WEA-MedPlus Plan

CERTIFICATE OF COVERAGE

Underwritten by the WEA Insurance Corporation

45 Nob Hill Road (53713-3959)
P.O. Box 7338 (53707-7338)
Madison, Wisconsin
Voice/TTY:
(800) 279-4000
(608) 276-4000

IC OGC 4011-1016

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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 may also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by contacting:

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

You may view all of the WEA Trust's insurance plans on our website, weatrust.com. If we amend your Certificate, we add the amendment to our online plan documents.

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WEA Trust WEA-MedPlus Plan

This indemnity insurance plan is an alternative group health insurance plan developed especially for Medicare-eligible retirees who want to lower their premium costs but still be insured under one of our group health plans. This plan generally pays benefits secondary to Medicare for services that are covered by both Medicare and this Certificate. It also provides coverage for limited vision care services based on a preferred provider Network.

There are very specific eligibility requirements for this plan. Section 3 of this Certificate provides complete information on the eligibility requirements for you and/or your spouse.

This plan is guaranteed renewable unless you or your spouse no longer meet the eligibility requirements or do not pay the premium when it is due.

This plan does not cover all health and vision care services. We reimburse only for those services that are explicitly defined in this Certificate, and 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. There is an exception: We cover those routine and preventive services expressly listed in this Certificate and additional preventive services that we list on our website. 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.

Note: This Certificate excludes coverage for prescription drugs and medications except for those that we are required by law to cover.

We limit reimbursement for health care services to the maximum allowable fee for cost-effective services, subject to applicable deductible and coinsurance, and coordination with Medicare. If a charge exceeds our maximum allowable fee, we may reimburse less than the billed charge.

We reimburse for covered vision care services based on your choice of provider, and the reimbursement limitations defined in this Certificate, and your Benefit Summary. You are responsible for charges that exceed the reimbursement limitations.

Read more about the factors that affect reimbursement in Section 4.

We cover some services only if you receive our 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 “Factors That Affect the Reimbursement Amount” in Section 4 and “Preauthorization Requirements” in Section 7.

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

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

If you have any questions about the vision care benefits or related requirements of this Certificate, contact our Administrator:

National Vision Administrators, L.L.C. (NVA)
P.O. Box 2187
Clifton, NJ 07015
(877) 262-7915

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Table of Contents

Section 1
Rights and Obligations of the Insured and the WEA Insurance Corporation

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General Information About This Plan

This is an indemnity insurance plan for retirees:

- Who are insured under both Part A and Part B of Medicare;
- Who are enrolled in Medicare's traditional fee-for-service program (Original Medicare Plan); **and**
- For whom Medicare is the primary insurer.

It pays benefits secondary to Medicare for services that are covered by both Medicare and this Certificate, but also may pay benefits for some services that are not covered by Medicare. If you are currently covered under an employer-sponsored WEA Trust group health plan, your benefits under this Certificate will be similar, but not identical, to your current coverage. For example, **this Certificate does not include coverage for prescription drugs nor does it include any optional benefits—such as coverage for the extraction and replacement of teeth, or waiver of premium—**that may be included in your employer-sponsored health plan.

Note: The premium rates for this plan are based on participants complying with Medicare's rules for payment under its traditional, fee-for-service program (Original Medicare Plan). Therefore, this Certificate coordinates benefits with what Medicare would have paid for your care had you followed those rules. If you have complied with Medicare's rules, you will receive a Medicare Summary Notice (MSN) after Medicare has made its payment. The MSN shows Medicare's allowable charge and its payment. We will coordinate our payment based on the MSN.

If, however, you have not qualified for Medicare reimbursement because you did not fully comply with Medicare's rules for payment, we will estimate what Medicare would have paid if you had followed its rules. We will coordinate our payment with that estimated amount. This results in significant out-of-pocket costs.

To minimize your out-of-pocket costs, you should use medical providers and suppliers that Medicare will reimburse for all services that Medicare covers. Providers that Medicare will reimburse have agreed to either:

- Accept Medicare's approved amount for services (in other words, they accept assignment), **or**
- Be subject to Medicare's limiting charge (115% of the approved amount).

To find out whether a provider is eligible for Medicare reimbursement, simply ask before you get health care services or supplies. Your Medicare Administrative Contractor (the company that processes your Medicare claims) can also tell you which doctors in your area accept assignment. You will find the

number for your Medicare Administrative Contractor on the MSN (explanation of benefits) you get in the mail after your claims are processed.

This Certificate also pays benefits for covered vision care services based on a preferred provider network.

This Certificate is guaranteed renewable unless you no longer meet the eligibility criteria or you fail to pay the premium when due. In accordance with its terms, we will reimburse the costs of covered health and vision care services incurred by covered individuals and their covered spouses, subject to our maximum allowable fee, reimbursement limits, and coordination of benefits with Medicare.

This Certificate does not provide reimbursement for all health or vision 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 Certificate. 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.

Some of the services covered by this Certificate require preauthorization. We require preauthorization when the specific facts of the patient's medical condition determine whether that service is appropriate and cost-effective. Preauthorization requirements are described in Section 7.

All reimbursements for health care services are limited to the maximum allowable fee for cost-effective 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 and coinsurance amounts. More information about our maximum allowable fee, as well as other factors that affect reimbursement, is included in Section 4.

All reimbursements for covered vision care services are subject to the applicable copayment amounts, fixed fees, retail allowances, and frequency limits defined in Section 4.

When we preauthorize services based on a specified expenditure, the specified expenditure is the reimbursement limit. See "Reimbursement Limit on Services That Require Preauthorization" in Section 4 for additional information.

If you have any questions about the benefits or requirements of this Certificate, or if you would like further information about our maximum allowable fee, call our customer service department for health care services at (800) 279-4000 or (608) 276-4000 (Voice/TTY), or call our Administrator for vision care services at (877) 262-7915.

When Premiums Are Due

We will send you a premium bill by the 10th day of each month for the following month's coverage. The premium is due each month on or before the 20th day of the month that precedes the month of coverage. You must pay all monthly premiums when they are due.

Amount of the Premium

You owe premium for each month in which you are covered by this plan for at least one day except that when your coverage begins after the 15th day of a month, your premium liability will begin on the first day of the following month. However, even if you have paid your premiums, we will not be obligated to provide benefits if you or your spouse are not eligible for coverage under the terms of this Certificate.

The amount of your monthly premium for initial coverage is shown on the enrollment form we provided to you. Your monthly premium is determined by the geographic area in which you live and receive your medical care. Therefore, if you move to a different area, your premium may increase or decrease when premium rates are adjusted each January.

You will receive written notice at least 31 days in advance of any increase in premium. We will never increase premium rates by 25% or more without giving you 60 days' notice.

Grace Period

We will allow a grace period of 31 days for the receipt of any premium due after the first premium. This Certificate will continue in force during the grace period. The grace period will start on the first day of the month following the day the premium is due. There will be no grace period, however, if either you or we have given written notice of termination to the other as indicated below.

Termination of the Certificate by the Insured Individual

You may terminate coverage under this Certificate effective at the end of any month by informing us of your desire to do so before that date. Although your coverage will automatically terminate if you fail to pay the premium when due, we would appreciate advance written notice of your decision to terminate. If you wish to terminate your coverage, please return your premium notice to us marked "cancel."

Termination or Nonrenewal of the Certificate by Us

Once you are covered under this Certificate, you have the right to continue coverage under this Certificate unless you no longer meet the eligibility criteria or fail to pay the premium when due. We have the right on January 1 to alter the plan's benefit design or increase premium if we do so for all covered individuals.

Your Duty to Provide Information

You must provide the information we need to administer the provisions of this Certificate and pay benefits. For example:

- **You must inform us when you move and give us your new address.** This includes informing us when you move temporarily. For example, if you live in Wisconsin during the summer and in Arizona during the winter, you must inform us when you change locations.
- **You must let us know if you become ineligible for coverage under this Certificate**. For example, if, for some reason, you are no longer covered by Medicare Parts A and B or you enroll in a Medicare Advantage plan.

- **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 this determination.

- **You must notify us when you or your covered spouse becomes covered by another group health or vision plan.** The State of Wisconsin has adopted rules that must be followed by all insurers who coordinate benefits. These rules specify which insurer pays first, which pays second, etc. See Section 9, Coordination of Benefits in Claims Payment.

- **You must inform us when you or your covered spouse 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 use this information to determine whether any benefits are owed to you under this Certificate, you must promptly provide us with any related information or documentation that we require. This Certificate 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 payment. See also "Our Right of Review and Recoupment" in Section 8.

If you or your spouse become ineligible for coverage under this Certificate but fail to notify us at the time that eligibility is lost, this failure will not extend coverage for the ineligible individual beyond the appropriate termination date as defined by this Certificate. We may refund, at our discretion, premium paid beyond the appropriate termination date for the applicable individual, up to a maximum of six months' premium, if claims were not paid during that time.

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 Certificate. No statement or representation relating to the interpretation or application of any provision of this Certificate will be binding unless an officer of our company issues it in writing.

Entire Insurance Contract

The entire contract of insurance consists of:

1. This Certificate and any amendments.

2. The Benefit Summary.

3. The Information and Rate Request form you completed to obtain an enrollment form from us, if applicable.

4. The enrollment forms completed by you and/or your spouse.

5. The benefit confirmation letter that specifies the date your coverage became effective.

Certificate Changes

No change in this Certificate will be valid unless written and signed by an officer of our company. If any Certificate 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 Certificate 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 Certificate. When these terms are capitalized in the text of the Certificate, they have the meaning that is defined below.

Administrator means the entity which services the visions care services under the Certificate as agreed to in a contract with the WEA Trust.

Benefit Period means the 12-month period specified on the Benefit Summary.

Contact Lenses, Elective –These are contact lenses an individual chooses to wear instead of eyeglasses for reasons of comfort or appearance.

Contact Lenses, Non-Elective –These are contact lenses that are prescribed solely for the purpose of correcting a specific medical condition. These lenses allow an individual to achieve a specified level of visual acuity that would not be possible using conventional eyeglasses.

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.

Eyeglass Lenses refer to a standard glass or plastic (CR39) lens, which is optically clear. Standard multifocal lenses include segments through flat top 35 for plastic bifocal and lenticular lenses, through flat top 28 for glass trifocals, and through flat top 35 for plastic trifocals.

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.
- Free-standing 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.

Materials mean corrective Eyeglass Lenses, frames and Contact Lenses.

Network Provider means an Ophthalmologist, Optometrist or Optician who has entered into an agreement with the Administrator to provide the covered services for a contracted rate. These providers are listed in the Network Provider directory. You will generally incur less out-of-pocket costs for services from a Network Provider.

Non-Network Provider means an Ophthalmologist, Optometrist or Optician who is not a Network Provider. These providers have not entered into an agreement with the Administrator to limit their charges. You will generally incur more out-of-pocket costs for services from Non-Network Providers.

Ophthalmologist means a person who is licensed by the state in which he or she practices as a Doctor of Medicine or Osteopathy and is qualified to practice within the medical specialty of ophthalmology. The Ophthalmologist cannot be 1) the covered individual or his or her covered dependent; or 2) retained by the employer.

Optician means a person or business that grinds and/or dispenses Eyeglass Lenses and Contact Lenses prescribed by either an Optometrist or Ophthalmologist. The Optician cannot be the covered individual or his or her covered dependent. The Optician must be licensed by the state in which services are rendered, if such state requires licensing.

Optometrist means a person licensed to practice optometry as defined by the laws of the state in which services are rendered. The Optometrist cannot be the covered individual or his or her covered dependent.

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 provided services are within the scope of the practitioner's professional license:

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

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

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

- Any time the word "**services**" appears in this Certificate, unless otherwise stated, it refers to any professional service, medical or health care treatment, hospitalization and other use of facilities, laboratory services, durable medical equipment, medical supplies, pharmaceuticals, vision care professional service, and vision correction Materials.
- Any time the words "**you**" or "**your**" appear in this Certificate, they refer to any individual who is covered by the Certificate. The exception to this is in Section 3, "Eligibility and Coverage of Retirees and Their Spouses," where "you" and "your" refer only to the retired employee whose prior employment is the basis for eligibility under this Certificate.
- Any time the word "**covered**" appears in the benefit provisions of this Certificate, it refers to services that are reimbursable if we find them to be medically necessary and medically appropriate in your specific circumstances. Reimbursement is subject to coordination with Medicare; our maximum allowable fee; any reimbursement limits that apply; this Certificate's cost-effectiveness limit; and our preauthorization requirements. See Sections 4 and 7 for a discussion of these concepts.

Section 3
Eligibility and Coverage of Retirees and Their Spouses

This section describes the eligibility criteria for coverage under this Certificate, when eligible individuals must elect coverage, and when coverage begins and ends.

Note: Whenever the terms **"you"** or **"your"** appear in this section, they refer only to the retired employee whose prior employment is the basis for eligibility under this Certificate.

How to Obtain Coverage

In order to obtain coverage under this plan, we must receive a completed enrollment form that establishes to our satisfaction that you meet the eligibility criteria. Your coverage under this plan is not effective until we have notified you in writing of the effective date of your coverage.

If you are enrolled in the WEA-MedPlus Plan, or if you meet certain eligibility criteria for coverage under this plan, your spouse may be eligible for coverage under this plan. To apply for coverage, your spouse must submit a completed enrollment form that establishes to our satisfaction that he or she meets all of the eligibility criteria described in this section. There is no coverage for other dependents.

When You Must Apply for Coverage

If you meet the eligibility criteria defined below, you have two opportunities to apply for coverage under this plan. These two opportunities also apply to a spouse who applies for coverage under this plan.

1. You may apply for coverage under this plan during the six-month period following the effective date of your Medicare Part B coverage; **or**

2. You may apply for coverage under this plan any time after the six-month period following the effective date of your Medicare Part B coverage; however, you must demonstrate that you were continuously covered by a comprehensive health insurance plan during the six months immediately preceding your application for coverage under this plan. The health insurance plan that covered you during that period must have had coverage equivalent to or better than a basic Medicare supplement plan.

Your Eligibility for Coverage

You are eligible for coverage under this plan if you meet **all** of the following criteria:

- You are age 65 or older.
- You are retired from all full-time employment.
- You are **not** working for an employer covered under a WEA Trust group health plan, as a regular part-time employee, as an independent contractor or consultant with an employment arrangement, or via an employee leasing or outsourcing arrangement.

- You are enrolled in Part A and Part B of Medicare's traditional fee-for-service program (Original Medicare Plan) and Medicare is the primary insurer of your health care costs. **Note:** You are **not** eligible for this plan if you enroll in a Medicare Advantage (Medicare Part C) plan.

  In addition, you must meet at least one of the following criteria at the time you apply for coverage under this plan:

- You are a WEA Trust health plan subscriber.
- You are a member of the WEAC Retired (WEAC-R) class.
- You were a WEA Trust health plan subscriber at some point during the past ten years.
- You were a WEAC member at some point during the past ten years.
- You were an employee of any Wisconsin unit of government or instrumentality of two or more units of Wisconsin government, at some point during the past ten years.
- You were an employee of one or more Wisconsin units of government or instrumentality of two or more units of Wisconsin government for a cumulative period of at least ten years. The ten years do not need to be consecutive.

Note: A Wisconsin unit of government includes but is not limited to, the state, each state agency, and any county, city, village, town, school district, technical college district, or other governmental unit.

Your Spouse's Eligibility for Coverage

Your spouse is eligible for coverage under this plan if your spouse meets **all** of the following eligibility criteria:

- Your spouse is age 65 or older.
- Your spouse is retired from all full-time employment.
- Your spouse is **not** working for an employer covered under a WEA Trust group health plan, as a regular part-time employee, as an independent contractor or consultant with an employment arrangement, or via an employee leasing or outsourcing arrangement.
- Your spouse is enrolled in Part A and Part B of Medicare's traditional fee-for-service program (Original Medicare Plan) and Medicare is the primary insurer of your spouse's health care costs. **Note:** Your spouse is **not** eligible for this plan if your spouse enrolls in a Medicare Advantage (Medicare Part C) plan.

In addition, the following criteria must be met at the time your spouse applies for coverage under this plan. You must be retired from full-time employment **and** you must meet at least one of the following criteria:

- You are enrolled in the WEA-MedPlus Plan.

- You are a WEA Trust health plan subscriber.
- You are a member of the WEAC Retired (WEAC-R) class.
- You were a WEA Trust health plan subscriber at some point during the past ten years.
- You were a WEAC member at some point during the past ten years.
- You were an employee of any Wisconsin unit of government or instrumentality of two or more units of Wisconsin government at some point during the past ten years.
- You were an employee of one or more Wisconsin units of government or instrumentality of two or more units of Wisconsin government for a cumulative period of at least ten years. The ten years do not need to be consecutive.

Note: A Wisconsin unit of government includes but is not limited to the state, each state agency, and any county, city, village, town, school district, technical college district, or other governmental unit.

If you marry while you are covered by this Certificate, you may obtain coverage for your new spouse **provided** he or she meets **all** of the spousal eligibility criteria above. You must apply for coverage for your new spouse within 30 days of your marriage. Coverage for a new spouse will begin on the date of your marriage **provided** we receive the required application for coverage and premium payment within 30 days of your marriage.

When Coverage Begins

Coverage under this Certificate will not begin until we notify you, in writing, of the effective date of coverage. When coverage under this Certificate is approved, it will become effective on the first day of the month following the month in which we notify you of our approval and receive the initial premium payment. A spouse's coverage under this Certificate will not begin until we notify him or her, in writing, of the effective date of coverage.

When Coverage Ends

Your coverage under this Certificate will end on the earliest of the following dates:

- The date this plan terminates for any reason.
- The end of the period for which the last premium was paid for you.
- The date you cease to be eligible for coverage under the terms of this Certificate.
- The date Medicare ceases to be your primary insurer.
- The date on which you fail to comply with any provision of this Certificate.
- The date of your death.

Coverage for your spouse will end on the earliest of the following dates:

- The date this plan terminates for any reason.
- The end of the period for which the last premium was paid for your spouse's coverage.
- The date your spouse ceases to be eligible for coverage under the terms of this Certificate.
- The date Medicare ceases to be your spouse's primary health insurer.
- The date on which your spouse fails to comply with any provision of this Certificate.
- The date of your spouse's death.

Your covered spouse may continue coverage under this Certificate after your death or divorce as long as desired if we timely receive the required premiums. To continue coverage, he or she must notify us within 60 days of your death or divorce so that we can update our records and adjust the premium.

Section 4
General Provisions That Apply to Benefits

This Certificate covers a comprehensive range of health and vision care services, including benefits required by state and federal law. However, not all health and vision 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.

Some services require our advance approval, or 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. Some services are explicitly excluded in Section 5 or in Section 6 under the specific benefit provision to which they pertain.

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

1. Maximum allowable fee.
2. Coding and billing standards.
3. Reimbursement limit on services that require preauthorization.
4. Use of Medicare providers to minimize out-of-pocket costs.
5. Cost-effectiveness limit.
6. Deductibles.
7. Coinsurance.

It also explains the factors that affect the amount of reimbursement for covered vision care services:

1. Your choice of vision care provider (Network or Non-Network Provider).
2. Copayments.
3. Fixed fees.

4. Retail allowances.

5. Frequency limits

How We Determine if a Health Care Service Is Covered

We cover health care 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 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 professional 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 and preventive services listed throughout Section 6 and additional preventive services that we list on our website.

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. Several examples are provided in Section 5, "Limitations and Exclusions."

Medically necessary services exclude services performed in the absence of a diagnosed Illness or Injury. There is an exception: We cover the specified routine and preventive services as explicitly listed throughout Section 6 and additional preventive services that we list on our website. This Certificate does not cover other preventive services or treatments.

When the patient desires services in response to a Physician's recommendation and those services do not meet our criteria for medically necessary care, we will, in accordance with our preauthorization procedure, receive and evaluate such a request to participate in the funding of such services. 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.

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.

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. 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 Certificate, 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 or 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 always consider medical devices, drugs, and biologicals safe if they have been accepted for marketing by the federal Food and Drug Administration (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. However, when the patient desires such services in the absence of proven medical alternatives, we will, in accordance with our preauthorization procedure, receive and evaluate a request to participate in the funding of such services. 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.

How We Determine if a Vision Care Service Is Covered

Covered vision services are shown on your Benefit Summary. To be a covered service, the service must be provided:

1. By an Ophthalmologist, Optometrist, or Optician;

2. To check vision or improve a vision condition;

3. Within the frequency limits shown on your Benefit Summary.

We reimburse the lesser of the following amounts:

- The actual cost incurred for the service provided; or,

- The applicable benefit limits shown on your Benefit Summary.

Factors That Affect the Reimbursement Amount for Health Care Services

Maximum Allowable Fee

We reimburse charges in accordance with our maximum allowable fee. If your provider accepts Medicare assignment, we generally consider Medicare's approved amount to be our maximum allowable fee. If your provider does not accept assignment, our maximum allowable fee will never exceed Medicare's maximum allowable charge (sometimes referred to as the Medicare limiting charge). On occasion, our reimbursement limit may be less than Medicare's approved amount, or limiting charge, if we have negotiated a lesser charge with a provider or if the provider has not followed all Medicare rules concerning charge limits.

When an approved amount has not been determined by Medicare, the first of the following options that applies to the provider from whom you seek care will determine our maximum allowable fee:

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. If there is no negotiated fee applicable to the provider who is billing you for this service, we will reimburse a percentage of the fee we have contracted to pay similar providers. Please see your Benefit Summary for the percentage of the contracted fee that applies.

If a charge for a service or group of services is below our maximum allowable fee, we will reimburse the provider's billed charge. If a charge for a service or group of services exceeds our maximum allowable fee, we will reimburse less than the billed charge. You are responsible for any amount that exceeds our maximum allowable fee.

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 at (800) 279-4000 or (608) 276-4000 (Voice/TTY). When you call, we will need this information in order 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.

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 our advance approval are listed on our website, weatrust.com.

You may receive preauthorized services from any qualified provider. However, we have contracts with certain specialty providers for some of the services that require preauthorization. In these cases, we have contracted with providers because of their outcomes and survival rates, credentialing and experience of staff, volume of procedures performed for each service, or overall cost-effectiveness. See Section 7 for more information about our preauthorization requirements.

If the preauthorized service is one for which we have contracted with a specialty provider as described in the preceding paragraph, our reimbursement limit is the contracted amount. Therefore, if you choose to receive the preauthorized service from a contracted specialty provider, we reimburse the cost of the service, less any applicable deductible and coinsurance, in accordance with the coordination of benefit rules under "How We Calculate Benefits When This Plan is Secondary" in Section 9. If you choose to receive the preauthorized service from another provider that is Medicare-certified, and thus comply with Medicare's rules for payment, we will pay as secondary insurer up to the lesser of the following amounts:

- The difference between Medicare's approved or limiting charge, whichever is applicable, and what Medicare paid.
- The difference between our contracted amount and what Medicare paid.

If you choose to receive the preauthorized service from a provider who is neither a contracted specialty provider nor a provider that Medicare will reimburse, we will estimate the amount we would have paid had you used such a provider and will coordinate our payment with that estimated amount. This will result in significant out-of-pocket costs.

If, however, you choose to receive a preauthorized service, or any service, from a provider that neither Medicare nor we consider a qualified provider, there will be no reimbursement under this Certificate or Medicare; for example, a facility that is not Medicare-certified for your transplant.

Use of Medicare Providers to Minimize Out-of-Pocket Costs

Participating Providers—You will receive maximum reimbursement for your covered health care services when you use providers that Medicare will reimburse; for example, Medicare-certified facilities and Physicians, and other qualified providers that accept Medicare. If you don't, we will estimate the amount Medicare would have paid if you had complied with its reimbursement rules and will coordinate our payment with that estimated amount. This will result in significant out-of-pocket costs for you.

To find out whether a provider is eligible for Medicare reimbursement, simply ask before you make an appointment or get health care services or supplies. Your Medicare Administrative Contractor (the company that processes your Medicare claims) can also tell you which doctors in your area accept assignment. You will find the phone number for your Medicare Administrative Contractor on the Medicare Summary Notice (explanation of benefits) you get in the mail after your claim is processed.

Medicare has a website that contains useful information, including a participating physician directory. You can access Medicare, the Official U. S. Government Site for People with Medicare, at medicare.gov.

Private Contracts With Providers—If you enter into a private contract with a provider, you will end up paying the entire cost of the service yourself. A private contract is an agreement between you and a provider who has decided not to participate in the Medicare program. Under a private contract, Medicare will not reimburse for any services you receive. Neither will we. In this case, you will be responsible for paying whatever the provider charges you, and there is no limit on what the provider can charge.

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 services are received in the least costly setting required for safe delivery of those services.

For example, 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

Reimbursements 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.

We apply an individual deductible to the maximum allowable fee for covered services incurred by each individual during a Benefit Period. This means that both you and your spouse, if covered, must each satisfy the individual deductible during each Benefit Period. The individual deductible amount is specified on your Benefit Summary.

Coinsurance

Reimbursements may be subject to a coinsurance payment. This means that we pay only a specified percentage of the maximum allowable fee for covered services, and you are responsible for paying the remainder. Your Benefit Summary specifies the coinsurance percentages you must pay and the services to which they apply.

Factors That Affect the Reimbursement Amount for Vision Care Services

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

Your choice of vision care provider determines how much we will reimburse for covered services and, consequently, how much you must pay for your vision care. You receive the most reimbursement your vision plan provides only when you obtain covered services from Network Providers. The amount you must pay out-of-pocket for your vision care will be significantly more when you receive services from Non-Network Providers.

Network Providers—When covered services are received from a Network Provider, we will pay the Network Providers directly, based on the Network benefits shown in the Benefit Summary.

Non-Network Providers—If you receive services from a Non-Network Provider, you must pay the provider in full. You are responsible for sending us a claim. See Section 8, "Claim Procedures." We will reimburse you up to the retail allowance amounts shown on your Benefit Summary, subject to applicable frequency limits.

Provider Directory

You can access the directory of vision Network Providers online at our Administrator's website specified on your Benefit Summary. If you prefer, you can request a paper copy of a vision Network Provider Directory by calling our Administrator at (877) 262-7915.

Provider information changes occasionally. Therefore, we recommend you confirm that your chosen provider is in the Network prior to receiving care.

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. Copayments do not apply to all services, and the amount may vary for different services. Your Benefit Summary specifies copayments you must pay and the services to which they apply.

Fixed Fees

These amounts, which are specified on your Benefit Summary, are the fixed fees you will pay under this Certificate for certain covered lens options when provided by a Network Provider. We encourage you to check your Benefit Summary so you know the fixed fee you will be required to pay for these covered services. Lens options not listed on the Benefit Summary will be priced by the Network Provider at their reasonable and customary retail price, less the discount percentage listed on your Benefit Summary. This Certificate does not reimburse for lens options provided by a Non-Network Provider.

Retail Allowances

This amount, which is specified on your Benefit Summary, is the maximum amount this Certificate will reimburse for certain services. We encourage you to check your Benefit Summary so you know which services are limited to a retail allowance and the retail allowance amount we will pay for these covered services.

Frequency Limits
The frequency limits determine how often you can receive reimbursement for certain covered services. We pay a benefit if you receive certain covered services within the applicable frequency limits while your coverage under this Certificate is in effect. Your Benefit Summary specifies the frequency limits that apply to certain covered services.

Coding and Billing Standards
We rely on medical documentation to determine if procedure or billing codes for services reported and billed by a 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.

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

Section 5
Limitations and Exclusions

Benefits are subject to the limitations and 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.

Limitations

The Certificate covers Contact Lenses for aniseikonia. It does not cover eyeglasses (frames and lenses) made for this condition.

Non-Elective Contact Lenses are covered only when prescribed for any of the following medical reasons:

- Aphakia (after cataract surgery).
- When visual acuity cannot be corrected to 20/70 in the better eye except through the use of Contact Lenses.
- Anisometropia of 4.0 diopters or more.
- Keratoconus.

Dilation is included as part of a routine exam under the Vision Exam benefit **only** when professionally indicated.

Exclusions

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 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 for comprehensive, intensive nutritional counseling by qualified providers for obese adults and adults at higher risk for diet-related chronic disease.

- Replacement of Contact Lenses, Eyeglass Lenses, frames, 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.
- 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.
- Smoking cessation, except for tobacco cessation screening and brief interventions described in the "Routine Physical and Preventive Care Benefits" described in Section 6.
- Gene therapies, treatments, or enhancements.

  Note: Other genetic testing and/or genetic counseling may be covered if it is authorized by us in advance in accordance with our preauthorization review criteria. Read about our preauthorization requirements and reimbursement limits that apply in Section 7.
- Services you receive that are neither covered by Medicare nor by this plan. These are not allowable expenses. Read about allowable expenses under "How We Calculate Benefits When This Plan Is Secondary" in Section 9.
- Transplant services received from a facility that Medicare has not certified for that particular type of transplant surgery. Both Medicare and this Certificate require that the facility be Medicare-certified for that type of treatment as a condition of reimbursement.
- Services you receive when you enter into a private contract with a provider (Medicare won't pay and neither will we.)
- Office visits, Physician charges, or any other service for, or in connection with, a procedure or service that this Certificate does not cover, even if the individual was not covered under this health plan when the noncovered procedure or service was performed. 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 treat or resolve complications resulting from the noncovered procedure or service, services to repair a failed procedure or service, services to repair scarring from services or surgery that this Certificate 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 list on our website.
- Services or items for physical fitness, wellness, health education, or personal hygiene.
- Nutritional or diet supplements, except for those that we list on our website.
- 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 improve appearance. Examples are hair restoration, 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 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 except for those that we are required by law to cover.

- Services received outside of the United States, except for services received in a medical emergency. A medical emergency exists when you experience an accidental Injury or the sudden and unexpected onset of severe symptoms of an Illness, which are of sufficient severity to require immediate attention.

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

- 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.

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

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

- 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.

- Experimental or non-conventional treatment or device.

- Services in connection with:
  - Plano (non-prescription) Contact Lenses or Eyeglass Lenses.
  - Subnormal visual aids such as magnifiers or adaptive telephones.

- Orthoptics, vision training, developmental visions procedures, and any associated supplemental testing.

- Two pair of eyeglasses (frames and lenses) in lieu of bifocals, trifocals, or progressives.

- Lens options provided by Non-Network Providers.
- An eye examination or corrective eyewear required by an employer as a condition of employment, and safety eyewear unless otherwise covered under the Certificate.
- Services provided by another vision or health plan.
- Services which are payable under any worker's compensation act, similar law, or any public program other than Medicaid, 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.
- Costs incurred while you are not covered by this Certificate, except that vision correction Materials ordered before your coverage under this Certificate ends will be covered if those Materials are dispensed to you within 31 days of that termination date.
- Missed appointments.
- Copying and providing medical or any other type of information in support of a claim.

Section 6
Specific Benefit Provisions

This section provides additional details about how the "General Provisions" of this Certificate (Section 4) apply to specific services. It also describes any 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.

The "Definitions" (Section 2), "General Provisions" (Section 4), and the "Limitations and 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," described in Section 4.

Important Reminders

- Some services require our advance approval, or 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.
- To minimize your out-of-pocket costs for medical services, you must follow Medicare's rules for reimbursement, including use of providers and facilities whose services Medicare will cover.

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 Certificate 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.

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.

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 or 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.

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 Certificate.

- 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 Certificate; 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 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 crowns, bridges, partial or full dentures, or implants.

- 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. Durable medical equipment for diabetes management, such as insulin infusion pumps and non-invasive continuous glucose monitors, are covered only if we have authorized the expenditure in advance. See Section 7 for information about our preauthorization requirements and reimbursement limits that apply. Information about our preauthorization criteria is provided under "Durable Medical Equipment and Supplies."

Covered Services

Covered supplies and equipment for diabetes treatment include:

- Insulin and other prescription drugs and medications prescribed for the treatment of diabetes. 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. You may 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, but only if we have authorized the expenditures in advance. We preauthorize 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.

We reimburse for rental or purchase of durable medical equipment, or its functional repair, only if we have authorized the expenditure in advance. See Section 7 for information about our preauthorization requirements and reimbursement limits that apply.

Information About Our Preauthorization Criteria

We base our preauthorization of expenditures for durable medical equipment on medical necessity, medical appropriateness, and cost-effectiveness.

Medical necessity—Durable medical equipment is medically necessary if it is **required** for the safe and effective delivery of **covered health care services**.

Medical appropriateness—Durable medical equipment is medically appropriate if contemporary medical consensus considers it both safe and effective in the patient's specific circumstances.

Cost-effectiveness—In comparing equipment alternatives, we consider whether distinct medical advantages justify greater cost or more frequent replacement. Thus, we do not authorize coverage of added costs for equipment that has no advantage over a suitable alternative other than convenience or personal preference. We also do not authorize 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 preauthorize:

- 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) that we may preauthorize, such as wheelchairs and hospital beds.
- Functional repair of durable medical equipment.

Covered Supplies

These are covered supplies that do not require preauthorization:

- Orthopedic appliances. Examples are custom made 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 have preauthorized.
- Ostomy care items, catheter maintenance supplies, and surgical stockings (for example, Jobst stockings).

Equipment and Supplies Not Covered

These are examples of items that are not covered and will never be authorized:

- Items that are useful in the absence of Illness, Injury, or disability. Examples are air conditioners, air cleaners and purifiers, humidifiers, whirlpools, dehumidifiers, shoe or 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 (OTC) supplies other than those listed above or in the subsection on "Diabetes Supplies and Equipment."

Emergency Services

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.

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.

A medical emergency exists when you experience an accidental Injury, or the sudden and unexpected onset of severe symptoms of an Illness, which are of sufficient severity to require immediate medical care.

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.

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, but **only** if we have authorized both the evaluation services and the implant procedures in advance in accordance with our preauthorization review criteria.

Read about our preauthorization requirements and reimbursement limits that apply in Section 7. Services we may authorize include the initial evaluation by an audiologist and otolaryngologist, Physician and Hospital services, and auditory and speech therapy following implant surgery. Note that we have the right to specify the reimbursement limit for preauthorized expenditures.

Services Not Covered

These are examples of services that are not covered:

- Batteries and cords.
- Hearing examinations or tests administered directly or indirectly for fitting a hearing aid or device.
- Hearing aids and devices, even when part of a cochlear implant evaluation.
- Services for, or in connection with, prescribing hearing aids or devices.

Home Health Care

We reimburse for medically necessary and medically appropriate home health care services based on a Physician-prescribed plan of care, but only if we authorize the expenditure in advance. See Section 7 for information about our preauthorization requirements and reimbursement limits that apply. While home health care benefits most often apply to part-time or intermittent medical care, we preauthorize more frequent services if they are a cost-effective alternative to other treatment arrangements.

Information About Our Preauthorization Criteria

We base our preauthorization of home health care services on your medical needs and our cost-effectiveness standards. We preauthorize 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 preauthorize 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

Preauthorized 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, your covered spouse, 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 and will never be authorized:

- Services provided by the covered employee, your covered spouse, 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 but only if we have authorized the expenditure in advance. See Section 7 for information about our preauthorization requirements and reimbursement limits that apply.

We preauthorize services 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 preauthorize:

- 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, 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.

Hospital Admission Notification Requirement

To receive maximum reimbursement, you must satisfy our Hospital admission notification requirement when you are admitted 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.

All other inpatient admissions, planned or elective, must satisfy our preauthorization requirements. Read about our preauthorization requirements and reimbursement limits that apply in Section 7.

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 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.

Services Not Covered

These are examples of services that are not covered:

- Costs of a private room unless it is essential for the safe and effective delivery of covered services or the Hospital offers only private rooms to deliver the covered services you received.
- 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 Certificate.

Kidney Disease Treatment

The State of Wisconsin requires that health policies reimburse up to $30,000 in a Benefit Period for the treatment of chronic renal disease (CRD) or end-stage renal disease (ESRD). This Certificate complies with this requirement but does not limit reimbursement to $30,000. Covered services include kidney dialysis and transplantation services that we have authorized in advance.

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, but only if we have authorized both the transplant evaluation services and the transplant procedures in advance. Read about our transplantation preauthorization review criteria under "Surgical Benefits" later in this section.
- 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, but only if we have authorized the expenditures in advance. This includes 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 Certificate.
- Procurement, transportation, and preservation of cadaveric donor kidneys.

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.

Remember: For maximum reimbursement, you must use providers whose services Medicare will cover. To find out whether a provider is eligible for Medicare reimbursement, simply ask before you make an appointment or receive services. 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.

Note: We cover court-ordered treatment only if the treatment meets our criteria for medical necessity and medical appropriateness.

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: You must obtain our authorization in advance for any planned or elective overnight hospitalization. You must also notify 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. When you call, we will let you and your Physician know whether the proposed facility and services meet the Certificate's requirements for reimbursement. We will also periodically check on the status of your recovery and let you know when hospitalization will no longer be covered. See Section 7 for details of our preauthorization or 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 states outside Wisconsin in a private psychiatric hospital is covered only if the facility has been certified by the State of Wisconsin or we have negotiated a contract with the hospital.

Transitional Treatment

Covered Transitional Treatment Services

We cover transitional treatment services provided by qualified providers 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 and frequency 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 not inpatient but is more intensive than outpatient treatment. Examples of types of transitional treatment include:

- Day treatment or evening treatment programs.
- Partial hospitalization.
- Intensive outpatient treatment.

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 by the State of Wisconsin. You can call us to find out if the services you anticipate receiving fulfill this requirement.

Transitional treatment received in states outside of Wisconsin is covered only if the facility has been certified by the State of Wisconsin, or we have negotiated a contract with the provider.

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 we authorize the services in advance. See Section 7 for information about our preauthorization requirements and reimbursement limits that apply. We preauthorize such 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 with whom we have negotiated a contract or a state-licensed:

- Psychiatrist. This is a state-licensed Physician with a specialty in psychiatry.
- Psychologist.
- Independent Clinical Social Worker (LICSW).
- Independent Social Worker (LISW).
- Professional Counselor (LPC).
- Registered nurse with a master's degree and certified as a specialist in psychiatric and mental health nursing.

Unless we have negotiated a contract with the provider, services by the following provider are covered only if the outpatient clinic in which the services are provided has been certified by the State of Wisconsin:

- Clinical Substance Abuse Counselor (CSAC).

Services received in states outside of Wisconsin 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 out-of-state provider meets these requirements.

Services Not Covered

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

- Residential mental health and eating disorder programs.
- 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.
- 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.
- 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 "Routine Physical and Preventive Care 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 decline or the patient represents an active danger to herself, himself, or others.

Physical, Speech, and Occupational Therapy

This Certificate provides benefits for rehabilitative therapy treatments that meet the conditions described below, but only if we have authorized both the evaluation and therapy services in advance.

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.

Information About Our Preauthorization Criteria

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

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

2. 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.

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.

Rehabilitative Therapy Services Not Covered

We neither preauthorize nor 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.

- Services rendered by a massage therapist.

- 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.

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 and preventive services listed throughout Section 6 and additional preventive services that we list on our website, even when you have no symptoms of an Illness or Injury. Some of those services are listed under:

- "Reproductive Health Benefits."

- "Routine Physical and Preventive Care Benefits."

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. Services that require preauthorization are listed on our website, weatrust.com. Read about our preauthorization requirements and reimbursement limits that apply in Section 7.

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 the 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.

Covered Contraception and Surgical Sterilization Services

We cover these services and supplies:

- All safe and effective devices in general use as contraceptives that require intervention by a Physician or other licensed health care provider. Examples include intrauterine devices (IUDs), cervical caps, and diaphragms.

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

- Surgical sterilizations such as tubal ligations and vasectomies.

Covered Preventive Services

Covered preventive services are limited to those listed throughout Section 6 and additional preventive services that we list on our website. We reimburse for diagnostic services that have been proven effective in detecting disease of the reproductive system. Such services must be performed by qualified, licensed providers (including nurse practitioners). Examples include these:

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

- Prostate cancer screening procedures 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.

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.

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

- Contraceptive 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.

- Contraceptive drugs and medications.

Routine Physical and Preventive Care Benefits
This Certificate generally covers only those medical services that diagnose or treat Illnesses and Injuries. However, we reimburse for the specified routine and preventive services listed throughout Section 6 and additional preventive services that we list on our website, 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, licensed 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 are listed throughout Section 6 and additional preventive services that we list on our website. Please see 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, pelvic examination, and prostate cancer screening. 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.

- Tobacco cessation screening and brief interventions for tobacco users who are 18 years of age or older, as required by law.

- Immunizations for adults that are deemed appropriate by a Physician. These include vaccines such as tetanus, diphtheria, influenza, pneumococcal travel-related vaccines, and those that appear on our current list of covered preventive services on our website.

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 routine hearing examinations or tests for, or in connection with, prescribing or fitting a hearing aid.

- Routine eye examinations.

Second Opinion Benefits

We reimburse for a second opinion of a diagnosis, proposed treatment plan, or surgery. To ensure that you receive maximum reimbursement for such a consultation, you must call us in advance and request preauthorization. Generally, we preauthorize second opinion consultations with Physicians who are neither involved in the diagnosis and treatment plan nor affiliated with the Physician who will provide the treatment. To obtain our preauthorization, call our customer service department.

Skilled Nursing Facility Care

We reimburse for skilled nursing facility care only if we authorize the expenditure in advance. See Section 7 for information about our preauthorization requirements and reimbursement limits that apply. Information about our preauthorization criteria is provided below. These benefits are limited to a maximum of 60 days for any one period of confinement in a skilled nursing facility. Period of confinement is defined below.

Note: Medicare determines skilled nursing facility benefits differently than we do. Medicare benefits are based on a benefit period as Medicare defines that term. Your benefits under this Certificate are based on a period of confinement. We coordinate the benefits of this Certificate with those available to you through Medicare. This can be confusing. So, when you call us to request preauthorization of

skilled nursing facility care, we will explain how Medicare's benefits and this Certificate's benefits work together.

Period of Confinement

A period of confinement begins when you enter a skilled nursing facility 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.

If you were discharged from a skilled nursing facility to your home or an assisted living facility because of the belief that you had recovered, but later return to a skilled nursing facility, we may determine, in our sole discretion, that a new period of confinement may begin. For example:

- If your home stay before re-entering a skilled nursing facility was lengthy, we may determine that you had sufficiently recovered from the first condition and, therefore, you are entitled to a new period of confinement.

- If you experience an unexpected recurrence of your original condition after recovery, or you have a new medical condition, we may determine that you are entitled to a new period of confinement.

In all cases, we determine whether a subsequent confinement is the same period of confinement or a new 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.

Information About Our Preauthorization Criteria

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

- You are convalescing or rehabilitating from an Illness or Injury.
- Your condition during recovery requires daily skilled nursing or skilled rehabilitation care.
- A skilled nursing facility is the most cost-effective means of providing that care.

Skilled nursing and skilled rehabilitation services are described below.

Covered Services

These are examples of skilled nursing facility services we may preauthorize:

- Room and board.
- Physician, skilled nursing, and skilled rehabilitation services.

Services Not Covered

We neither preauthorize nor 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 Services

We reimburse for skilled rehabilitation services but only if we have authorized both the evaluation and the rehabilitation services in advance. See Section 7 for information about our preauthorization requirements and reimbursement limits that apply.

Skilled rehabilitation providers include licensed physical and occupational therapists, speech pathologists, and audiologists. Services may be received in a health care facility or in your place of residence.

Information About Our Preauthorization Criteria

We preauthorize 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 preauthorize:

- 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.

Services Not Covered

We will neither preauthorize nor cover any service that does not meet **all** of our preauthorization 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.

Important Reminders

- Some surgical services require our advance authorization; for example, reconstructive or plastic surgery and transplantation procedures. Services that require preauthorization are listed on our website, weatrust.com.
- In addition, if your surgery requires a Hospital stay, you must call us in advance to fulfill our Hospital admission notification or preauthorization requirements. See Section 7 for information about our Hospital admission notification and preauthorization 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 Certificate, 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 **both** of these criteria are met:

1. We have authorized both the transplant evaluation services and the transplant procedures in advance.

2. 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).

If these requirements are not met, there will be no reimbursement under this Certificate.

When we receive a request to preauthorize a transplantation procedure, we apply our established preauthorization 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 Certificate 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. Then, if we determine the procedure is covered, we apply our preauthorization criteria.

Preauthorized services may include transplant evaluation services, Hospital and Physician services, organ procurement, and tissue typing. Living donor services are preauthorized and covered only if the transplant recipient is covered by this Certificate. 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, provided we authorize it in advance. We preauthorize second opinion consultations with Physicians who are neither involved in the recommended surgery nor affiliated with the Physician who will perform the surgery. See Section 7 for information about our preauthorization requirements.

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 Certificate (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:

- TMD treatments, surgical and nonsurgical, that we have authorized in advance.
- 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.

This Certificate limits reimbursement to the preauthorized services and expenditures for surgical and nonsurgical treatment, and the maximum allowable fee for covered diagnostic services, less applicable deductible or coinsurance.

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 with other diagnostic procedures:

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

    Certain diagnostic tests require our preauthorization. See Section 7 for our preauthorization requirements and reimbursement limits that apply.

2. Surgical and nonsurgical treatment that contemporary medical consensus considers safe and effective and that we have preauthorized. See Section 7 for information about our preauthorization requirements and reimbursement limits that apply. These are examples of services that we may preauthorize:

    - 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 neither preauthorize nor 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.

Vision Services

Vision Examination—This Certificate reimburses for one complete examination of your eyes and related structures within the frequency limit specified on your Benefit Summary. The examination, to evaluate a new or existing visual condition, must be performed by a licensed optometrist or ophthalmologist.

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—This Certificate covers frames and Eyeglass Lenses, or Contact Lenses, prescribed by a licensed ophthalmologist or licensed optometrist for vision correction. The Certificate covers all types of Contact Lenses such as hard, soft, gas permeable and disposable lenses.

We will cover each of the following within the frequency limits specified on your Benefit Summary:

- A retail allowance toward one pair of frames.
- A retail allowance toward two Eyeglass Lenses for frames or a supply of Contact Lenses, Elective or Non-Elective, as prescribed.

Note: There is one exception. For the treatment of aphakia (after cataract surgery), a pair of prescription single vision or multifocal Eyeglass Lenses is covered in addition to Non-Elective Contact Lenses for this condition.

The following necessary professional services are covered, but are reimbursed as part of the retail allowance for the applicable covered vision correction Material:

- Prescribing and/or ordering proper lenses.
- Assisting in the selection of a frame.
- Verifying the accuracy of the lens(es).
- Proper fitting and adjustment of eyeglasses.
- Fitting and follow up services associated with Contact Lenses (if Contact Lenses are provided as part of the coverage), up to your release from care.

We also cover these 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.
- 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. Please see the subsection on "Durable Medical Equipment" earlier in this section for information about our preauthorization criteria for durable medical equipment.

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:

- Vision services rendered by a provider other than ophthalmologists, optometrists, or opticians acting within the scope of their licensure.
- Refractive eye surgery, such as radial keratotomy.
- Vision training procedures and orthoptics.
- Nonprescription lenses.

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 Requirement

We require that you notify us of any overnight hospitalization when you are admitted due to an emergency. If you do not, your reimbursement will be reduced. See "Penalty if You Do Not Comply" below.

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.

A planned admission is one that is, or reasonably can be, planned in advance. Planned or elective admissions are subject to our preauthorization requirements. See "Preauthorization Requirements" below.

Penalty if You Do Not Comply

If you do not notify us within the time required by this Certificate, 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. (For a detailed discussion of coordination of benefits and primary and secondary insurers, see Section 9.)

What You Must Do

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 emergency 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.

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

Preauthorization Requirements
We require preauthorization for all planned or elective inpatient admissions, and services for which specific facts of a medical condition determine whether a service is covered. For example, transplantation is covered by this Certificate, 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 request or 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. 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 in writing 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.
- Reimbursement limits that apply.

Details about each of these components are included below.

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.

Suppliers, Providers, Facilities—You may receive preauthorized services from any qualified provider. However, we have contracts with certain specialty providers for some of the services that require preauthorization. In these cases, we have contracted with providers because of their outcomes and survival rates, credentialing and experience of staff, volume of procedures performed for each service, or overall cost-effectiveness. When we preauthorize services, we will inform you of any such providers with whom we have contracted for your preauthorized service.

Reimbursement Limits—If the preauthorized service is one for which we have contracted with a specialty provider as described in the preceding paragraph, our reimbursement limit is the contracted amount. Therefore, if you choose to receive the preauthorized service from a contracted specialty provider, we reimburse in accordance with the coordination of benefit rules under "How We Calculate Benefits When This Plan is Secondary" in Section 9. If you choose to receive the preauthorized service from another provider that is Medicare certified, and thus comply with Medicare's rules for payment, we will pay as secondary insurer up to the lesser of the following amounts:

- The difference between Medicare's approved or limiting charge, whichever is applicable, and what Medicare paid; or
- The difference between our contracted amount and what Medicare paid.

If you choose to receive the preauthorized services from a provider who is neither a contracted specialty provider nor a provider that Medicare will reimburse, we will estimate the amount we would have paid had you used such a provider and will coordinate our payment with that estimated amount. This will result in significant out-of-pocket costs.

If, however, you choose to receive a preauthorized service, or any service, from a provider that neither Medicare nor we consider a qualified provider, there will be no reimbursement under this Certificate or Medicare; for example, a facility that is not Medicare certified for your transplant.

If the preauthorized service is not one for which we have contracted with a specialty provider, reimbursement is limited to the maximum allowable fee for the service and is subject to coding compliance rules, multiple surgery rules, and all of the Certificate's reimbursement rules following the coordination of benefits rules in Section 9.

Section 8
Claim Procedures

To receive reimbursement, you or someone on your behalf must send us, within 90 days, a written claim and proof that you have incurred a covered loss. Wisconsin law extends this period to 12 months beyond the 90 days required by this Certificate, but only if we are not prejudiced by the delay and it was not reasonably possible for you to meet our 90-day limit.

Claim for Health Care Services

To make filing health care claims easier, we have entered into a Coordination of Benefits Agreement with the Centers for Medicare and Medicaid Services (CMS) for automatic submission of Medicare Part A and Part B claims to WEA Insurance after Medicare has processed them. You are ultimately responsible for assuring that claims are properly filed with us and that the claims contain all of the information we need to evaluate them.

You can use the automatic submission process described below, or you can get claim forms from us. The identification card we issue you after enrollment gives the address to which claims must be submitted.

Your claim must include this information:

- The name and address of the covered retired employee whose prior employment or WEAC membership is the basis for eligibility under this Certificate.
- The group number of your plan (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.
- Information regarding any other group insurance coverage, including Medicare.
- 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.

Automatic Claims Filing for Most Medicare Claims

After you receive medical services, your health care provider sends your claims to the Medicare Administrative Contractor responsible for the claim. We have contracted with Medicare to have most of your claims automatically filed with us after the Medicare Administrative Contractor has determined its payment. This service applies to both assigned and non-assigned Medicare claims.

- You are ultimately responsible for ensuring that claims are properly filed with us. Even with our Coordination of Benefits Agreement with Medicare, you or your health care provider may still have to file a claim with us in certain circumstances, such as when you receive services that are not covered by Medicare.

In situations where the automatic claims filing service is not used, you or your health care provider must file a claim for these services by sending us the Medicare Summary Notice (MSN) along with an itemized bill. We are happy to accept provider-submitted claims that meet industry-accepted standards. The materials sent to us must include all of the information listed above in "Claim for Health Care Services."

Claim for Vision Care Services

If you seek routine vision care services from a Network Provider, you can present your identification card or you may simply let them know that you have a WEA Trust plan with vision care services administered by NVA. 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.

If you receive services from a Non-Network Provider, you must pay the entire cost of services received at the time of service. You must submit claims for services from Non-Network Providers that satisfy our requirement to prove that you have incurred a covered loss. You can request a claim form from our Administrator by visiting the website specified on your Benefit Summary. We will then reimburse you for any covered services.

We rely on documentation from your patient record to determine if procedure or billing codes for services reported and billed by a vision 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.

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 health care or vision care providers from whom you received the services, unless they have already been paid. If we know you have paid them, we reimburse you.

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

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

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

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 reimburse up to 100% of your allowable medical expenses or 100% of your liability for medical expenses, whichever is less.

Coordination With Medicare

As a condition of eligibility for coverage under this Certificate, you must be enrolled in the Original Medicare Plan (the traditional fee-for-service program), both Part A and Part B, and Medicare must be the primary insurer of your health care benefits. When you receive services that are covered by Medicare, we will be the secondary payer of your benefits.

If you are covered by another insurance plan as well as Medicare and this Certificate, Medicare will be the primary insurer, and the responsibility of this Certificate and the other group plan for any remaining charges will be determined by the rules described below. In coordinating benefits with Medicare, we follow all federal rules that regulate coordination with Medicare benefits.

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 rules described below in deciding whether this plan is your primary or secondary plan, except that for coordination with Medicare, Medicare is always the primary insurer. Your benefits under this Certificate 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, 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 Medicare is your primary insurer, but you receive services from a physician or practitioner who does not qualify to be a Medicare provider, we will estimate what Medicare would have paid and coordinate the benefits of this plan with that amount.

Coordination With Other Plans

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 must pay as the primary insurer in your case after Medicare.

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. If the individual is covered by Medicare, any applicable federal Medicare regulations will supersede this rule.

3. 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.

4. 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.

5. 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 Plan Is Secondary

An allowable expense is any necessary, reasonable and customary 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. If your health care provider accepts Medicare assignment, we generally consider Medicare's approved amount to be the allowable expense. If your provider does not accept assignment, the allowable expense will never exceed Medicare's maximum allowable charge (often referred to as Medicare's limiting charge). On occasion, our reimbursement limit may be less than Medicare's approved amount or limiting charge if we have negotiated a lesser charge with a provider or if the provider has not followed all of the Medicare rules concerning charge limits.

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. **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.

Important Reimbursement Notes: If you are eligible for a Medicare benefit, or would be if you complied with rules established by Medicare to govern its benefits, we will coordinate the benefits of this Certificate with the benefits payable by Medicare, whether or not you apply for or receive such benefits.

Therefore, to minimize the amount you must spend out-of-pocket for your covered health care services, you must follow Medicare's rules for reimbursement. This includes using providers whose services Medicare will cover; for example, Medicare-certified facilities and Physicians that accept Medicare. If you don't, we will estimate the amount Medicare would have paid if you had complied with its reimbursement rules and will coordinate our payment with that estimated amount.

Further, if another non-Medicare plan would have assumed responsibility to pay a benefit before this plan 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.

If you enter into a private contract with a provider, or 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 Certificate. Because neither we nor Medicare will reimburse in these cases, you will be responsible to pay all of the charges.

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, in accordance with law, 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 Certificate. This section explains the rights you have under this Certificate and by law to receive explanations of what your Certificate 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

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

After we receive and process a claim for health 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.

Vision Care Services— If you have questions about your vision care benefits under this Certificate, or how to receive maximum reimbursement for your routine vision care services, or if you have a complaint about our benefit determination, you may call and talk with one of our Administrator's customer service representatives at (877) 262-7915.

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 or our vision Administrator's customer service representative, we encourage you to call our dispute resolution specialist at (800) 279-4000 or (608) 276-4000 (Voice/TTY). Our dispute resolution specialist will promptly investigate your complaint and keep you informed about the progress of the investigation.

Right to Submit a Grievance

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

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

- You believe you have not received the reimbursement the Certificate promises.
- You believe you have been denied coverage promised by the Certificate.
- You are dissatisfied with covered services you received from one of our providers.
- You believe 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 Certificate and the known facts, it will issue instructions for corrective action.

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

- The duration of the standard grievance resolution process will result in serious jeopardy to your life or health or to your ability to regain maximum function.
- In the opinion of a Physician with knowledge of your medical condition, the standard grievance process would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance.
- A Physician with knowledge of your medical condition determines that the coverage determination shall be treated as an expedited benefit determination.

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

Right to an Independent External Review

You have the right to an independent external review of a final coverage denial determination that is based on this Certificate'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 Certificate's criteria for medical necessity, medical appropriateness, or cost-effectiveness. These terms are explained in detail in Section 4 of this Certificate. 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 Certificate provisions on which we based our decision, and any other relevant documents or information used in our grievance determination. The review organization has 45 days from the date it receives the required information to notify you and us in writing of its decision. The decision is binding on both of us.

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

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

Another legal right you have is the right to file a complaint with the **Office of the Commissioner of Insurance**, a state agency that enforces Wisconsin's insurance laws. You can 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 Certificate 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 Certificate to provide proof of loss.

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

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 plan 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 Certificate 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.