligent use or abuse.

- Equipment or supplies to facilitate participation in physical activity or sports.

- Over-the-counter supplies other than those listed above or in the subsection on "Diabetes Supplies and Equipment" earlier in this section.

- Foot orthotics.

Emergency Services

We recognize that if you need services as a result of a medical emergency, as defined below, there may be times when it is not reasonably possible for you to reach a Network provider for those services. Therefore, under such circumstances, we will reimburse for covered emergency services at the same deductible, coinsurance, and copayment amounts that apply to Network providers, even if received from a non-network provider or outside of the United States. Our reimbursement will be subject to our maximum allowable fee and all policy provisions, including our Hospital admission notification requirements. We will continue such reimbursement for covered emergency services until you are stabilized and able to be transported to a Network provider.

The copayment amount specified on your Benefit Summary for services received in an emergency room is waived if you are admitted as an inpatient for at least 24 hours as a result of the medical emergency.

Remember: If you are hospitalized overnight due to an emergency admission, you or a family member, Physician, or Hospital employee must notify us within 72 hours of being admitted or as soon as it is medically feasible for you to do so, whichever is later. If you don't notify us as required, your reimbursement will be reduced by the amount listed on your Benefit Summary, and this penalty does not apply toward your maximum out-of-pocket limit.

We reimburse for the use of Hospital emergency facilities only if an emergency room setting is required for obtaining covered services and the facility used is a Hospital as that term is defined in Section 2. If you receive services that could have been delivered safely and effectively in a less costly setting, or if the services received are not covered services, then we do not reimburse the cost of the emergency room. When they are sufficient for the delivery of appropriate medical services, an outpatient clinic, a Physician's office, or an urgent care center may be a cost-effective alternative to a Hospital emergency room. We will evaluate costs, medical circumstances, and those alternative facilities that are reasonably available to you when we determine whether Hospital emergency costs are covered.

Emergency care means services provided in an emergency facility for a bodily injury or sickness manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of that individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment of bodily functions.
- Serious dysfunction of any bodily organ or part.
- A significant change for the worse without immediate medical or surgical treatment.

Emergency care does not mean services for the convenience of the covered person or the provider of treatment or services.

These are examples of medical emergencies:

- 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.

These are examples of conditions that are not medical emergencies:

- Ordinary sprains.
- Cuts that do not require stitches.
- Earaches.
- Colds.

E-visits

We reimburse for covered e-visit services. An e-visit (online medical evaluation) is a real-time audio/visual interaction with a medical practitioner through a secured electronic channel

designated specifically for the purpose of providing a medical evaluation. An e-visit is typically member-initiated and used to address non-urgent, acute symptoms.

Information on our e-visit providers can be found on our website, weatrust.com.

Hearing Services

Covered Services

Covered hearing-related services are limited to:

- Diagnostic tests to establish or confirm a hearing loss and determine the cause.
- Treatment of hearing pathology caused by an Illness or Injury.
- Surgery to repair malformed or malfunctioning hearing-related structures.
- Cochlear implants.

  Services we may cover include the initial evaluation by an audiologist and otolaryngologist, Physician and Hospital services, and auditory and speech therapy following implant surgery.
- Hearing aids for you and your covered dependents certified as deaf or hearing impaired by a Physician or licensed audiologist. A hearing aid is an instrument or device, including related parts, attachments, or accessories, that is worn externally and designed to aid or compensate for impaired hearing. For your dependent child under age 18, our reimbursement is limited to one hearing aid per ear in each three-year period. For adults, our reimbursement is limited to one hearing aid per ear per lifetime. We cover the examinations, tests, or services for prescribing or fitting a hearing aid or device covered under this policy.

Services Not Covered

These are examples of services that are not covered:

- Batteries and cords.

Home Health Care

We reimburse for a limited number of medically necessary and medically appropriate home health care services per Benefit Period, based on a Physician-prescribed plan of care. While home health care benefits most often apply to part-time or intermittent medical care, we may cover more frequent services if they are a cost-effective alternative to other treatment arrangements.

Information About Our Coverage Criteria

We base our coverage of home health care services on your medical needs and our cost-effectiveness standards. We cover expenditures only if **all** of the following apply:

- You are convalescing or rehabilitating from an Illness or Injury.
- Your condition during recovery requires skilled nursing or skilled rehabilitation care.

- Home health care is the most cost-effective means of providing that care.

Services that qualify as skilled nursing and skilled rehabilitation care are described later in Section 6 under "Skilled Nursing Services" and "Skilled Rehabilitation Services."

Before we pay for services, we must receive and approve a written plan of care established by your Physician. In addition to the written plan, your Physician must certify both that:

- Your care would otherwise require confinement in a health care facility.

- The services you require are not available from members of your family or others living in your home without causing undue hardship.

After we approve the written plan of care, we have the right to determine and select the most cost-effective home health care providers to coordinate and/or deliver the services you need, and to negotiate and contract with them on your behalf. We select home health care providers from among the following: a licensed or Medicare-certified home health care agency, a certified rehabilitation agency, or a home health care agency that meets our standards.

Covered Services

Covered services may include:

- Evaluation of the need for home health care and development of a home care plan by a registered nurse or medical social worker, when approved or requested by the attending Physician.

- Part-time or intermittent skilled nursing care provided by, or under the supervision of, a registered nurse who is other than the covered employee, covered dependents, or one who ordinarily resides in the patient's home.

- Part-time or intermittent home health aide services provided under the supervision of a registered nurse or medical social worker, including assistance in the performance of normal activities of daily living when such assistance is incidental to medical services.

- Skilled rehabilitation services.

- Prescribed medical supplies, drugs and medications, and laboratory services.

- Home infusion services.

- Prescribed intravenous (parenteral) or feeding tube (enteral) nutritional support systems. We cover food substitutes used for enteral nutrition when they provide at least 60% of nutrition and the need is medically documented.

- Nutritional counseling provided or supervised by a certified or registered dietitian or nutritionist.

Services Not Covered
These are examples of services that are not covered:

- Services provided by the covered employee, covered dependents, or others who ordinarily reside in the patient's home.

- Services that, after instruction and demonstrated competence, can be reasonably and safely performed by the patient or the patient's family. Examples include, but are not limited to, routine insulin injection, self-urinary catheterization, general range-of-motion exercises, wound care for noninfected postoperative or chronic medical conditions, and long-term feeding by gastrostomy or jejunostomy tube.

Hospice Care
We reimburse for hospice care for terminally ill patients if the patient's condition would otherwise require confinement in a Hospital or a skilled nursing facility and hospice care is a cost-effective alternative. Hospice care includes services provided by a licensed public agency or private organization intended primarily to provide pain relief, symptom management, and medical support services to the terminally ill. Services may be rendered at hospice facilities or in the patient's place of residence.

Covered Services
These are examples of hospice services we may cover:

- Room and board at a hospice facility, including services to alleviate physical symptoms.

- Physician and nursing care.

- Home health care services.

- Prescription and nonprescription medications provided by the hospice agency, organization, or facility.

Hospital Benefits
We reimburse for the use of Hospital facilities, emergency or non-emergency, only if a Hospital setting is required for obtaining covered services and the facility used is a Hospital as that term is defined in Section 2. If you receive services that could have been delivered safely and effectively in a less costly setting, or if the services received are not covered services, then we do not reimburse the costs of the hospitalization. When they are sufficient for the delivery of appropriate medical services, a hospice, a skilled nursing facility, a skilled rehabilitation facility, a residential treatment facility, an outpatient surgery clinic, or a Physician's office may be a cost-effective alternative to a Hospital. We will evaluate costs, medical circumstances, and those alternative facilities that are reasonably available to you when we determine whether Hospital costs are covered.

We reimburse for covered services you receive from non-network providers at Network facilities; however, our reimbursement will be limited to the maximum allowable fee. You will

be responsible for any applicable deductible, coinsurance, and copayment amounts. You will also be responsible for the difference between the non-network provider's charges and our maximum allowable fee.

Hospital Admission Notification Requirement

To receive maximum reimbursement, you must notify us of any overnight hospitalization. If your hospitalization is or can be planned in advance, you must notify us before you are admitted—at least 5 days in advance, whenever possible. If you are hospitalized due to an emergency, you must notify us within 72 hours of being admitted or as soon as it is medically feasible for you to do so, whichever is later. If you don't notify us as required, your reimbursement will be reduced by the amount of the penalty shown on your Benefit Summary. See Section 7 for details of our Hospital admission notification requirements.

Special note about childbirth: Remember that you must notify us within 72 hours of your hospitalization for childbirth, unless you and your baby(ies) have been discharged within 72 hours of your admission. These notification requirements apply for other maternity-related emergency admissions as well, such as an admission for pre-term labor or other maternity complications when childbirth does not occur. If you do not notify us within the time required, your reimbursement will be reduced by the amount specified on your Benefit Summary, and this penalty does not apply to your maximum out-of-pocket limit.

Covered Services

Covered Hospital services include:

- Room and board charges.
- Outpatient and inpatient services ordered by a Physician essential for diagnosis or treatment.
- The attending Physician's medically necessary services. We cover services by another Physician at the request of the attending Physician only if those services are medically necessary due to the complexity of the patient's condition.
- Physician-ordered diagnostic tests and services expected to reveal new information that is useful for diagnosis or treatment. Examples include X rays, laboratory services, EEG, EKG, CT scans, ultrasound, and MRI.
- Emergency room treatment only if necessary due to the sudden and unexpected onset of severe symptoms.
- Hospital or ambulatory surgery center charges, including anesthesia, for dental care, but only if you are less than 5 years old or if you have a chronic disability or medical condition that requires hospitalization or general anesthesia for dental care.
- Covered drugs and medications administered during your Hospital stay.

Note: Take-home drugs are not reimbursed as part of your Hospital stay even if the prescription is filled at the Hospital pharmacy. Claims for take-home medications must be submitted in accordance with "Claim for Prescription Drugs" in Section 8. To avoid significant out-of-pocket cost, have your prescription filled at a participating pharmacy. Most Hospital pharmacies are nonparticipating pharmacies.

Services Not Covered

These are examples of services that are not covered:

- Nursing services performed during hospitalization by nurses who are not employees of the Hospital.

- Convenience items or services other than those that are incidental to room occupancy.

- X ray, laboratory, and other diagnostic services in connection with dental care, other than for oral surgery covered by this policy.

Kidney Disease Treatment

We reimburse for the treatment of chronic renal disease (CRD) or end-stage renal disease (ESRD), as required by state law. Covered services include medically necessary and medically appropriate kidney dialysis and transplantation services.

If you become entitled to benefits under Medicare solely because of ESRD, we will reimburse you as your primary insurer for the period required by Medicare laws. After that period, Medicare will be your primary insurer, and we will reimburse you as your secondary insurer even if you do not apply for Medicare benefits. To read about reimbursement rules that govern payments by primary and secondary insurers, see Section 9, "Coordination of Benefits in Claims Payment."

Information About Our Coverage Criteria for Kidney Disease Treatment

We apply the coverage criteria described in Section 4, "General Provisions That Apply to All Benefits" to your specific medical circumstances, but in general:

- We cover dialysis when recommended by a nephrologist and received at a renal dialysis center or facility certified by Medicare.

- We cover kidney transplantation when recommended by a transplant Surgeon and received at a facility that Medicare has certified for kidney transplantation. Read about our transplantation coverage criteria later in this section under "Surgical Benefits."

- We cover services at renal dialysis centers or renal transplant centers certified by Medicare.

Covered Services

These are examples of services we cover:

- Inpatient Hospital treatment including dialysis, surgery, and postoperative care.

- Dialysis performed at home by a trained ESRD patient or helper, or both.

- Inpatient, outpatient, or self-dialysis at a renal dialysis facility.

- Kidney transplantation, including coverage for both the recipient and the living donor. Covered services for living donors include evaluation, hospitalization, surgical costs, and postoperative care. Note that living donor services are covered only if the transplant recipient is covered by this policy.

- Procurement, transportation, and preservation of cadaveric donor kidneys.

Maternity and Newborn Benefits

We reimburse for maternity care for all women covered by this policy. We also reimburse for special diagnostic services for one or both parents in high-risk circumstances.

Newborns are insured from the moment of birth if family coverage is in force. If you have single coverage, you must notify us of the birth and pay the required premiums for family coverage within 60 days of the birth date. If you don't, we will refuse to insure the newborn unless within one year of the child's birth we receive all required premiums, plus interest as permitted by law, from the date of birth.

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 earlier.

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 our Hospital admission notification requirement.

Hospital Admission Notification Requirement

Remember that you must notify us within 72 hours of your hospitalization for childbirth, unless you have been discharged within 72 hours of your admission. These notification requirements apply for other maternity-related emergency admissions as well, such as an admission for pre-term labor or other maternity complications when childbirth does not occur. If you do not notify us within the time required, your reimbursement will be reduced. Read about our Hospital admission notification requirements in Section 7.

Covered Maternity Services

These are examples of covered maternity services:

- Prenatal care. This includes physical examination, Pap test, laboratory tests, and HIV antibody test.

- Physician services related to labor, delivery, and postpartum care.

- Nurse-midwife services related to prenatal care, labor and delivery, and postpartum care performed by either (1) a registered nurse certified to practice as a nurse-midwife by the American College of Nurse-Midwives and the State of Wisconsin; or (2) a licensed registered nurse certified as a nurse-midwife in the state in which he or she practices. Except for emergency circumstances, you must receive the nurse-midwife services in a health care facility approved for the practice of nurse-midwifery by the state in which it is located.

- Hospital room and board.

Covered Special Services When a Pregnancy Exists

We cover amniocentesis, genetic testing, genetic counseling, and chromosome studies if any of these circumstances exist:

- The pregnant woman is 35 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, or the pregnant woman's mate was exposed to such disease or chemicals before the pregnancy began.

Covered Special Services When No Pregnancy Exists

We cover genetic testing, genetic counseling, and chromosome studies that are expected to reveal new information relevant to the decision to have a child if any of these 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.

Covered Newborn Services

Covered newborn services include:

- Services required by a newborn immediately after birth including care and treatment for pre-term or premature birth, low birth weight, Respiratory Distress Syndrome (RDS), failure to thrive, and abnormal or inadequate liver function. **Note:** We do not cover extended Hospital stays for a mother beyond 48 hours following a vaginal delivery, or beyond 96 hours following delivery by Cesarean section, unless she also requires and concurrently receives care for her own medical condition.

- Treatment of congenital defects and birth abnormalities including functional repair necessary to achieve normal body function. However, we do not cover cosmetic surgery performed only to improve a newborn's appearance. See "Congenital Heart Disease Surgery" earlier in this section for more details regarding surgery for congenital heart conditions.

- Routine or "well baby" Physician visits after birth. See "Covered Services" under "Routine Physical and Preventive Care Benefits" later in this section for more details.

Maternity and Newborn Services Not Covered

These are examples of services that are not covered:

- Midwife labor and delivery services outside of a Hospital unless received in a facility that has met our requirements and has been approved as a qualified provider under this policy.

- Amniocentesis or ultrasound performed to alleviate anxiety or to determine the gender of the fetus.

- Childbirth education or preparation courses; for example, Lamaze classes.

Mental Health and Substance Abuse Benefits

We reimburse for services prescribed and performed by qualified providers for treating mental health and substance abuse disorders that meet our definition of Illness if those services are medically necessary and medically appropriate as we have explained these terms in Section 4. When we determine whether services are medically necessary and medically appropriate, we consider all of the following:

- The clinical information documenting your condition at the time services are required.

- Your treatment history.

- The proposed treatment plan.

Benefits include inpatient, transitional, and outpatient treatment, whichever alternative is the most cost-effective and medically appropriate for receiving necessary services safely and

effectively. You can read about our cost-effectiveness limit in Section 4. We have identified qualified providers of each type of treatment in the subsection to which they apply.

Inpatient Treatment

We cover Hospital confinement for the inpatient treatment of mental health and substance abuse disorders for each day for which clinical records substantiate that Hospital confinement is medically necessary and medically appropriate.

Reminder: We require you to notify us of any planned overnight hospitalization in advance. You must also inform us of any emergency admission within 72 hours of being admitted or as soon as it is medically feasible for you to do so, whichever is later. Upon your request, we will let you or your Physician know whether the proposed facility and services meet the policy's requirements for reimbursement. We will also periodically check on the status of your recovery and let you know when a covered hospitalization will no longer be covered. See Section 7 for details of our Hospital admission notification requirements.

Covered Inpatient Treatment Services

The following are examples of circumstances under which we consider Hospital confinement medically necessary and medically appropriate for the treatment of mental health and substance abuse disorders:

- Brief periods of Hospital confinement during which the individual is an active danger to herself or himself or others and therefore requires suicide or homicide precautions and continuous monitoring and intervention by skilled professionals.

- A period during which the patient requires medications that must be continuously monitored by skilled professionals.

- A period during which the patient's Illness has led to such severe physical or mental decline that the patient can no longer responsibly tend to his or her own general safety and physical well-being.

- A period during which the patient experiences acute and dangerous substance withdrawal symptoms that require continuous monitoring and intervention by skilled professionals.

In all cases, Hospital confinement ceases to be medically necessary and medically appropriate when:

- The acute stage has passed.

- The patient no longer needs continuous monitoring, observation, and intervention by skilled professionals.

- The patient's condition has stabilized.

At that time, a less intensive and less restrictive type of treatment may be medically necessary and medically appropriate.

Qualified Providers of Inpatient Treatment
General medical and surgical Hospitals are qualified providers of covered inpatient treatment.

Inpatient treatment received in a private psychiatric Hospital is covered only if the facility has been certified by the state in which covered services are received.

Transitional Treatment

Covered Transitional Treatment Services
We cover transitional treatment services provided by qualified providers, including a residential treatment program with a pre-defined length of stay, for each day for which clinical records substantiate that the treatment is medically necessary, medically appropriate, and cost-effective.

Transitional treatment is medically necessary, medically appropriate, and cost-effective only if the required intensity, frequency, or duration of treatment cannot be provided safely and effectively through outpatient treatment services.

Transitional treatment refers to mental health and alcohol or other substance abuse treatment that is provided at a subacute level and is more intensive than outpatient treatment. Examples of types of transitional treatment include:

- Day treatment or evening treatment programs.
- Partial hospitalization.
- Intensive outpatient treatment.
- Services at a residential treatment facility.

  Note: Residential treatment facility admissions must satisfy our Hospital admission notification requirements. See Section 7 for details of our Hospital admission notification requirements.

Qualified Providers of Transitional Treatment
Qualified providers are those whose services and treatment programs we are required by law to cover and who have been certified or licensed by the state in which covered services are received.

A qualified residential treatment facility program provides specialized 24-hour treatment and meets the following criteria:

- Is staffed by a multi-disciplinary team, which includes health care professionals such as registered nurses, occupational therapists, social workers, psychologists, physicians/psychiatrists, or substance abuse counselors. The team should complete an

assessment and develop an individualized, problem-focused treatment plan within 72 hours of admission.

- Provides observation and assessment by a psychiatrist at least weekly.

You can call us to find out if the services you anticipate receiving fulfill these requirements. Transitional treatment is covered only if the facility has been certified or licensed by the state in which covered services are received

Outpatient Treatment

Covered Outpatient Treatment Services

We cover face-to-face outpatient treatment provided by qualified mental health providers for each visit for which clinical records substantiate that treatment is medically necessary and medically appropriate.

We cover psychological and neuropsychological testing **only** if **all** of the following apply:

- A thorough clinical assessment by a qualified provider has been conducted. A thorough clinical assessment includes 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.

We cover nutritional counseling, when part of an approved treatment plan prescribed by a Physician, provided by a certified or registered dietitian or nutritionist, and necessary for the effective treatment of a life-threatening Illness (e.g., anorexia nervosa or bulimia).

Qualified Providers of Outpatient Treatment

A qualified outpatient mental health provider is a provider who is a state-licensed or state-certified:

- Psychiatrist. This is a Physician with a specialty in psychiatry.

- 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 Abuse Counselor (SAC).
- Clinical Substance Abuse Counselor (CSAC).
- Art Therapist (ATRL).
- Behavior Analyst.
- Registered nurse with a master's degree and certified as a specialist in psychiatric and mental health nursing.
- Physician Assistant (PA-C)

Services are covered only if the provider is licensed or certified by the state in which covered services are received and the services received are within the scope of the provider's license or certification. We do not reimburse for these services until you prove to our satisfaction that your provider meets these requirements.

Services Not Covered

These are examples of mental health and substance abuse services that are not covered:

- Custodial or long term care. See Section 5 for a description of custodial care. Examples include group homes and halfway houses for supportive and maintenance care for mental health or substance abuse Illnesses.
- Residential treatment for the sole purpose of preventing relapse, for legal purposes, or for respite for the 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, whether or not the school actually provides them and whether or not you choose to use those services.

- Treatment of a behavioral or psychological problem that, although it may appropriately be the focus of desired professional attention or treatment, is not attributable to a clinically diagnosed mental health Illness. Examples include 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 associated with compulsive gambling or nicotine addiction (except as specified under the "Tobacco Cessation Benefits" provision later in this section).

- Mental health services for, or in connection with, developmental delays (e.g., Rett's Disorder).

- Inpatient treatment that continues after the medical necessity of hospitalization has passed and the patient is awaiting placement.

- Inpatient treatment of a chronic mental health or substance abuse disorder unless clinical records document significant physical or mental decline or the patient represents an active danger to herself, himself, or others.

Physical, Speech, and Occupational Therapy

This policy distinguishes between rehabilitative and habilitative therapy treatments.

- Rehabilitative treatments are aimed at restoring a functional ability that was once achieved but has been diminished or lost because of an Illness or Injury. They also include treatments that minimize functional degeneration associated with a chronic progressive Illness such as multiple sclerosis.

- Habilitative treatments are aimed at acquisition of a functional ability that has been significantly delayed or impaired by congenital defect, birth abnormality, or early childhood Illness or Injury.

We reimburse for a limited number of physical, speech, and occupational therapy services that meet all of the conditions specified below for each type of therapy.

Covered Rehabilitative Therapy Services

If Illness or Injury causes you to lose a previously achieved functional ability, we cover therapy services reasonably expected to rehabilitate that functional deficit or impairment. We also cover therapy services that minimize functional degeneration associated with a chronic progressive Illness.

We cover rehabilitative therapy treatment only if it meets **all** of the following criteria. The therapy must be:

- Prescribed by a Physician in a treatment plan that identifies both the expected goals and the frequency and duration of treatment.

- Reasonably expected to promptly and significantly restore or minimize the degeneration of the functional ability.

  We decide whether prompt and significant progress can reasonably be expected. When we make this determination, we consider your diagnosis, prognosis, medical records, progress notes related to prior therapy, contemporary medical consensus, and the advice of our medical consultants.

- Provided in a manner consistent with the treatment plan by an individual licensed to perform the therapy in the state in which he or she practices.

Rehabilitative Therapy Services Not Covered

We do not cover any service that does not meet all of the above criteria. For example, none of the following is covered:

- Therapy that continues after you have recovered from the acute stage of inability and, in our opinion, further meaningful progress will be minimal or difficult to measure.

- Therapy that continues after you achieve your expected improvement, resolution, or stabilization of a health condition, as determined by us.

- Services intended to prevent a relapse, reversal, or exacerbation of a health condition.

- Therapy provided on a routine or scheduled basis in the absence of functional impairment even if intended to maintain optimal body functioning.

- Group therapy.

- Equipment or services to prevent Injury or to facilitate participation in physical activity or sports.

- General observation of exercises that can be performed in a home or health club setting.

- Services in which you have been instructed and demonstrated competence; for example, general range-of-motion exercises.

- Lifestyle educational services and materials even if provided to enhance therapy. Examples include chronic pain management classes, stress management classes, physical fitness instruction, behavior modification classes, nutritional counseling, books and other instructional materials related to health conditions, and classes to educate family members.

Covered Habilitative Therapy Services

While this policy generally covers only services to restore a function lost because of an Illness or Injury, it provides a limited benefit for services aimed at the acquisition of a physical functional ability. The policy does not cover services to enhance or attain all physical functional abilities or to develop all physical capacities considered normal or appropriate for an individual's

chronological age. The policy covers habilitative therapy services only if they meet our specific criteria.

We cover habilitative therapy services that are reasonably expected to produce prompt and significant progress toward acquiring a functional ability that:

- Has been **significantly** delayed or impaired by congenital defect, birth abnormality, or early childhood Illness or Injury; **and**

- Is essential for performing these basic self-care activities: eating, toileting, dressing, functional mobility, and functional communication.

In addition, the services must meet **all** of the following criteria. The therapy must be:

1. Prescribed by a Physician in a treatment plan that:

    - Identifies the delayed or impaired essential functional ability.

    - Establishes the expected achievable goals toward the required level of functioning.

    - Specifies the frequency and duration of treatment necessary to achieve those goals.

2. Reasonably expected, in the patient's specific circumstances, to produce prompt and significant progress toward the treatment goals.

3. Provided in a manner consistent with the treatment plan by an individual licensed to perform the therapy in the state in which he or she practices.

Therapy will not be covered when we determine that the patient has **either**:

- Acquired a level of functioning sufficient for performing self-care activities; **or**

- Acquired the maximum functional ability for his or her maturational age, **whichever comes first**.

We decide whether treatment meets these criteria for coverage. In making this determination, we consider the diagnosis, prognosis, medical records, meaningful progress toward performing basic self-care activities as documented in progress notes related to prior therapy, contemporary medical consensus, and the advice of our medical consultants. We have the right to require an independent evaluation by a professional of our choice as often as is needed for us to decide whether we will cover or continue to cover services. When we do so, we pay the cost of the evaluation.

Habilitative Therapy Services Not Covered

We will not cover any service that does not meet **all** of the above criteria. For example, none of the following is covered:

- Therapy that continues after the patient has stabilized at a level of functioning; that is, medical records do not clearly document meaningful, measurable progress toward the patient's ability to perform basic self-care activities.

- Therapy that continues after the patient has acquired the maximum level of functioning for his or her maturational age.

- Services in which the patient has been instructed and demonstrated competence; for example, general range-of-motion exercises.

- Services that the child's school is legally obligated to provide, whether or not the school actually provides them and whether or not you choose to use those services.

- Services aimed at developing or enhancing the patient's ability to perform school tasks such as grasping a pencil, writing, using a scissors, accessing playground equipment, developing play skills, reading, or understanding reading materials.

- Auditory processing evaluation and treatment (except as covered in connection with and following a cochlear implant). Examples include, but are not limited to, auditory integration training, aural rehabilitation, and auditory training.

- Services aimed at developing social awareness and social skills that do not meaningfully contribute to acquiring a functional ability essential for performing a basic self-care activity or communicating basic needs.

- Services that are available from a governmental or other public or private organization.

- Services that can be provided by members of your family without causing undue hardship.

Physician's Office and Outpatient Care Benefits

We reimburse for services by qualified providers in a Physician's office or other outpatient setting only if they are medically necessary and medically appropriate to diagnose or treat Illnesses or Injuries. There is an exception: We cover the specified routine services listed throughout Section 6, and those preventive services that we are required by law to cover, even when you have no symptoms of an Illness or Injury. Some of those services are listed under:

- "Maternity and Newborn Benefits."

- "Reproductive Health Benefits."

- "Routine Physical and Preventive Care Benefits."

Prescription Drug Plan

Your prescription drug plan has several distinguishing features, described in detail below, including:

- We cover prescribed drugs and medications according to a drug formulary, which is a list of drugs and medications approved for use and covered under the plan. Not all prescription drugs are in the formulary. Prescription drugs in the formulary are categorized into groups, or tiers, each with its own coinsurance or copayment. To find out if a drug is in the formulary or the tier in which it is placed, please visit our website, weatrust.com.

- 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 copayments that apply to Value Drugs are lower than copayments for other Tier 1 drugs.

- Not every therapeutic class of drugs will contain a Value Drug.

- Tier 1 generic equivalent or therapeutically equivalent drugs are required, when they exist, for maximum reimbursement.

- Obtaining prescription drugs from a nonparticipating pharmacy will usually result in significant out-of-pocket costs.

  We have an extensive participating pharmacy network. See "Pharmacy Selection" below.

- Some drugs require preauthorization. Other drugs are subject to our medical review 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 under this plan.

- Dispensing is limited to a medically appropriate dosage, or what we have established as a 30-day supply with the exception of some drugs purchased through our Home Delivery Program, or at pharmacies participating in the 90-Day Retail Benefit (see "Dispensing Limitation" below).

To make the best and most knowledgeable use of your prescription drug benefits, always purchase your prescription drugs from a participating pharmacy. Participating pharmacies have up-to date information about whether a specific drug is covered under the formulary. They can also inform you about coinsurance, copayments, preauthorization requirements, less expensive therapeutic alternatives, and dispensing limitations. Therefore, they are able to help you keep your out-of-pocket cost as low as possible. You can obtain the names of participating pharmacies in your area by visiting our website, weatrust.com, or by calling our customer service department.

Note: This policy 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 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.

The drug formulary includes a comprehensive range of prescription drugs. However, not all prescription drugs are covered even if they may be beneficial and are prescribed by a Physician. We reimburse for a prescribed drug only when we find it medically necessary, medically appropriate, and cost-effective. Thus, we may not cover a drug that has not been proven to be more effective than a less expensive, therapeutically equivalent alternative. If you choose a drug that is not covered, you must pay the full cost yourself. We will consider an exception on the rare occasion when **all** of the following apply:

- You have tried all the covered drugs in the appropriate therapeutic category.
- Your Physician provides us with compelling contemporaneous clinical evidence that either (1) none of the covered drugs is effective for you, or (2) 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.

Note: Any exception request must be submitted to us by your Physician and authorized by us in advance of your receiving the prescription.

Medical Necessity—A prescription drug is medically necessary if it is required to heal, cure, or alleviate the symptoms or the underlying cause of an Illness or Injury.

Medical Appropriateness—A prescription drug is medically appropriate if we find it to be both a safe and an effective response to your medical circumstances. We will consider a drug safe if the FDA has accepted it for marketing for the purpose for which it is being used. However, FDA approval does not guarantee we will find the drug to be effective. For example, drugs that have not been demonstrated in randomized clinical trials to have long-term efficacy, drugs that we deem to be marginally effective, and drugs that we deem inconsistent with current medical standards of prescribing will not be considered effective.

We have the right to deny coverage for new drugs until we have investigated them and found them to be medically appropriate.

Drug Tiers

Prescription drugs in the formulary are placed into categories, or tiers. The tier in which we place a specific drug affects the amount we reimburse. (See "Reimbursement Factors" below.)

Tier 1 includes most, but not all, generic drugs, some brand name drugs, and a few over-the-counter drugs. Value Drugs are a subgroup of Tier 1 drugs specifically chosen for their clinical effectiveness, safety profile, and overall value. The copayment that applies to Value Drugs is lower than the copayment for other Tier 1 drugs. Value Drugs provide you with the lowest out-of-pocket cost.

Tier 1 brand name and over-the-counter drugs are therapeutically equivalent to drugs in Tier 2 or Tier 3. All other covered generic and brand name drugs are placed in Tier 2 or Tier 3, based on cost, therapeutic efficacy, and the recommendations of our Pharmacy and Therapeutics Committee.

Specialty Drugs—Specialty drugs are prescription medications that require special handling, administration or monitoring. These drugs are used to treat complex, chronic conditions such as multiple sclerosis, rheumatoid arthritis, hepatitis C, and hemophilia. Some specialty drugs require preauthorization (see "Drugs Subject to Preauthorization or Medical Monitoring" below). In accordance with the policy's cost-effectiveness limit, we may require that you receive these specialty drugs through our specialty drug program for maximum reimbursement.

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, weatrust.com, 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 Physician(s) 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, weatrust.com.

Reimbursement Factors

The amount we reimburse and, thus, the amount you must pay for your covered prescription drugs depends on four factors:

1. You must satisfy your deductible before any covered service is paid.

2. The coinsurance or copayment that applies 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.

3. The pharmacy you select; that is, whether you select a participating or nonparticipating pharmacy.

4. Whether you receive a cost-effective drug from among the viable alternatives.

These reimbursement factors are discussed below.

Deductible—Your Benefit Summary specifies the deductible that applies to your plan. The deductible is the amount that you must pay in a Benefit Period for covered services before we will reimburse you for any covered costs you incur during the remainder of that Benefit Period. The deductible must be satisfied in each Benefit Period.

We will pay for certain preventive prescription drugs before the deductible is met if your Benefit Summary indicates that you have the Preventive Prescription Drug Optional Benefit. A list of the prescription drugs that are included in this benefit is on our website, weatrust.com.

Coinsurance or Copayment—Your Benefit Summary specifies the coinsurance or copayment that applies to Value Drugs and to each tier of your prescription drug benefits. The specified amount applies separately to each prescription or refill.

Pharmacy Selection—You may purchase prescription drugs at any pharmacy. However, we limit reimbursement to the amount charged us by a pharmacy that participates in our prescription drug program. You can obtain the names of participating pharmacies in your area by visiting our website, weatrust.com, or by calling our customer service department.

If you are covered by this drug plan, you may use your insurance identification card to purchase prescription drugs from a participating pharmacy. If you purchase prescription drugs from a nonparticipating pharmacy, you will be required to pay the full cost of the drug and submit a claim form. You can obtain claim forms for this purpose by printing them from our website or by calling our customer service department. We will reimburse **the amount we would have paid a participating pharmacy**, less the applicable coinsurance or copayment. Your out-of-pocket costs will usually be significantly higher when you use nonparticipating pharmacies.

Reimbursement Limit—This policy limits reimbursement to the most cost-effective treatment from among viable alternatives (see "Cost-Effectiveness Limit" in Section 4). If you purchase a brand name drug, we may limit reimbursement to the amount charged us by a participating pharmacy for the FDA-approved generic equivalent. In this case, you must pay the difference between the cost of the drug you received and the amount charged us by a participating pharmacy for the FDA-approved generic equivalent, **in addition** to your coinsurance or copayment. This usually results in significant out-of-pocket expense.

Note: An indication from your Physician that a drug must be dispensed as written, without supporting objective, contemporaneous medical documentation, is not, by itself, sufficient evidence for us to reimburse for that drug. Any exception request must be submitted to us by your Physician and authorized by us in advance of your receiving the prescription.

Dispensing Limitation

All prescriptions or refills are limited in quantity to a medically appropriate dosage or what we have established as a 30-day supply. A 30-day supply may be either more or less than 30 unit dosages. If your Physician prescribes a quantity that exceeds our established 30-day supply and you present the prescription at a participating pharmacy, the pharmacist will inform you before filling the prescription. We reimburse only for the quantity that we consider a 30-day supply.

We will consider exceptions on the rare occasion when compelling clinical evidence indicates a larger dosage is medically necessary and medically appropriate for your specific medical circumstances.

Home Delivery Program—Prescriptions and refills purchased through our specified Home Delivery Program are limited to a 90-day supply instead of a 30-day supply. A 90-day supply may be subject to two copayments instead of 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 participating retail pharmacies. You can obtain the names of these pharmacies in your area by visiting our website, weatrust.com, or by calling our customer service department. A 90-day retail prescription is subject to a copayment equal to what you would pay for three separate 30-day refills of the prescription.

Specialty Drugs—Specialty drugs are limited to a 30-day supply even through our Home Delivery Program and are subject to one copayment per 30-day supply.

You can obtain information about your drug plan and our Home Delivery Program by visiting our website, weatrust.com.

Drugs Subject to Preauthorization or Medical Monitoring

We have the right to require preauthorization or to initiate medical review and monitoring for:

- Drugs with significant potential for drug-related toxicity.
- Drugs for which a step-therapy approach is appropriate.

  Under a step-therapy approach, Physicians follow a sequence of prescribing drugs, based on generally accepted clinical protocols, FDA guidelines, manufacturer labeling information, symptom severity, and drug treatment history. The sequence usually starts with the safest, clinically accepted first-line drug for treating the Illness or symptoms and progresses to more aggressive second- or third-line drugs if previous drugs cause an adverse reaction or are not effective. An example is requiring the use of a generic penicillin the first time a patient is diagnosed with a sinus infection, rather than proceeding immediately to a more powerful antibiotic.

- Drugs with unique prescribing or monitoring indications.

The list of these drugs that are subject to preauthorization or medical monitoring is small but will change frequently with new developments. You can view the most current list at our website, weatrust.com. If your Physician prescribes one of these drugs and you present your prescription at a participating pharmacy, the pharmacist will inform you and you can call us to initiate any required review. If you present your prescription at a nonparticipating pharmacy, you will be required to pay for the prescription in advance. In this case, you take the risk that we will not reimburse you for the drug because preauthorization would have been denied or, if we do reimburse you, that your out-of-pocket costs will be significant (see "Pharmacy Selection" above).

Note: Charges in excess of our maximum allowable fee, and penalties imposed for failing to receive any required preauthorization do not count toward your maximum out-of-pocket limit.

Covered Prescription Drugs

We cover drugs and medications in the formulary when we find them to be medically necessary, medically appropriate, and cost-effective:

- Those required to carry the legend, "Federal law prohibits dispensing without prescription."
- Those that may be dispensed only upon a Physician's written prescription as required by state law.
- Those 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 Section 6, "Tobacco Cessation Benefits."

Drugs and Services Not Covered

We never cover these:

- Drugs or medications that can lawfully be obtained without a prescription, even if your Physician prescribes them. The rare 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 to the value choice drug plan list. Such over-the-counter drugs require a prescription from your Physician.
- 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. This includes drugs reformulated to extend the manufacturer's patent, without significant therapeutic advancement.

- 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 policy is required by law to cover.)

- Any drug that has not been approved by the FDA for at least 6 months for the purpose for which it is being used.

- Drugs or medications for the treatment of alopecia or hair loss; for example, minoxidil or Rogaine.

- Drugs or medications prescribed primarily to improve appearance. This includes all dosage forms of tretinoin (for example, Retin-A) for individuals who are 26 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 Section 6, "Tobacco Cessation Benefits."

- 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 Physician, or any refill dispensed after one year from the date of the Physician's original order. For example, 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 policy.

How to Receive Reimbursement for Prescription Drugs

If you are covered by this drug plan, you may receive reimbursement of covered prescription drug expenses in either of two ways:

1. You may present your insurance identification card to a participating pharmacy and pay the applicable coinsurance or copayment 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 by printing them from our website, weatrust.com, or by calling our customer service department. Remember, we reimburse only the amount that is charged us by a participating pharmacy, less the applicable

coinsurance or copayment. If you use a nonparticipating pharmacy, our reimbursement to you may be significantly less than you were charged.

Reproductive Health Benefits

We reimburse for a limited number of services in connection with infertility, surgical sterilizations, and contraception. We also reimburse for specified preventive services intended to detect a medical problem that has not yet manifested itself in symptoms or Illness. Some services may require preauthorization. Read about our preauthorization requirements and reimbursement limits that apply in Section 7.

Covered Contraception and Surgical Sterilization Services

We cover these services and supplies:

- All safe and effective drugs, medications, and devices in general use as contraceptives that require a prescription or intervention by a Physician or other licensed health care provider. Examples include birth control pills, Norplant or similar contraceptives, Depo Provera, injectable contraceptives, intrauterine devices (IUDs), cervical caps, and diaphragms.

- Necessary services of a Physician or other licensed health care provider in connection with covered contraception. Such services include assessment, diagnosis, administration, insertion, or prescription.

- Surgical sterilizations such as tubal ligations and vasectomies.

Covered Preventive Services

Covered preventive services are limited to those we are required by law to cover and to diagnostic services that have been proven effective in detecting disease of the reproductive system. Such services must be performed by qualified providers (including nurse practitioners). Examples include:

- Pelvic examination, Pap test, and mammogram performed once each Benefit Period.

We cover these services at more frequent intervals if performed to treat a diagnosed Illness or if warranted due to family history or other risk factors.

Covered Infertility Services

We cover **only** these infertility-related services:

- Services performed **exclusively** to diagnose the cause(s) of infertility. Once a diagnosis has been rendered, no further diagnostic tests are covered unless they are reasonably expected to reveal another clinical cause for infertility.

- Surgical procedures necessary to repair or restore a malformed or malfunctioning body part or process found to be the cause of infertility in order to enable natural conception. **Note**: the reversal of tubal ligations and vasectomies is not covered.

Services Not Covered

These are examples of services that are not covered:

- Diagnostic tests performed in connection with the treatment of infertility. Examples are diagnostic studies to determine the time of ovulation, abdominal ultrasounds to determine follicle growth, and diagnostic services that would not be performed in the absence of infertility treatment.

- Physician, Hospital, or any other service directed at, or for or in connection with, treating the cause of infertility other than surgical repair; for example, laparoscopic or transvaginal retrieval of ovum.

- Services for or in connection with any artificial, mechanical, or other alternative to the natural process of conception. Examples include 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 similar methods or procedures.

- Medication prescribed for treating infertility. Examples are drugs for hyperstimulation of the ovaries (for example, Clomiphene Citrate) or drugs for treating low sperm count or motility.

- Services for, or in connection with, the reversal of surgical sterilization such as tubal ligations and vasectomies.

- Contraceptive drugs, supplies, or devices that can be obtained without intervention by a Physician or other licensed health care professional. Examples include condoms and contraceptive foam or gel.

Routine Physical and Preventive Care Benefits

We cover preventive services as required by the federal Patient Protection and Affordable Care Act. If you receive a covered preventive service from a Network provider, you will not have to pay a deductible, coinsurance, or copayment.

Although this policy generally covers only those medical services that diagnose or treat Illnesses and Injuries, we reimburse for the following specified routine services and those preventive services required by law, even in the absence of symptoms of Illness or Injury. Those services include appropriate diagnostic procedures that are effective in preventing or detecting disease. We consider diagnostic services appropriate if they meet **all** four of these conditions:

1. Contemporary medical consensus considers them reliable and effective.

2. They are performed by qualified providers.

3. 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.

4. They will provide new and relevant information about your health and are not redundant when performed with other procedures that have been or are performed.

Covered Services

We cover these routine and preventive services:

- Routine physical examination performed once each Benefit Period.

- Preventive services that we are required by law to cover. Please see our website, weatrust.com, for the most current list of covered preventive services. You may also obtain a paper copy of the current list by calling our customer service department.

- Appropriate diagnostic procedures performed once each Benefit Period. Examples include complete blood count, total blood cholesterol test, thyroid function test, HIV antibody test, urinalysis, colorectal cancer screening procedures, mammogram, clinical breast examination, Pap test, and pelvic examination. We cover these procedures at more frequent intervals if performed to treat a diagnosed Illness or if warranted by family history or other risk factors.

- Prenatal and maternity care. For more information see "Maternity and Newborn Benefits" earlier in this section.

- Well baby and child care. This includes hearing and vision tests, hemoglobin and hematocrit tests, and blood tests to detect lead exposure.

- Immunizations required by law or deemed appropriate by a Physician, except for immunizations obtained solely for the purpose of traveling outside of the United States. These include vaccines such as diphtheria-pertussis-tetanus (DPT), measles-mumps-rubella (MMR), hepatitis B (HBV), oral poliovirus (OPV), hemophilus influenza B, pneumococcal, and varicella.

- Routine hearing screenings or tests for dependent children under age 18.

Services Not Covered

These are examples of services that are not covered:

- Diagnostic procedures that contemporary medical consensus considers ineffective, unreliable, unproven, or of dubious value to an individual with your medical and other risk factors.

- Office visits and hearing examinations or tests in connection with prescribing or fitting a hearing aid, except as specified under "Hearing Services" earlier in this section.

Second Opinion Benefits

We reimburse for a second opinion of a diagnosis, proposed treatment plan, or surgery.

Skilled Nursing Facility Care

We reimburse for skilled nursing facility care for patients who enter a skilled nursing facility within 24 hours after discharge from a general Hospital.

Period of Confinement

A period of confinement begins when you enter a skilled nursing facility, within 24 hours after discharge from a general Hospital, because you need daily skilled care. It ends when you are released from the skilled nursing facility because you have sufficiently recovered from the condition that caused your confinement. If you subsequently re-enter a skilled nursing facility because you need skilled care for the same condition that caused your first confinement, re-entry days continue to count toward your original period of confinement. For example:

- You may leave the skilled nursing facility for a necessary Hospital stay. When you are released from the Hospital, you need to return to the skilled facility because of the same condition for which you were first confined.

- You may believe that you have sufficiently recovered and so you leave the skilled nursing facility and return home. After a short period, you find your discharge was in error and you need to return to the skilled nursing facility because of the same condition for which you were first confined.

In the above cases, the initial and subsequent stays in the skilled nursing facility are related to the same condition and, therefore, all days count toward one period of confinement.

Qualified Providers of Skilled Nursing Facility Care

A skilled nursing facility is a licensed facility other than a Hospital that is certified to provide 24-hour continuous skilled services on an inpatient basis in the state in which it operates. It may be a freestanding facility or a separate unit of a Hospital or other institution. The following are not skilled nursing facilities:

- An institution operated primarily for care and treatment of mental health disorders, drug abuse, or alcoholism.

- A facility that primarily provides residential, retirement, custodial, or long term care.

- A private room or apartment.

We base our coverage of skilled nursing facility care on your medical needs and our cost-effectiveness standards. We cover expenditures only if **all** of the following apply:

- You enter a skilled nursing facility within 24 hours after discharge from a general Hospital.

- You are convalescing or rehabilitating from an Illness or Injury.

- Your condition during recovery requires daily skilled nursing or skilled rehabilitation services.

- A skilled nursing facility is the most cost-effective means of providing that care.

Covered Services
These are examples of skilled nursing facility services we may cover:

- Room and board.
- Physician, skilled nursing, and skilled rehabilitation services.
- Prescription and nonprescription medications.

Services Not Covered
We do not cover skilled nursing facility care if the services are primarily custodial or long term care. By this, we mean services that can generally be provided by persons without professional medical training or skills and that are primarily for one or more of the following purposes:

- Maintaining an individual's existing physical or mental condition of health.
- Preserving an individual's condition from further decline.
- Assisting an individual in performing the activities of daily living.
- Protecting an individual from threats to health and safety due to cognitive impairment.
- Meeting an individual's personal needs.

We consider such services to be custodial or long term care even if provided by registered nurses, licensed practical nurses, or other trained medical personnel.

Skilled Nursing Services
We reimburse for skilled nursing care prescribed by a Physician if your medical safety during recovery from an Illness or Injury requires the services or supervision of skilled nursing personnel. Skilled nursing personnel include registered nurses and licensed practical nurses.

Services may be received in your place of residence or in a facility. When received in a facility (for example, Hospital or skilled nursing facility), these services are included in room and board charges and we do not reimburse for them separately. When received in your place of residence, they require advance authorization (see "Home Health Care" earlier in this section).

Covered Services
These are examples of covered skilled nursing services:

- Managing and evaluating a Physician-ordered plan of care that requires skilled services.
- Observing and assessing the patient's condition to evaluate the need to modify the plan of care.

- Treating open wounds or ulcers that require skilled evaluation. This includes application of dressings involving aseptic technique and prescription medication.
- Intravenous, intramuscular, and subcutaneous injections; insulin administration, but only when diabetes is newly diagnosed or the patient requires frequent dosage adjustments.
- Nasogastric, gastrostomy, and jejunostomy feedings, but only in cases where there is risk of aspiration or complications.
- Insertion, sterile irrigation, and replacement of urinary catheters.
- Initial phases of oxygen or other inhalation therapies.
- Initial phases of intravenous chemotherapy or other intravenous medications.
- Instructing a patient on the management of a self-care program.
- Training a patient, family, or other caregiver to perform any of the above services.

Services Not Covered

These are examples of services that do not require the supervision of, or performance by, skilled nursing personnel. We do not cover these services unless they are incidental to covered skilled nursing care:

- Planning and managing a plan of care that does not require skilled services.
- Periodic turning and positioning of a nonambulatory patient.
- Prophylactic or palliative skin care; for example, bathing and applying creams or lotions.
- Administering routine medications, eye drops, and ointments.
- Wound care for noninfected postoperative or chronic medical conditions.
- General administration of oxygen and other inhalation therapy after the initial phase of treatment adjustments and training the caregiver are completed.
- Services that, after instruction and demonstrated competence, can be reasonably and safely performed by the patient or the patient's family. Examples include, but are 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 (see Section 5 for a description of custodial care).

Skilled Rehabilitation Facility Care

We cover inpatient rehabilitation facility services. We base our coverage of inpatient rehabilitation facility services on your medical needs and our cost-effectiveness standards. We cover expenditures only if all of the following apply:

- You are rehabilitating from an Illness or Injury.
- Your condition during recovery requires skilled rehabilitation services for a minimum of three hours per day for at least five days per week.
- Your condition during recovery requires that you see a skilled rehabilitation physician or physiatrist at least three times per week.

Covered Services

These are examples of inpatient rehabilitation facility services we may cover:

- Room and board.
- Physician, skilled nursing, and skilled rehabilitation services.
- Prescription and nonprescription medications.

Services Not Covered

We do not cover inpatient rehabilitation facility care if the services are primarily custodial or long term care. By this, we mean services that can generally be provided by persons without professional medical training or skills and that are primarily for one or more of the following purposes:

- Maintaining an individual's existing physical or mental condition of health.
- Preserving an individual's condition from further decline.
- Assisting an individual in performing the activities of daily living.
- Protecting an individual from threats to health and safety due to cognitive impairment.
- Meeting an individual's personal needs.

We consider such services to be custodial or long term care even if provided by registered nurses, licensed practical nurses, licensed therapists or other trained medical personnel.

Skilled Rehabilitation Services

We reimburse for skilled rehabilitation services. Skilled rehabilitation providers include licensed physical and occupational therapists, speech pathologists, speech-language pathologists, audiologists, and respiratory therapists. Services may be received in a health care facility or in your place of residence.

Information About Our Coverage Criteria

We cover skilled rehabilitation services necessitated by an Illness or Injury and prescribed by a Physician if **both** of the following apply:

- Your prescribed care requires the services or supervision of skilled rehabilitation providers.

- The services are reasonably expected to promptly and significantly restore you to your previous functional ability. We decide whether prompt and significant progress can be reasonably expected. When we make this decision, we consider your diagnosis, prognosis, medical records, contemporary medical consensus, and the advice of our medical consultants.

Covered Services

These are examples of skilled rehabilitation services we may cover:

- Physical therapy for specific neurological, muscular, or skeletal problems resulting from an Illness or Injury.

- Teaching mobility or transfer skills.

- Range-of-motion exercises if they are part of the prescribed active treatment for a specific medical condition resulting in loss or restriction of mobility.

- Design of a maintenance program to be performed by the patient to prevent or minimize deterioration of the patient's condition. Services to aid the patient in performing this maintenance program are not covered unless the need is medically documented.

- Prescribed speech, physical, or occupational therapy services to promptly restore a previously possessed function that was lost as a result of an Illness or Injury.

- Pulmonary rehabilitation therapy.

- Cardiac rehabilitation therapy.

- Post-cochlear implant aural therapy.

Services Not Covered

We will not cover any service that does not meet **all** of our coverage criteria. For example, none of the following is covered:

- Services that do not require the supervision of, or performance by, skilled rehabilitation providers.

- Services that continue after you have recovered from the acute stage of your Illness or Injury and, in our opinion, further progress is expected to be minimal or difficult to measure.

- General observation of exercises, including range-of-motion exercises.

- Services in which the patient has been instructed and demonstrated competence; for example, general range-of-motion exercises.

Surgical Benefits

We reimburse for surgical procedures performed by Physicians, Surgeons, surgical assistants, anesthesiologists, and anesthetists if they are essential to accomplish one of the following:

- Diagnose an Illness or Injury.
- Cure an Illness.
- Repair an Injury or a malfunctioning body part.

Important Reminders

- Some surgical services require our advance authorization.
- In addition, if your surgery requires a Hospital stay, you must call us in advance to fulfill our Hospital admission notification requirements.
- If your surgery will be performed in a surgical facility (e.g., inpatient or outpatient ambulatory surgery center), we encourage you to call us in advance to confirm whether the use of the surgery facility will be covered.

Reconstructive Surgery Following Mastectomy

If you have had or are going to have a mastectomy that is covered by this policy, we also provide benefits for the following services:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedema.

Transplants

We cover transplantation procedures **only** if the transplant evaluation and the transplant surgery are received at a facility that meets these requirements:

- For solid organs, the facility must be certified by Medicare for the particular type of transplant surgery being performed.
- For stem cell transplants, the facility must be certified to work with the National Marrow Donor Program (NMDP).

When we receive a request to cover a transplantation procedure, we apply our established review criteria to any procedure that meets one or more of the following standards:

- The procedure is covered by Medicare.

- The procedure is covered by the Wisconsin Medicaid program.

- The procedure has been recommended for coverage by Medicare by the Office of Health Technology Assessment (OHTA).

If the procedure meets none of the above standards, we determine whether, in our sole discretion, this policy covers the procedure in whole or in part. In exercising our discretion, we consult with experts in the appropriate medical field, board-certified specialists, research agencies, or professional organizations regarding the medical community's position on the procedure as a standard of care for your medical history and condition.

Covered services may include transplant evaluation services, Hospital and Physician services, organ procurement, and tissue typing. Living donor services are covered only if the transplant recipient is covered by this policy. We do not cover animal to human transplants or artificial or mechanical devices designed to replace human organs.

Special Presurgical Second Opinion Benefit

Whenever your Physician recommends surgery, we encourage you to obtain a presurgical second opinion consultation. We reimburse the maximum allowable fee of such a consultation. We cover second opinion consultations with Physicians who are neither involved in the recommended surgery nor affiliated with the Physician who will perform the surgery.

Reimbursement Factors That Pertain to Surgeries

Reimbursement for all surgeries is subject to the following guidelines for global surgical fees, multiple and bilateral surgical procedures, services of a second Surgeon or surgical assistant, and use of surgical facilities.

Global Surgical Fee—We reimburse for surgeries on a global surgical fee basis. This assumes that certain services, pre-operative, operative, and post-operative, are included in the Surgeon's total charges. Operative care comprises all services that are an essential and usual part of the primary surgical procedure. Examples include preparing and positioning the patient, consulting with the anesthesiologist or anesthetist, placing tubes and catheters, and the surgery itself. Post-operative care comprises all services necessary to monitor the patient's recovery. It begins when surgery is completed and continues for as long as is commonly accepted as adequate post-operative care for that procedure.

Multiple and Bilateral Surgical Procedures—When more than one surgical procedure is performed during one operative session, we decide whether to reimburse for the second and subsequent procedures as separate surgeries. This applies whether the procedures are performed by the same or different Physicians. If we decide the surgeries are not separate, we reimburse for the second and subsequent procedures at a reduced rate. If your surgery requires two or more specialized Physicians (e.g., a urologist and a general Surgeon), we reimburse at a rate higher than for a single surgery but lower than for separate surgeries. We base these decisions on the standards established by the Centers for Medicare and Medicaid Services.

Services of a Second Surgeon or Surgical Assistant—We reimburse for services by a second Surgeon or licensed surgical assistant only if those services are necessary for the safe and effective performance of a covered surgical procedure. We base our decisions about the necessity of a second Surgeon or surgical assistant on the standards established by the Centers for Medicare and Medicaid Services.

Use of Surgical Facilities—We reimburse for the use of surgical facilities only if such facilities are required for obtaining the covered services. If your surgical services can be delivered safely and effectively in a less costly setting, or if the services received are not covered services, then we do not reimburse the cost of the surgical facility use. When it is sufficient for receiving appropriate surgical services, an outpatient ambulatory surgery center may be a cost-effective alternative to a Hospital. Similarly, when it is sufficient for receiving appropriate surgical services, a Physician's office may be a cost-effective alternative to an outpatient ambulatory surgery center.

The use of a surgical facility, whether inpatient or outpatient, is a major expense; and the fact that your Physician and/or Surgeon recommends, schedules, or performs your surgery at a surgical facility does not guarantee that we will find the facility to be necessary for the services performed. To ensure that you are not left with a significant expense for a surgical facility that is not covered by your health plan, we encourage you to call us in advance to see if use of a facility is covered for your specific surgery.

Covered Services

These are examples of covered surgical services:

- Surgical services of the Physician, Surgeon, or surgical assistant. This includes oral surgery performed by a Doctor of Dental Surgery (D.D.S.) or a Doctor of Medical Dentistry (D.M.D.) in connection with a service that is covered by this policy (e.g., removal of impacted wisdom teeth).

- Anesthesia services only if not generally included in the global surgical fee.

- Care provided by an anesthesiologist or anesthetist to monitor the patient's vital physiological signs.

- Essential ancillary services such as whole blood or blood plasma.

Services Not Covered

These are examples of surgical services that are not covered:

- Services for, or in connection with, surgeries that we regard as unsafe, ineffective, or unproven.

- Services for, or in connection with, surgical procedures primarily performed to improve appearance (i.e., cosmetic surgery) when there is little or no accompanying meaningful improvement in the functioning of a malformed body part or restoration of a bodily function.

- Services for, or in connection with, any surgical treatment for obesity.

- Bariatric surgery, gastric restrictive or bypass procedures, or similar surgeries.

- Services that are generally included in the global surgical fee.

- Services for, or in connection with, a surgical procedure that is not covered.

- Costs for, or in connection with, early admission prior to surgery if pre-surgery services could be performed in an outpatient setting.

Temporomandibular Disorder (TMD) Treatment

We reimburse only for:

- Surgical and nonsurgical TMD treatments.

- TMD testing that contemporary medical consensus considers safe and effective.

We do not cover unproven or unconventional services even when recommended or prescribed by a Physician. In determining what services contemporary medical consensus considers to be safe and effective, we rely on the standards of the medical organization that represents the profession of the provider from whom you receive the services; for example, the American Academy of Orofacial Pain (AAOP). Thus, we may not cover all recommended treatment. If you wish, you may submit a written plan to us, and we will let you know whether we will cover the proposed treatment.

Covered Services

These are examples of services we cover:

1. Initial diagnostic evaluation. This includes initial history, physical examination, and relevant laboratory and diagnostic services. The following diagnostic services are covered if they are responsive to your specific symptoms, likely to yield additional information useful for planning treatment, and not redundant when performed with other diagnostic procedures:

    - Panoramic or TMD tomography, if warranted by your history and physical examination.

    - Magnetic resonance imaging (MRI), if the Physician's evaluation indicates the presence of joint disease and an MRI is needed to assist in the diagnosis.

    - Psychosocial assessment to determine if evaluation by a psychologist or psychiatrist is appropriate. However, comprehensive psychological inventories are not covered.

- Blood testing and urinalysis to identify blood, musculoskeletal, chemical, or other abnormalities suggestive of systemic disease.

- Diagnostic injections, such as nerve blocks.

2. Surgical and nonsurgical treatment that contemporary medical consensus considers safe and effective. These are examples of services that we may cover:

    - Reversible intraoral prosthetic devices and appliances, such as removable splints.

    - Physical therapy treatments reasonably expected to produce prompt and significant improvement.

    - Steroid joint injections.

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

Services Not Covered

We do not cover diagnostic tests that general medical consensus considers unproven or unconventional. These are examples of such services:

- Electromyography (EMG) or muscle testing.

- Electronic jaw-tracking systems.

- Thermography and kinesiography.

- Ultrasonography.

- Radiography or regular dental X rays.

These are examples of treatment we will not cover because general medical consensus considers them unproven or unconventional:

- Orthodontic (use of braces) and orthognathic (use of surgery) treatment for changing the bite.

- Occlusal adjustment or modification of a dental surface to change the bite.

- Restorative therapy or prosthodontic treatment (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 to treat a chronic condition or any condition for which there is no reasonable expectation of a prompt and predictable improvement in your health status.

- Services that continue after you reach the expected state of improvement, resolution, or stabilization of your health condition.

Tobacco Cessation Benefits

Covered tobacco cessation benefits are limited to tobacco users who are 18 years of age or older. We reimburse for tobacco cessation screening and brief interventions as required by law. We also reimburse for specified tobacco cessation aids. Specified tobacco cessation aids include both prescription drugs and over-the-counter aids. You can view the list of covered tobacco cessation aids by visiting our website, weatrust.com, or by calling our customer service department.

You can receive up to 90 days of tobacco cessation aids once every 12 months. Tobacco cessation aids must be prescribed by a Physician, purchased for use one 30-day supply at a time, and used during 90 consecutive days. Receiving one 30-day supply at a time offers you the opportunity to try different tobacco cessation aids over the 90-day period if the previous aids were not effective for you.

Reimbursement for Tobacco Cessation Aids

If you are covered by the Trust prescription drug plan, we process claims for tobacco cessation aids through the prescription drug plan. We limit reimbursement to the amount charged to us by a pharmacy that participates in our prescription drug program. Participating pharmacies belong to our prescription drug administrator's nationwide network. You can view a list of participating pharmacies by visiting our website, weatrust.com, or by calling our customer service department.

You may receive reimbursement for covered tobacco cessation aids through your prescription drug plan in either of two ways:

1. You may present your insurance identification card to a participating pharmacy. We will then reimburse the pharmacy directly.

2. You may pay the entire cost of the covered tobacco cessation aid at any pharmacy and then submit a prescription drug claim form with the required information. We will then reimburse you up to the amount allowed for a participating pharmacy. You can obtain prescription drug claim forms by printing them from our website, weatrust.com, or by calling our customer service department.

If you are not covered by the Trust prescription drug plan, we process claims for covered tobacco cessation aids through your health plan. Use your Medicare prescription drug plan (Part D) identification card to obtain your tobacco cessation aids. Send us a copy of the pharmacy's receipt showing the Medicare prescription drug plan's payment and we will determine the amount of our payment as your secondary plan. Our reimbursement will be subject to applicable

deductible and coinsurance amounts and our maximum allowable fee. If you are not enrolled in a Medicare prescription drug plan, please call our customer service department for assistance in filing your claim.

To help you succeed in your efforts to quit using tobacco, we recommend that you call the Wisconsin Tobacco Quit Line, a free tobacco counseling service. The toll-free phone number is (800) QUIT-NOW (800) 784-8669. The Quit Line also offers Web coaching, discussion forums, and more information at its website, ctri.wisc.edu.

Urgent Care

We realize that there may be times when you need urgent care outside of your provider's normal office hours. Or, on occasion, you may need urgent care when it is not possible for you to reach a Network provider. If you receive such urgent care services under these circumstances, we will reimburse for covered services at the deductible and coinsurance amounts that apply to Network providers. Our reimbursement will be subject to your policy's copayment requirements, our maximum allowable fee, and all policy provisions.

Urgent care is the treatment for a condition that requires prompt attention, but does not pose an immediate, serious health threat. Such conditions require medical attention within hours rather than days in order to avoid complications or undue suffering. An example of a condition that might require urgent care is a urinary tract infection that, left untreated over a weekend, would cause the individual substantial distress and could progress and cause widespread infection or kidney damage.

Vision Services

Covered Services

We cover only these non-routine vision services:

- Diagnosis and treatment of eye pathology.
- Eye surgery to cure an Illness or heal an Injury to the eye. **Note:** We do not cover refractive eye surgery, such as radial keratotomy, to correct a vision impairment that can be corrected with lenses.
- The initial lens after cataract surgery. **Note:** This does not include eyeglasses or contact lenses.
- Therapeutic contact lenses for treating an Illness or Injury, such as keratoconus.
- The initial artificial eye to replace an eye lost because of Illness or Injury. **Note:** After this initial replacement, we do not reimburse expenses for or related to artificial eyes unless we have authorized them in advance.

Services Not Covered

We do not cover vision services other than those listed above. For example, we do not cover any service or supply for, or in connection with:

- Refractive eye surgery, such as radial keratotomy.
- Vision training procedures and orthoptics.
- Routine eye examinations.
- Refractions, eyeglasses, contact lenses, or fitting of eyeglasses or contact lenses.
- Nonprescription contact lenses or glasses.

Section 7
Hospital Admission Notification and Preauthorization Requirements

To receive the maximum reimbursement to which you are entitled for Hospital and other specified benefits, you must comply with our Hospital admission notification and preauthorization requirements. This section describes each procedure and the penalties if you don't comply.

Hospital Admission Notification Requirements

We require that you notify us of any overnight hospitalization. You must do so within a certain time, depending on whether your hospitalization results from a planned admission or an emergency admission. If you do not, your reimbursement will be reduced. See "Penalty if You Do Not Comply" below.

A planned admission is one that is, or reasonably can be, planned in advance.

An emergency admission is one that is necessitated by an accidental Injury, or the sudden and unexpected onset of severe symptoms of an Illness and for which hospitalization lasts 72 hours or longer. See "Emergency Services" in Section 6 for more information about medical emergencies.

Penalty if You Do Not Comply

If you do not notify us within the time required by this policy, we will reduce your reimbursement by the amount listed on your Benefit Summary. This penalty applies even if you are covered by another insurance plan and we coordinate benefits as your secondary insurer. This penalty does not count toward your maximum out-of-pocket limit. (For a detailed discussion of coordination of benefits and primary and secondary insurers, see Section 9.)

What You Must Do

- If yours is a planned admission, you must notify us before you enter the Hospital—at least 5 days in advance, whenever possible. We encourage you to call us to comply with this requirement as soon as you know you will be hospitalized.

- If you are hospitalized overnight due to an emergency admission, you or a family member, Physician, or Hospital employee must notify us within 72 hours of being admitted or as soon as it is medically feasible for you to do so, whichever is later.

We will need this information when you call or write to notify us of an overnight hospitalization:

- 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 nature of the hospitalization, we may need more information.

Special note about childbirth: Remember that you must notify us within 72 hours of your hospitalization for childbirth, unless you and your baby(ies) have been discharged within 72 hours of your admission. This notification requirement applies for other maternity-related emergency admissions as well, such as an admission for pre-term labor or other maternity complications when childbirth does not occur. If you do not notify us within the time required, your reimbursement will be reduced. See "Penalty if You Do Not Comply" above.

What We Do

We review the information you provide. Upon your request, we will let you or your Physician know whether the proposed facility and services meet the policy requirements for reimbursement. We will also periodically check on the status of your recovery and let you know when a covered hospitalization will no longer be covered.

Preauthorization Requirements

We require preauthorization for certain services, equipment, prescription drugs, and supplies for which specific facts of a medical condition determine whether a service is covered. For example, transplantation is covered by this policy, but we reimburse only under circumstances in which the patient's diagnosis and current medical condition meet our criteria and the facility where the procedure is performed fulfills our qualifications, and only to the extent that the cost is within our reimbursement limit.

Penalty if You Do Not Comply

If you do not receive our advance authorization of expenditures for services that require preauthorization, we have no obligation to reimburse you. If we receive a claim for such unauthorized services, we may evaluate, upon your request, participation in funding those services. If we determine the service is a covered expense, we will impose a penalty of 50% of the maximum allowable amount, before the deductible, coinsurance, and copayments are applied, up to $500 per covered service. This penalty does not count toward your maximum out-of-pocket limit. The extent of our participation in any case will be determined in our sole discretion and will create no obligation with respect to future cases.

Services That Require Preauthorization

Services that require preauthorization are listed on our website, weatrust.com. The list is subject to change. Please check the website to learn if the service you are seeking requires preauthorization, or call our customer service department to obtain a paper copy of the current list.

Note: We have the right to add to, or delete from, the list of services that require preauthorization provided we post an updated list of services requiring preauthorization on our website, weatrust.com, at least 60 days in advance of implementing the new requirement.

What You Must Do

You must contact us before you incur expenses for any service that requires our preauthorization. We will need this information to make a decision concerning your preauthorization request:

- Your diagnosis.
- The recommended treatment plan and any applicable treatment procedure codes. You can get these from your Physician.
- Medical rationale for treatment, relevant medical history and test results, and any complicating circumstances.

Depending on the specific circumstances, we may need more information. If we do, we will tell you and/or your Physician what we need. You are responsible for providing the information we need to make a decision concerning your preauthorization request.

What We Do

We review the information you provide and inform you or your Physician of our decision regarding your preauthorization request. We will tell you if we deem the service medically necessary and medically appropriate in your specific circumstances. Whenever we have questions about whether services meet these criteria, we rely on objective, contemporaneous medical records and the advice of our medical consultants. Upon your request, we will also tell you:

- Any suppliers, providers, and facilities you must use to receive maximum reimbursement.
- The reimbursement limits that apply.

Medical Necessity and Medical Appropriateness—We apply our review criteria to the individual medical circumstances of the patient. Our criteria are based on contemporary medical consensus, evidence of safety and effectiveness as supported by current, objective scientific research in the applicable medical specialty, and the advice of our medical consultants. We preauthorize services if we determine that our criteria are met. If we determine that our criteria are not met, or if we are unable to establish the medical necessity and medical appropriateness based on the information provided by you and your Physician, we will not preauthorize the services. Our decisions are final and binding, provided our criteria are reasonable and our decision is a reasonable application of those criteria to your circumstances.

Section 8
Claim 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 policy, 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 non-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 non-network providers, and you must in turn pay the non-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 Insurance Corporation.
- 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 you have 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 a participating 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 a participating pharmacy, less the applicable coinsurance or copayment amount. If you use a nonparticipating pharmacy, our reimbursement to you may be significantly less than you were charged. **Note:** Most Hospital pharmacies are not participating pharmacies. If your Physician gives you a prescription when you leave the Hospital, you may want to go to a participating 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 non-network providers, and you must in turn pay the non-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 benefits are paid under this policy 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 policy 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 policy, 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.

Section 9
Coordination of Benefits in Claims Payment

If you are covered by more than one group insurance plan including Medicare, we coordinate our benefits with any and all other benefits you are entitled to, whether or not you apply for or receive them. We coordinate benefits so that, whenever possible, the benefits available to you from all sources provide up to 100% of your allowable medical expenses or 100% of your liability for medical expenses, whichever is less.

Note: If you are eligible for Medicare, it is important to know whether Medicare or this policy is your primary insurance. Please contact us if you are not certain whether your primary insurer is Medicare or us. If Medicare is your primary insurer, it is important that you sign up for both Medicare Part A and Part B because we will coordinate benefits with Medicare Parts A and B whether or not you apply for and receive those benefits. This means that we will estimate what Medicare would have paid had you complied with reasonable rules established by Medicare to govern its benefits, and will coordinate the benefits of this policy with that amount. In this case, you will have significant out-of-pocket costs. (In coordinating benefits with Medicare, we follow all Medicare rules, including the adoption of Medicare's maximum charge as the allowable expense.)

Primary and Secondary Plans

When you have a loss that is covered by two group insurance plans, one of them is the primary plan and the other, the secondary plan. The primary plan pays its benefits first as if no other coverage were involved. Then the secondary plan determines its payment, taking into account the benefits paid by the primary plan. We use the "Order of Benefit Determination Rules" below in deciding whether this policy is your primary or secondary plan, except that for coordination with Medicare we follow the federal rules that regulate coordination with Medicare benefits. Your benefits under this policy will not be reduced when it is your primary plan, but they may be reduced when it is your secondary plan.

The term "plan" refers to any insurance policy, benefit program, or other arrangement that provides benefits or services for medical care. "Plan" includes these:

- Any 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 organization, or other prepayment, group practice, or individual practice plan.

- 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 state 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.

- All benefits that are available to you, or that you are eligible to receive, under Medicare, whether or not you apply for and receive such benefits. This means that, 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 the benefits of this policy with that amount. This also means that if Medicare is your primary insurer, but you receive services from a physician or practitioner who has opted out of Medicare, or does not qualify to be a Medicare provider, we will estimate what Medicare would have paid and coordinate the benefits of this policy with that amount.

Order of Benefit Determination Rules

The State of Wisconsin has adopted rules that must be followed by all insurers who coordinate benefits, except that coordination of benefits with Medicare follows federal rules. Those state rules are summarized below. The first rule that applies to you is the rule that determines which insurance plan is primary in your case.

1. If the other plan does not have a coordination of benefits provision, it is primary.

2. The plan that covers the individual as an employee, member, or subscriber (in other words, other than as a dependent) is primary. The plan that covers the individual as a dependent is secondary. There is one exception: If the individual is covered by Medicare, any applicable federal Medicare regulations will supersede this rule.

3. When a child is covered as a dependent under the plans of both parents, and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the calendar year is primary. If both parents have the same birthday, the plan that covered a parent for the longer period of time is primary. There is one exception: If the other plan does not use the birthday rule just described, but instead uses a rule based on the gender of the parent, the rule based on gender will determine the order of benefits.

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

    - The plan of the custodial parent.

    - The plan of the spouse of the custodial parent.

    - The plan of the noncustodial parent.

There are two exceptions: (1) If a court decree specifies which parent is responsible for health care expenses, the plan of the specified parent will be primary; and (2) If a court decree states that parents share joint custody but does not state which parent is responsible for the child's health care expenses, the order of benefits will be determined by rule 3 above.

5. A plan that covers an individual as an active employee or as that employee's dependent will be primary over a plan that covers an individual as a laid-off or retired employee or a dependent of such an individual. There are two exceptions: (1) If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule will be ignored; and (2) If a dependent is a Medicare beneficiary, any applicable federal Medicare regulations will supersede this rule.

6. If an individual has continuation coverage provided pursuant to federal or state law and is also covered under another plan, benefits will be determined in this order:

   - The plan that covers the individual as an employee, member, or subscriber or as the dependent of such an individual will be primary.

   - The plan that provides continuation coverage will be secondary.

   There is one exception: If the other plan does not have this rule and, as a result, the plans do not agree on the order of benefits, this rule is ignored.

7. 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.

Effect on Benefits When This Policy Is Secondary

An allowable expense is any necessary charge for health care that is covered by at least one of the plans. When a plan provides services instead of cash reimbursement, the reasonable cash value of the services is considered both an allowable expense and a benefit paid.

When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans are not more than the total allowable expenses. We coordinate benefits so that, whenever possible, the benefits available to you from all sources provide up to 100% of your allowable medical expenses or 100% of your liability for medical expenses, whichever is less. In addition, when this plan is secondary it shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of the other health care coverage. **Note:** If your primary plan would have paid a benefit had you submitted a claim to that plan, we will treat that amount as a primary plan payment when we determine our payment as your secondary plan. Also, if you are eligible for Medicare Parts A and B, and Medicare would be your primary insurer, we will coordinate the benefits of this policy with the benefits payable by Medicare, whether or not you have enrolled. (In coordinating benefits with Medicare, we follow all Medicare rules, including the adoption of Medicare's maximum charge as the allowable expense.)

If you are eligible for a benefit under Medicare Part A or B, or would be if you complied with reasonable rules established by Medicare to govern its benefits, we will coordinate the benefits of this policy with the benefits payable by Medicare whether or not you apply for or receive such benefits.

Moreover, if you choose to have a transplant performed at a facility that Medicare has not certified for your particular transplant surgery, there will be no reimbursement under this policy.

Our Rights Under This Provision

We need certain information in order to coordinate benefits. If you submit a claim for benefits, you must give us the information we need to determine our payment. We have the right to decide what information we need to determine our payment, and to get that information from any organization or person.

Similarly, we have the right to give such information to another organization or person when necessary to coordinate benefits.

If we make a payment that exceeds the amount required by this provision, we may recover the excess from any person or organization to whom, or on whose behalf, the payment was made.

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 policy. This section explains the rights you have under this policy and by law to receive explanations of what your policy 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 policy 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 policy promises.

- You believe you have been denied coverage promised by the policy.

- You are dissatisfied with covered services you received from one of our providers.

- You believe your coverage has been unfairly terminated.

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 7338
Madison, WI 53707-7338

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. 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 insurance policy 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

You have the right to an independent external review of a final coverage denial determination that is based on this policy's requirements for medical necessity, medical appropriateness, health care setting, level of care, cost-effectiveness of a covered benefit, or our determination that a treatment is Experimental/Investigative.

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 policy's criteria for medical necessity, medical appropriateness, or cost-effectiveness. These terms are explained in detail in Section 4 of this policy. Adverse determinations also include our decision that services are not covered because we consider them to be Experimental/Investigative.

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 policy 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 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

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 policy unless **all** of the following apply:

- You have exhausted the grievance procedures provided by law and outlined above.
- You file a legal action within 3 years of the date you were required by this policy 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.

Section 11
Our Right of Subrogation

In some circumstances, we may pay benefits to you or on your behalf even though another party or insurance company is liable for medical costs caused by your Injury, Illness, or other loss. We have the right in such circumstances to seek repayment from any liable party or parties. This is known as the right of subrogation.

We have a subrogation right against any party or insurance policy that is liable for your Injury, Illness, or other loss for the amount of benefits we have paid. This includes any payments to which you are entitled under the uninsured or underinsured motorist provisions of an automobile insurance policy or a no-fault insurance policy.

This policy obligates you to cooperate with us in our investigation of an injury or accident and in our attempts to recover payments we have made on your behalf when another party is liable. This means that you will make no settlement or agreement with any company or any person that prejudices our subrogation rights. It also means that if another company or person reimburses you for a loss that we have already paid, you must repay us promptly. If you do not, we may recover some or all of that amount by reducing subsequent benefits payable or by applying premium refunds due you.

Your right to be made whole for your loss will take priority over our right to recover the benefits we paid on your behalf from any liable party. However, this does not obligate us to waive our legal rights.

If you do not fulfill your obligations as described above, we may file suit against you or take lesser legal action. If we do, you will be liable for reasonable costs and attorney's fees that we incur in doing so.

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 policy.

Domestic Partner Coverage

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

Domestic partners and their children are eligible for coverage under this policy as dependents of covered employees. Domestic partners have the same rights, responsibilities, and entitlements as a legal spouse under this policy, with a few exceptions resulting from the different treatment of spouses and domestic partners under the law. Those exceptions are described below. If we approve a domestic partner's enrollment, his or her biological or legally adopted children who meet the policy's requirements for eligibility have the same rights, responsibilities, and entitlements as an employee's stepchildren under this policy. These covered dependents, the employee, and the employee's other covered dependents, if any, comprise a family as that term is used in this policy.

Definition of Domestic Partner

We define a domestic partner as an individual with whom you have agreed to live as sole domestic partners in a relationship that is characterized by **all** of the following:

- You have a committed spousal-type relationship of mutual support and caring, and you intend to remain in the relationship indefinitely.
- Your domestic partnership is, and has been for the past 6 months, publicly acknowledged and commonly recognized within the communities in which you live and work.
- You share financial resources and have agreed to be responsible for each other's common welfare.

Qualifying for Eligibility as a Domestic Partner

To establish that an individual qualifies for eligibility as your domestic partner, both of you must attest to all of the following on our *Designation of Domestic Partner* form:

1. You are both 18 years of age or older.
2. You are both mentally competent to make the declarations required by the form.
3. You are not related by blood closer than would bar marriage in the state of Wisconsin.
4. For at least the past 6 months, all of the following have been true:
    - You have lived together in the same dwelling unit.
    - Neither of you was married or legally separated in marriage.

- Neither of you was a party to an action or proceeding for divorce or annulment.
- Neither of you was in another domestic relationship.
- You were financially interdependent as evidenced by at least two of the following:

    1. Common or joint ownership of a residence.
    2. Joint ownership of a motor vehicle.
    3. Joint credit account; for example, a credit card.
    4. Joint checking or savings account.
    5. Your domestic partner identified as primary beneficiary in your will, life insurance policy(ies), tax-sheltered annuity account(s), IRA(s), or other retirement accounts.
    6. Joint financial investments.
    7. Other evidence of mutual financial interdependency that we deem acceptable.

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.

How to Obtain Coverage

Your domestic partner's coverage begins on the date he or she is eligible if **both** of the following apply:

- We receive the required documents within 30 days of that date.
- We approve enrollment based on the information submitted.

The required documents are these:

1. An enrollment form, listing all individuals for whom you wish coverage.
2. The signed *Designation of Domestic Partner* form.

If we do not receive the required documents within 30 days of initial eligibility, the policy's rules for late enrollment, described in Section 3, apply.

Policy Provision Exceptions That Apply to Domestic Partners

Policy provisions that pertain to an employee's covered spouse apply to your covered domestic partner. Exceptions are these:

1. This policy will pay as secondary insurer to Medicare for a covered domestic partner who is age 65 or older because of the federal rules that regulate coordination with Medicare benefits.

2. 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.

Eligibility of Your Domestic Partner's Children

Biological or legally adopted children of your covered domestic partner are eligible for coverage as dependents on the same date as the domestic partner is eligible. Coverage for these children begins on the date they are eligible if **both** of the following apply:

- We receive your application for their coverage within 30 days after they first become eligible.

- We approve coverage for your domestic partner.

Policy provisions that pertain to the stepchildren of a covered employee apply to your domestic partner's children. Therefore, they are eligible for coverage only as long as your domestic partner remains covered.

When the Domestic Partnership Ends

For purposes of this insurance, the domestic partnership ends on the earlier of these dates:

- The date your domestic partnership ceases to fulfill one or more of the criteria on the *Designation of Domestic Partner* form.

- The death of one of the two individuals in the domestic partnership.

The end of a domestic partnership has the same consequences under this policy as divorce or annulment of marriage, or the death of the covered employee. Therefore, the domestic partner and his or her children are no longer eligible for coverage after the last day of the month in which the domestic partnership ends.

Same Gender
Domestic Partner Coverage

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

Domestic partners of the same gender and their children are eligible for coverage under this policy as dependents of covered employees. Domestic partners have the same rights, responsibilities, and entitlements as a legal spouse under this policy, with a few exceptions resulting from the different treatment of spouses and domestic partners under the law. Those exceptions are described below. If we approve a domestic partner's enrollment, his or her biological or legally adopted children who meet the policy's requirements for eligibility have the same rights, responsibilities, and entitlements as an employee's stepchildren under this policy. These covered dependents, the employee, and the employee's other covered dependents, if any, comprise a family as that term is used in this policy.

Definition of Domestic Partner

We define a domestic partner as an individual with whom you have agreed to live as sole domestic partners in a relationship that is characterized by **all** of the following:

- You have a committed spousal-type relationship of mutual support and caring, and you intend to remain in the relationship indefinitely.
- Your domestic partnership is, and has been for the past 6 months, publicly acknowledged and commonly recognized within the communities in which you live and work.
- You share financial resources and have agreed to be responsible for each other's common welfare.

Qualifying for Eligibility as a Domestic Partner

To establish that an individual qualifies for eligibility as your domestic partner, both of you must attest to all of the following on our *Designation of Same Gender Domestic Partner* form:

1. You are members of the same gender.
2. You are both 18 years of age or older.
3. You are both mentally competent to make the declarations required by the form.
4. You are not related by blood closer than would bar marriage in the state of Wisconsin.
5. For at least the past 6 months, all of the following have been true:

- You have lived together in the same dwelling unit.
- Neither of you was married or legally separated in marriage.
- Neither of you was a party to an action or proceeding for divorce or annulment.
- Neither of you was in another domestic relationship.
- You were financially interdependent as evidenced by at least two of the following:

    1. Common or joint ownership of a residence.
    2. Joint ownership of a motor vehicle.
    3. Joint credit account; for example, a credit card.
    4. Joint checking or savings account.
    5. Your domestic partner identified as primary beneficiary in your will, life insurance policy(ies), tax-sheltered annuity account(s), IRA(s), or other retirement accounts.
    6. Joint financial investments.
    7. Other evidence of mutual financial interdependency that we deem acceptable.

The signed *Designation of Same Gender Domestic Partner* form is part of the contract of insurance, and 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.

How to Obtain Coverage

Your domestic partner's coverage begins on the date he or she is eligible if **both** of the following apply:

- We receive the required documents within 30 days of that date.
- We approve enrollment based on the information submitted.

The required documents are these:

- An enrollment form, listing all individuals for whom you wish coverage.

- The signed *Designation of Same Gender Domestic Partner* form.

If we do not receive the required documents within 30 days of initial eligibility, the policy's rules for late enrollment, described in Section 3, apply.

Policy Provision Exceptions That Apply to Domestic Partners

Policy provisions that pertain to an employee's covered spouse apply to your covered domestic partner. Exceptions are these:

1. This policy will pay as secondary insurer to Medicare for a covered domestic partner who is age 65 or older because of the federal rules that regulate coordination with Medicare benefits.

2. 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 Same Gender Domestic Partner* form during the 3 years preceding the covered employee's death.

Eligibility of Your Domestic Partner's Children

Biological or legally adopted children of your covered domestic partner are eligible for coverage as dependents on the same date as the domestic partner is eligible. Coverage for these children begins on the date they are eligible if **both** of the following apply:

- We receive your application for their coverage within 30 days after they first become eligible.

- We approve coverage for your domestic partner.

Policy provisions that pertain to the stepchildren of a covered employee apply to your domestic partner's children. Therefore, they are eligible for coverage only as long as your domestic partner remains covered.

When the Domestic Partnership Ends

For purposes of this insurance, the domestic partnership ends on the earlier of these dates:

- The date your domestic partnership ceases to fulfill one or more of the criteria on the *Designation of Same Gender Domestic Partner* form.

- The death of one of the two individuals in the domestic partnership.

The end of a domestic partnership has the same consequences under this policy as divorce or annulment of marriage, or the death of the covered employee. Therefore, the domestic partner and his or her children are no longer eligible for coverage after the last day of the month in which the domestic partnership ends.

Coverage for Domestic Partners

(As Defined by Chapter 770 of the Wisconsin Statutes)

This eligibility provision applies to your coverage only if your Benefit Summary indicates "Coverage for Domestic Partners (As Defined by Chapter 770 of the Wisconsin Statutes)."

Domestic partners and their children are eligible for coverage under this policy as dependents of covered employees. Domestic partners have the same rights, responsibilities, and entitlements as a legal spouse under this policy, with a few exceptions resulting from the different treatment of spouses and domestic partners under the law. Those exceptions are described below. If we approve a domestic partner's enrollment, his or her biological or legally adopted children who meet the policy's requirements for eligibility have the same rights, responsibilities, and entitlements as an employee's stepchildren under this policy. These covered dependents, the employee, and the employee's other covered dependents, if any, comprise a family as that term is used in this policy.

Definition of Domestic Partner

We define a domestic partner as an individual with whom you have obtained a declaration of domestic partnership issued by the county clerk, as described in Chapter 770 of the Wisconsin Statutes, and the partnership has not been terminated.

Qualifying for Eligibility as a Domestic Partner

To establish that an individual qualifies for eligibility as your domestic partner, you must provide us with a copy of the declaration of domestic partnership issued by the county clerk pursuant to Chapter 770 of the Wisconsin Statutes.

The copy of the declaration of domestic partnership 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.
- Within 30 days of the date the declaration of domestic partnership is recorded with the county register of deeds.

How to Obtain Coverage

Your domestic partner's coverage begins on the date he or she is eligible if **both** of the following apply:

- We receive the required documents within 30 days of that date.

- We approve enrollment based on the information submitted.

The required documents are these:

1. An enrollment form, listing all individuals for whom you wish coverage.

2. A copy of the declaration of domestic partnership issued by the county clerk, pursuant to Chapter 770 of the Wisconsin Statutes.

If we do not receive the required documents within 30 days of initial eligibility, the policy's rules for late enrollment, described in Section 3, apply.

Policy Provision Exceptions That Apply to Domestic Partners

Policy provisions that pertain to an employee's covered spouse apply to your covered domestic partner. Exceptions are these:

1. This policy will pay as secondary insurer to Medicare for a covered domestic partner who is age 65 or older because of the federal rules that regulate coordination with Medicare benefits.

2. If your plan includes the "Surviving Dependent Continuation" or "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.

Eligibility of Your Domestic Partner's Children

Biological or legally adopted children of your covered domestic partner are eligible for coverage as dependents on the same date as the domestic partner is eligible. Coverage for these children begins on the date they are eligible if **both** of the following apply:

- We receive your application for their coverage within 30 days after they first become eligible.

- We approved coverage for your domestic partner.

Policy provisions that pertain to the stepchildren of a covered employee apply to your domestic partner's children. Therefore, they are eligible for coverage only as long as your domestic partner remains covered.

When the Domestic Partnership Ends

For purposes of this insurance, the domestic partnership ends on the earlier of these dates:

- The date your domestic partnership terminates, as described in Chapter 770 of the Wisconsin Statutes.

- The death of one of the two individuals in the domestic partnership.

The end of a domestic partnership has the same consequences under this policy as divorce or annulment of marriage, or the death of the covered employee. Therefore, the domestic partner and his or her children are no longer eligible for coverage after the last day of the month in which the domestic partnership ends.

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 policy only if it is listed on your Benefit Summary.

Under these provisions, the coverage you and/or your dependents are eligible to continue will be the same health plan in effect for the 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 policy with the benefits payable by Medicare, whether or not the individual enrolls. See Section 9 for information about how we calculate benefits when this policy 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 policy as an active employee, your coverage will continue under this provision as long as all of the following apply:

- 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 voluntarily terminate coverage under this provision at any time, you cannot re-enroll later.

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 policy.
- 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.

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 policy as an active employee, your coverage will continue for as long as you are Disabled and all of the following apply:

- 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 voluntarily terminate coverage under this option at any time, you cannot re-enroll later.

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 policy.

- All of the "Rules for Late Enrollments" specific to eligible dependents as explained in Section 3, will apply.

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 policy 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 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 your surviving spouse continues family coverage and they continue to qualify as dependents under this policy.

If your dependents voluntarily terminate coverage under this provision at any time after your death, they cannot re-enroll later.

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

Waiver of Premium Benefit

This eligibility provision applies to your coverage only if your Benefit Summary indicates "Waiver of Premium Benefit."

Waiver of Premium

After a covered employee is Disabled for more than 60 continuous calendar days, we will waive the monthly premium required for coverage of the covered employee and his or her covered dependent(s). We will waive the premium beginning on the first day of the month following 60 consecutive days of Disability until the earliest of the following dates:

- The date the covered employee ceases to be Disabled as determined by us.
- The date the covered employee becomes eligible for Medicare benefits.
- The date the covered employee dies.
- The date the covered employee fails to furnish proof satisfactory to us of continued Disability.
- The date this policy terminates for any reason.
- The date the covered employee ceases to be eligible for coverage under the terms of this policy.

Premium will be waived for a maximum of 30 months for any one Period of Disability.

Premium payments must be resumed beginning with the month in which the covered employee resumes his or her regular job duties as a member of the class of eligible employees specified by the employer.

Period of Disability means one continuous Period of Disability beginning on the covered employee's date of Disability as determined by us or the prior insurer if applicable, and ending on the date on which the covered employee dies or ceases to be Disabled. Successive Periods of Disability will be deemed to be the same Period of Disability unless:

- Due to an unrelated cause and separated by a return to the regular performance of job duties for the employer; or
- Due to the same or related cause but separated by a return to the regular performance of job duties for the employer for 6 consecutive months.

The 60-day qualifying period referred to above must be satisfied only once for a Period of Disability. If a Disabled employee endeavors to resume work for the employer during a Period

of Disability, the maximum period of premium waiver will be extended. It will be extended by the number of days on which the covered employee works and for which resumed premium payments are made.

To qualify for waiver of premium, the employee must be under the regular care of a Physician. This means that:

- The employee is being seen by a Physician at intervals of time appropriate for treating the disabling impairment(s);

- The Physician is rendering and/or prescribing a pertinent treatment plan or a practical protocol, if one exists, for alleviating or eliminating the impairment(s) causing the Disability; **and**

- The employee is complying with all aspects of the Physician-prescribed treatment plan.

Waiver of premium applies only to a covered employee who becomes Disabled **after** the effective date of this policy. There is one exception. A Disabled employee whose premium is waived under the prior group health plan's waiver of premium provision at the time this policy goes into effect may be eligible for waiver of premium.

Waiver of premium applies only to the type of coverage (single or family) in effect for the covered employee on the date of Disability, or in effect on the date this policy replaces the prior group health plan.

Waiver of premium does not apply to a covered employee who was not Disabled at the time of his or her retirement and who is covered under either the "Retired Employee Continuation ," or the "Retired Employee Continuation—Limited Duration" optional eligibility provision.

As part of the Waiver of Premium Benefit, eligibility criteria for Disabled employees are added to Section 3, "Eligibility and Coverage of Employees and Their Dependents." A Disabled employee whose premium is waived under the prior group health plan's waiver of premium provision may be eligible to enroll in this plan.

In Section 3, a "Disabled Employees" provision is inserted after "Current Active Employees" under "Eligibility and When Coverage Begins" as follows:

Eligibility and When Coverage Begins
Current Active Employees

. . .

Disabled Employees
You are eligible for coverage on the date this policy takes effect only if **all** of the following apply:

- You belong to the class of eligible employees specified by your employer under this policy.

- You are Disabled on the date this policy takes effect.

- You are covered under the group health plan being replaced by this policy under a waiver of premium provision due to your own Disability.

Your coverage will begin on the date this policy takes effect if we receive your enrollment form within 30 days of that date.

New Employees

. . .

Limited Waiver of Premium Benefit

This eligibility provision applies to your coverage only if your Benefit Summary indicates "Limited Waiver of Premium Benefit."

This provision is the same as the "Waiver of Premium Benefit" provision, with one exception:

- Premium will be waived for a maximum of 12 months, rather than 30 months, for any one Period of Disability.

Eligibility Exclusion for Spouse

This provision applies to your coverage only if your Benefit Summary indicates "Eligibility Exclusion for Spouse."

This provision removes eligibility for coverage for a legal spouse by amending the "Your Dependents" provision within Section 3, "Eligibility and Dates of Coverage of Employees and Their Dependents." "Your legal spouse" is deleted and the remaining dependent descriptions are renumbered.

This provision further removes all other references to your spouse as an eligible dependent in Section 3.

Appendix

Optional Benefit Provisions

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 our authorization in advance of purchasing the service. See our website, weatrust.com, for a list of services that require preauthorization.

Also see your Benefit Summary for the coinsurance, copayment 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 Section 6, this policy covers the extraction of natural teeth.

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

1. The initial replacement of the extracted natural teeth.

2. 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.

3. 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 Section 6 of the policy 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

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

In addition to the vision services described in Section 6, this policy 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.

Enhanced DME Benefits

This benefit provision applies to your coverage only if your Benefit Summary indicates "Enhanced DME Benefits."

This benefit provision enhances the Durable Medical Equipment (DME) and Supplies coverage under Section 6, "Specific Benefit Provisions." It provides additional benefits by removing all exclusions for the following services:

- Foot orthotics.
- Compression stockings.
- Cranial banding.
- Blood pressure cuffs.
- Ultrasonic nebulizer.
- Non-wearable AED.

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.

Preventive Prescription Drug Benefit

This benefit provision applies to your coverage only if your Benefit Summary indicates "Preventive Prescription Drug Benefit."

Preventive Prescription Drugs

In addition to the prescription drug benefit described in Section 6, this policy covers medically necessary and medically appropriate preventive prescription drugs without applying deductible, coinsurance, or copayment amounts. To see a list of the preventive prescription drugs included in this benefit, please visit our website, weatrust.com.

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 policy is revised in two places to support this benefit.

In Section 5, "General Exclusions," the exclusion regarding prescription drugs 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:

  1. Employees who are actively at work and their covered dependents.

  2. Individuals who are covered by our standard family plan.

  3. Individuals who continue coverage under any of the Expanded Eligibility Options.

  4. Individuals who are covered under state and federal continuation (COBRA) coverage, unless they choose to waive prescription drug coverage under this plan.

  5. 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 "Prescription Drug Plan" provision within Section 6, "Specific Benefit Provisions," is amended. The "Note" is deleted and replaced with the following:

Note: This policy 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.

. . .