Essential Health Plan

CERTIFICATE OF COVERAGE

Underwritten by the WEA Insurance Corporation

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

CERTIFICATE OF COVERAGE
FOR
WEA Trust Essential Health PPO

IMPORTANT LEGAL NOTICES

Your Right to Return Policy

Please read this **Certificate of Coverage** within 24 hours of receiving it. If **You** are not satisfied with this **Policy** for any reason, **You** may cancel it within 10 days of receiving **Your Policy**. Upon cancellation, this **Certificate** will become invalid. WEA Trust will refund any **Premium** payments to **Your** employer. **You** have the right to buy **Your** own health insurance plan if **Your** employer-sponsored policy does not meet federal affordability requirements.

Your Responsibility To Be Correct and Complete

Please review the data you gave **Us** about **You** and/or **Your Family**. **Your** application form, which is part of **Your Policy**, has this data. Errors or missing facts could cause a valid **Claim** to be denied. Carefully check the form and contact WEA Trust within 10 days if any facts on the form are not correct and complete.

We can cancel this **Plan** if **We** find that **You** applied using false, missing or misleading information. We can also cancel this **Plan** if **You** submit a **Claim** for coverage using false or misleading information.

Notice Regarding Pediatric Dental Coverage

This **Plan** does not include pediatric dental services as required under the federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact **Your** insurance carrier, agent or the Federally Facilitated Marketplace (FFM) if **You** wish to purchase pediatric dental coverage or a stand-alone dental services product.

Guaranteed Compliant

This **Plan** is guaranteed to meet or exceed all rules from Federal and State of Wisconsin agencies that oversee insurance, including those relating to healthcare reform. **We** may send you amendments to this **Policy** as these laws evolve. For questions about healthcare reform, visit healthcare.gov.

INTRODUCTION TO WEA TRUST LARGE GROUP PPO

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

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

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

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

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

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IMPORTANT NOTICES

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

Maximum Allowable Fee: **Our** reimbursement for **Covered Services** provided by an **Out-of-Network Provider** is limited to **Our Maximum Allowable Fee**. The amount **We** pay for **Your Covered Services** may be less than the billed charges **You** get from the provider. For more details, see the discussion of **Maximum Allowable Fee** in Section 2: General Provisions That Apply to All Benefits, as well as the Definition of **Maximum Allowable Fee** in Section 1: Definitions. **You** can also call Customer Service at (800) 279-4000 (TTY 711).

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

Our Commitment to You

Because WEA Trust is here to serve **You**, **We** want to ensure that:

- **You** are well-informed about **Your** legal rights.
- There is mutual respect and cooperation between **You**, **Your Health Care Providers** and employees of WEA Trust.
- **You** have access to high-quality healthcare at a fair cost.

This document summarizes some federal and state laws that are in place to protect **You**, the rules **We** expect **You** to follow as a **Member**, and the methods **We** use to oversee the quality of care **You** are receiving. As a customer of WEA Trust, **We** welcome **Your** feedback and **We** will look into any concerns that **You** share with **Our** team.

SECTION 1: DEFINITIONS

Active Status

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

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

Activity of Daily Living (ADL)

A basic task that most people are able to do each day without any help, including but not limited to bathing, eating, dressing, toileting and transferring.

Adverse Benefit Determination

A decision that results in:

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

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

- An individual being ineligible for coverage in the **Plan**;
- A utilization review decision;
- A decision that a service or item is experimental or investigational; or
- A decision that a service or item is not **Medically Necessary** or **Medically Appropriate**.

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

Appeal

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

Authorized Representative

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

Autism Spectrum Disorder

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

Behavior Analyst

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

Behavioral Therapy

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

Benefit Period

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

Benefit Summary

The document that lists **Your Cost-Sharing Amounts** for the **Covered Services** under **Your Plan**.

Bone-Anchored Hearing Aid

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

Calendar Year

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

Certificate of Coverage (Certificate)

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

Claim

A request for payment from WEA Trust.

Cochlear Implant

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

Coinsurance

After **You** have met **Your Deductible**, a specified percentage of the **Maximum Allowable Fee You** are required to pay each time **You** receive **Covered Services**. Please see the **Benefit Summary** for the specific **Coinsurance** percentage **You** must pay for **In-Network** and **Out-of-Network Covered Services**, and to which **Covered Services** they apply.

Complaint

Any expression of dissatisfaction **You** or **Your Authorized Representative** make to **Us** about **Us**, an **In-Network Provider**, or any other provider with whom **We** have a direct or indirect contract.

Confinement/Confined

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

Confinement Period

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

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

Copayment

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

Cosmetic Surgery

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

Cost-Effective or Cost-Effectiveness Limit

The service that meets both of these conditions:

- The service is the least costly of alternative services that are comparably equivalent in safety and effectiveness for **Your** medical condition; and
- The service is received in the least costly setting required for safe delivery of those services.

Cost-Sharing Amounts

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

Covered Service

A service, item or supply that is:

- Needed due to an **Illness** or **Injury**;
- **Medically Necessary**;
- **Medically Appropriate**; and
- Eligible for payment under this **Plan**.

Custodial or Long Term Care

Services that can generally be provided by someone who does not have professional medical training or skills. They are **Custodial** even if provided by a registered nurse, licensed practical nurse, or other training medical personnel.
The purpose of **Custodial** or **Long Term Care** services are primarily for one or more of the following purposes:

- Maintaining an individual's existing physical and mental health and sense of wellbeing.
- Preventing an individual's health from declining further.
    - Helping someone perform the **Activities of Daily Living**, such as bathing, eating, dressing, toileting and transferring.

Deductible

The amount that **You** must pay each **Benefit Period** before **We** start to pay for **Covered Services**. For more specific information about **Your Deductible**, including the difference between the Single and **Family Deductible** amounts, please see Section 2: General Provisions That Apply to All Benefits of this **Certificate** and **Your Benefit Summary**.

Dependent

The following individuals are considered a **Dependent** under this **Plan**:

- A **Subscriber**'s lawful **Spouse**;
    - A **Spouse** ceases to be a **Dependent** on the date in which a divorce decree or annulment is granted.
- A **Subscriber**'s natural blood-related child; adopted child; child placed for adoption with the eligible individual; stepchild(ren); or child(ren) under the age of 26 for whom the **Subscriber** acts as legal guardian.
    - "Placed for adoption" is defined in Wis. Stat. § 632.896.
    - If the **Subscriber** is the father of a child born outside of marriage, the child does not qualify as a **Dependent** unless there is a court order declaring paternity or acknowledgment of paternity is filed with the Wisconsin Department of Health Services or the equivalent agency if the birth was outside of the state of Wisconsin. Upon qualification, coverage for the child will be effective according to Section 6: Eligibility, Enrollment and Effective Date of Coverage.
    - A stepchild ceases to be a **Dependent** on the date in which a divorce decree or annulment is granted.
    - A **Dependent** child ceases to be a **Dependent** on the date he or she becomes insured as an employee.
    - A covered **Dependent** child who attains the limiting age while insured under the **Plan** shall remain eligible for benefits if he or she is incapable of self-sustaining employment because of permanent mental or physical disability which existed before the **Dependent** attained the limiting age.
        - The **Dependent** must continue to be chiefly dependent on the **Subscriber** for support and maintenance.
        - Written proof of incapacity and dependency must be provided to **Us** in a form satisfactory to **Us** within 31 days after the **Dependent**'s attainment of the limiting age.
        - **We** may require the **Dependent** to be examined by an **In-Network Provider** to determine the existence of the incapacity prior to granting continued coverage. Such examinations may occur at reasonable intervals during the first two years after continuation under this section is granted and annually thereafter.
        - The **Employee** must notify **Us** immediately of a cessation of incapacity or dependency.
- A **Dependent** child (as described in item 2, above, regardless of age) who is a **Full-Time Student** as defined by this **Plan**, if the child was called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces while the child was under 27 years of age when attending, on a full-time basis, an institution of higher learning.
    - To qualify for extended coverage, the child must apply to an institution of higher education as a **Full-Time Student** within 12 months of the date the child fulfilled his or her active duty obligation.
    - If the child is called to active duty more than once within a 4-year period of time, **We** will use the adult child's age when first called to active duty for determining eligibility under this paragraph.
    - The child ceases to be a **Dependent** when he or she ceases to be **Full-Time Student**.
        - Proof of attendance is required upon request from WEA Trust.
        - **Full-Time Student** status is to be defined by the institution in which the student is enrolled. **Full-Time Student** status includes any intervening vacation period if the child continues to be a **Full-Time Student**. **Full-Time Student** status also includes a **Medically Necessary** leave of absence during which the child ceases to be a **Full-Time Student**. **We** may require the child to submit documentation and certification of the **Medical Necessity** of the leave of absence from the child's attending **Physician**. **Full-Time Student** status due to a **Medically Necessary** leave of absence ends when any of the following occurs:
            - The child advises **Us** that he or she does not intend to return to school full time.
            - The child becomes employed full time.
            - The child obtains other health care coverage.
            - The child marries and is eligible for coverage under his or her **Spouse**'s health care coverage.

- Coverage of the eligible individual is discontinued or not renewed.
- One year has elapsed since the child ceased to be a **Full-Time Student** due to the **Medically Necessary** leave of absence, and the child has not returned to school full- time.

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

Disability or Disabled

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

Efficacious Treatment or Strategy

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

Eligible Employee/Employee

An employee qualified under the terms of the contract between **Us** and the employer.

Emergency Care

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

Emergency Detention

When a law enforcement officer, or person authorized to take a child or juvenile into custody, detains an individual because he or she has cause to believe that:

- The individual is mentally ill, drug **Dependent**, or developmentally **Disabled**; and
- The individual displays signs or symptoms of any of the conditions included in Wis. Stat. § 51.15.

Detention includes detainment in:

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

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

Emergency Medical Condition

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

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

Evidence-Based Therapy

Therapy, service and treatment that is:

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

Expedited Independent External Review

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

Expedited Grievance

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

Experimental/Investigational Services

Services 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**/**Investigational** 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.

Family

The **Subscriber** and enrolled **Dependents**.

Final Adverse Benefit Determination

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

Final Independent External Review Decision

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

Formulary

A WEA Trust-developed list of covered **Prescription Drugs**.

Full-Time Student

A covered **Dependent** who is enrolled in an accredited institution of higher education. The school in which the student is enrolled defines full-time status.

A **Full-Time Student** is considered enrolled on the date that he or she is recognized as a **Full-Time Student** by the school, which is typically the first day of classes. **Full-Time Student** status includes any intervening vacation period if the **Dependent** continues to be a **Full-Time Student** immediately following such vacation period. A person stops being a **Full-Time Student** at the end of the calendar month during which he or she graduates or otherwise stops meeting the criteria for **Full-Time Student** status.

Generic Drug

A drug product similar to a brand name drug which is not advertised, generally resulting in a lower cost.

Genetic Testing

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

Grievance

Any dissatisfaction **You** have with **Us**, or how **We** administer this **Plan**, that **You** submit to **Us** in writing, or that someone submits to **Us** in writing on **Your** behalf. **You**, or someone on **Your** behalf, can also submit an **Expedited Grievance** orally.

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

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

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

Habilitative Services

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

Hearing Aid

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

Health Care Provider

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

HIPAA

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

Home Health Aide Services

Nonmedical services performed by a home health aide which:

- Are not required to be performed by a registered nurse or licensed practical nurse; and
- Primarily aid the patient in performing normal **Activities of Daily Living**.

Home Health Care Visit

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

Hospital

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

Hospital:

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

Illness

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

Immediate Family

The **Subscriber**, the **Subscriber**'s **Spouse**, children, stepchildren, legal wards, parents, grandparents, siblings, and their **Spouses**.

Independent External Review

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

Independent Review Organization

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

Injury

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

In-Network Provider

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

Intensive-Level Services

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

Maximum Allowable Fee

The maximum amount **We** will pay for a **Covered Service**, based upon **Our Maximum Allowable Fee** schedule.

Maximum Benefit Amount

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

Maximum Out-of-Pocket Limit

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

Medically Appropriate/Medical Appropriateness

Health care services, supplies or items **We** have determined, based on **Your** medical circumstances, to be safe, effective, and of value.

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

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

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

Medically Necessary/Medical Necessity

Health care services, supplies or items needed to prevent, diagnose, or treat an **Illness**, **Injury**, condition, disease or its symptoms and that meet accepted standards of medicine.

Medically Necessary care must:

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

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

Member

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

Member ID Card

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

Non-Intensive Level Services

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

Out-of-Network Provider

A **Health Care Provider** that is not in the most current Provider Directory.

Outpatient Care

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

Physician or Surgeon

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

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

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

Plan

The health insurance coverage offered by WEA Trust, as described in this **Certificate** and other contract documents. For more information about which documents, when combined, constitute the entire contract of insurance, please see Section 10: General Provisions of this **Certificate**, under "**Entire Policy** Contract and Changes."

Policy/Entire Policy

The following documents, combined:

- This **Certificate**;
- Any Amendments;
- **Benefit Summary**;
- The Group Health Insurance Agreement between the employer and **Us**.
- The employer's application form; and

The employees' (and **Dependents**) enrollment and **Member** change forms

Post-Service Claim

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

Premium

The amount that must be paid for **Your** health insurance. **You** or **Your** employer pay it monthly.

Prescription Drug

Drugs and medications that by law require a prescription.

Pre-Service Claim

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

Primary Care

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

Primary Care Provider (PCP)

A **Physician** (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or **Physician** assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Prior Authorization

A decision that a **Covered Service**:

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

You or **Your Health Care Provider** must request from **Us**, and **We** must provide, **Prior Authorization** for certain **Covered Services** before **We** will cover them.

Prosthetic

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

Qualified Behavioral Health and/or Substance Use Treatment Facility

A **Hospital**, facility, institution or clinic licensed and/or certified by the state in which it is located to provide behavioral health and/or substance use treatment.

Qualified Behavioral Health and/or Substance Use Treatment Disorder Provider

A **Health Care Provider** who is:

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

Qualified Intensive-Level Professional

An individual working under the supervision of an outpatient mental health clinic who is a licensed treatment professional as defined in DHS § 35.03 (9g), and who has completed at least 2,080 hours of training, education and experience, including all the following:

- 1,500 hours of supervised training involving direct one-on-one work with individuals with **Autism Spectrum Disorders** using Evidence-Based, **Efficacious** therapy models.
- Supervised experience with all of the following:
    - Working with families as part of a treatment team and ensuring treatment compliance.
    - Treating individuals with **Autism Spectrum Disorders** who function at a variety of cognitive levels and exhibit a variety of skill deficits and strengths.
    - Treating individuals with **Autism Spectrum Disorders** with a variety of behavioral challenges.
    - Treating individuals with **Autism Spectrum Disorders** who have shown improvement to the average range in cognitive functioning, language ability, adaptive and social interaction skills.
    - Designing and implementing progressive treatment programs for individuals with **Autism Spectrum Disorders**.
- Academic coursework from a regionally accredited higher education institution with demonstrated coursework in the Application of **Evidence-Based Therapy** models consistent with best practice and research on effectiveness for individuals with **Autism Spectrum Disorders**.

Qualified Intensive-Level Provider

- Any of the following providers who provide Evidence-Based **Behavioral Therapy** which qualifies as **Intensive-Level Services** and has completed at least 2,080 hours of training, education and experience as described below, or a **Qualified Paraprofessional** working under the supervision of one of these providers:
    - A psychiatrist acting within the scope of a currently valid, state-issued license for psychiatry.
    - A person who practices psychology that is acting within the scope of a currently valid, state-issued license for psychology.
    - A social worker acting within the scope of a currently valid, state-issued certificate or license to practice psychotherapy.
    - A **Behavior Analyst** who is acting with the scope of a currently valid, stated-issued license for behavior analysis.
- Required training, education and experience:
    - 1,500 hours supervised training involving direct one-on-one work with individuals with **Autism Spectrum Disorders** using Evidence-Based, **Efficacious** therapy models.
    - Supervised experience with all of the following:
    - Working with families as the primary provider and ensuring treatment compliance.
        - Treating individuals with **Autism Spectrum Disorders** who function at a variety of cognitive levels and exhibit a variety of skill deficits and strengths.
        - Treating individuals with **Autism Spectrum Disorders** with a variety of behavioral challenges.
        - Treating individuals with **Autism Spectrum Disorders** who have shown improvement to the average range in cognitive functioning, language ability, adaptive and social interaction skills.
        - Designing and implementing progressive treatment programs for individuals with **Autism Spectrum Disorders**.
    - Academic coursework from a regionally accredited higher education institution with demonstrated coursework in the Application of **Evidence-Based Therapy** models consistent with best practice and research on effectiveness for individuals with **Autism Spectrum Disorders**.

Qualified Paraprofessional

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

- Attains at least 18 years of age.
- Obtains a high school diploma.
- Completes a criminal background check.

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

Qualified Professional

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

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

Qualified Provider

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

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

Qualified Supervising Provider

A **Qualified Intensive-Level Provider** who has completed at least 4,160 hours of experience as a supervisor of less experienced providers, professionals and paraprofessionals.

Qualified Therapist

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

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

Referral

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

Rehabilitative Services

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

Rescission

A decision **We** make to:

- Withdraw coverage back to the initial date of coverage; or
- Modify the terms of the **Plan**.

Routine Foot Care

Includes, but is not limited to:

- Services rendered in the examination, treatment or removal of all or part of corns, calluses, or plantar keratosis; and
- Services related to the cutting, trimming, or other non-operative partial removal of toenails.

Service Area

The geographical area in which **We** are authorized to offer a health plan.

Skilled Nursing Facility

A licensed facility, other than a **Hospital**, that is certified to provide continuous, 24-hour inpatient **Skilled Nursing Services**. It can be a freestanding facility, or a separate unit of a **Hospital** or other institution.
None of the following are a **Skilled Nursing Facility**:

- An institution that primarily cares for and treats individuals with behavioral health or substance use disorders.
- A facility that primarily provides residential, retirement, **Custodial** or **Long Term Care**.
- A private room or apartment.

Skilled Nursing Services

Services ordered by a **Physician** that:

- Require the skills of a registered nurse (RN) or a licensed practical nurse (LPN); and
- Are provided either directly by or under the supervision of an RN or LPN.

Skilled Rehabilitation Facility

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

Skilled Rehabilitation Services

Services ordered by a **Physician** that:

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

Specialty Care

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

Spouse

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

Stabilize/Stabilized

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

Subscriber

The employee covered under the terms of the **Policy** between **Us** and the employer.

Total Disability/Totally Disabled

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

Urgent Claim

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

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

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

Virtual Visit

A **Member**-initiated online medical or behavioral health evaluation performed by a licensed **Physician** or practitioner. The patient and the **Physician** must interact using multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and a **Physician** or practitioner.

Walk-In Retail Clinic

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

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

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

- Any time the word "services" appears in this **Certificate**, it refers to any professional service, medical or health care treatment, Hospitalization and other use of facilities, laboratory services, durable medical equipment, medical supplies, and pharmaceuticals.
- Any time the words "**We**", "**Us**," or "**Our**" appear in this **Certificate**, they refer to the WEA Trust.
- Any time the words "**You**" or "**Your**" appear in this **Certificate**, they refer to any individual who is covered by the **Plan**. The exception to this is in Section 6: Eligibility, Enrollment and Effective Date of Coverage, where "**You**" and "**Your**" refer only to the employee of the employer who purchased this group health insurance **Plan**.

- Any time the word “covered” appears in the benefit provisions of this **Certificate**, it refers to services that are reimbursable if **We** find them to be **Medically Necessary** and **Medically Appropriate** in **Your** specific circumstances. Reimbursement is subject to **Our Maximum Allowable Fee**; any **Deductible**, **Coinsurance**, or **Copayments** that apply; this **Certificate**’s **Cost-Effectiveness Limit**s; and **Our Prior Authorization** requirements. See Section 2: General Provisions That Apply to All Benefits for a discussion of these concepts.

SECTION 2:
GENERAL PROVISIONS THAT APPLY TO ALL BENEFITS

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

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

First, there are some services that are explicitly excluded from coverage. For more information about services that are explicitly excluded from coverage, please see Section 3: Medical Benefits, Section 4: **Prescription Drug** Benefits, and Section 5: General Exclusions and Limitations" of this **Certificate**.

Next, for services not explicitly excluded from coverage, there are several criteria **We** look at to decide if the **Plan** will cover them. To be covered, **Your** service must be:

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

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

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

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

Factors Used to Determine Coverage

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

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

Please see Section 1: Definitions of this **Certificate** for more information how **We** define these terms.

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

Also, **We** have the right to require that **You** be examined by a **Health Care Provider** of **Our** choice, at **Our** expense, when necessary to evaluate a **Claim**.

Access to Health Care Providers

Your choice of **Health Care Provider** determines how much **We** will pay for **Covered Services**, and how much **You** will pay in out-of-pocket expenses.

We have many **In-Network Providers** who can care for **You**. When **You** see an **In-Network Provider**, **We** will pay the amount **We** have contracted to pay for each **Covered Service**. **You** will have to pay the **In-Network Cost-Sharing Amount**(s) listed in **Your Benefit Summary** for the service.

When **You** see an **Out-of-Network Provider**, **You** will have to pay the **Out-of-Network Cost-Sharing Amount**(s) for the service listed in **Your Benefit Summary**. **We** will pay according to **Our Maximum Allowable Fee** schedule. **You** can find more information about **Our Maximum Allowable Fee** schedule later in this section.

Referrals

Your choice of **Health Care Provider** determines how much **We** will pay for **Covered Services**, and how much **You** will pay in out-of-pocket expenses.

You can get **Covered Services** from any **In-Network Provider** without a **Referral**. **You** can find a list of **In-Network Providers** in **Our** Provider Directory. **You** can find the Provider Directory on **Our** website at weatrust.com

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

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

You do not need a **Referral** to get urgent or **Emergency Care** from an **Out-of-Network Provider**. Please see Section 3: Medical Benefits for more information about how **We** cover urgent and **Emergency Care** from an **Out-of-Network Provider**.

Prior Authorization Requirements

We require **Prior Authorization** for many types of **Covered Services**. We decide whether to approve a **Prior Authorization** request based on the specific medical facts applicable to **Your** medical condition. **We** also look at whether the requested service meets the coverage requirements described in "Factors Used to Determine Coverage" earlier in this section.

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

Hospital Admission Notification Requirements

You must notify **Us** when **You** are admitted to the hospital overnight due to childbirth or after **You** receive **Emergency Care**. If **You** do not, **Your** reimbursement will be reduced by the penalty amount listed in **Your Benefit Summary**.

To notify **Us**, **You**, an **Immediate Family** member, a **Physician**, or **Hospital** employee must contact **Us** within 72 hours of **Your** admission, or as soon as is medically feasible for **You** to do so, whichever is later. **We** will ask for **You** to provide the following information:

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

Depending on the situation, **We** may ask for more information.

If **You** are admitted to the hospital for childbirth, **You** must notify **Us** within 72 hours. This notification requirement applies for other maternity-related emergency admissions as well, such as for pre-term labor or other maternity complications even if **You** do not give birth.

Maximum Allowable Fee

The **Maximum Allowable Fee** is the maximum amount **We** will pay for a **Covered Service**. This amount is determined by **Our Maximum Allowable Fee** schedule.

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

Generally, it will be an **Out-of-Network Provider** that will bill this difference to **You**. This includes **Out-of-Network** emergency and urgent care **Health Care Providers** and **Out-of-Network Providers** for whom **You** have an approved **Referral** to see.

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

Cost-Sharing Amounts: Deductibles, Coinsurance and Copayments

You must pay a **Deductible**, **Coinsurance** and/or **Copayment** amount for most **Covered Services**. These are the different types of **Cost-Sharing Amounts** applicable to this **Plan**. **You** can find more information about these terms in Section 1: Definitions of this **Certificate**.

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

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

Family Deductible: The **Family Deductible** amount is the most that the **Subscriber** and his or her covered **Dependents** must pay in a Benefit Year before **We** will pay for **Covered Services**. The amounts that each **Family** member pays toward his or her Single **Deductible** are added together to meet the **Family Deductible**. Once **Your Family** meets the **Family Deductible**, **We** will begin paying **Claims** for the entire **Family** as described in the **Benefit Summary**.

Coinsurance: Coinsurance payments begin once **You** meet any applicable **Deductible**.

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

Maximum Out-of-Pocket Limit

The **Maximum Out-of-Pocket Limit** is the most **You** will pay in **Deductible**, **Coinsurance** and **Copayment** amounts for **Covered Services** during any **Benefit Period**. Please see **Your Benefit Summary** for the **Maximum Out-of-Pocket Limit** that applies to **Your Plan**, as well as which **Cost-Sharing Amounts** apply to the **Maximum Out-of-Pocket Limit**.

The single **Maximum Out-of-Pocket Limit** is the most that each **Member** will pay out of pocket each **Benefit Period**. The **Family Maximum Out-of-Pocket Limit** is the most that the **Subscriber** and his or her covered **Dependents**, combined, will pay out of pocket each **Benefit Period**.

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

- Amounts **You** pay that exceed the **Maximum Benefit Amount** listed in **Your Benefit Summary**.
- Amounts **You** pay for non-**Covered Services**.
- Amounts **You** pay for charges that exceed **Our Maximum Allowable Fee**.
- Amounts **You** pay that exceed **Our** reimbursement limit on services for which **You** received **Prior Authorization**.
- Penalty amount for failure to comply with **Our Hospital** admission notification requirements.
- Amounts **You** pay for charges that do not comply with the **Plan's** reimbursement rules.

Maximum Benefit Amount

This amount, which is listed in **Your Benefit Summary**, is the total amount this **Plan** will reimburse for certain types of treatment or services for each covered individual during the **Benefit Period**. **We** encourage **You** to check **Your Benefit Summary** so **You** know which services are subject to a **Maximum Benefit Amount** and the **Maximum Benefit Amount We** will pay for these **Covered Services**.

Continuity of Care

Under certain circumstances, if **Your Health Care Provider** leaves the WEA Trust provider network, **You** may continue to receive care from that **Health Care Provider**.

If **Your Health Care Provider** is terminated without cause and **You** are in an active course of treatment, **You** may continue to get treatment from this **Health Care Provider** until the treatment is complete or for 90 days, whichever is shorter. During this period, **We** will continue to pay **Your Health Care Provider** the same amount that **We** paid while he or she was an **In-Network Provider**. **Member Cost-Sharing Amounts** will apply, including amounts billed by the provider that are more than the **Maximum Allowable Fee**.

Active course of treatment is defined as:

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

Coding and Billing Standards

When **Your Health Care Provider** submits a **Claim** for payment, he or she includes certain procedure and billing codes on the **Claim**. These codes describe the services that **You** received. **We** then look at medical documentation to see if the codes are appropriate.

If the medical documentation shows that another code is more appropriate, **We** have the right to calculate **Our** reimbursement amount based upon the most appropriate code. **We** also have the right to deny a **Claim** if it is billed inconsistently with industry-accepted coding standards.

Plan Changes

If any provision is changed while **Your** coverage is in force, the change applies only to **Covered Services** that you get on or after the effective date of the change.

Noncompliance with Plan Requirements

If **We** waive a **Plan** requirement one time, this does not mean that **We** will continue to waive this requirement. If **We** fail to insist on compliance for any **Plan** provision, this does not mean that **We** waive or amend that provision.

SECTION 3: MEDICAL BENEFITS

Benefits

This section describes the health care services, equipment and supplies that make up the benefits this **Plan** covers.

When possible, **We** have identified services, equipment, and supplies that **We** do not cover. However, this is not a complete, all-inclusive list. Please see Section 5: General Exclusions and Limitations for a list of general exclusions that apply to all benefits.

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

- All of the coverage requirements discussed below have been met; and
- When required, **You** have requested **Prior Authorization**, and **We** have approved **Your** request.

Coverage Requirements

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

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

Prior Authorization

To be covered, certain services, equipment and supplies require **Prior Authorization**. When required, **You** or **Your** Provider must ask for **Prior Authorization**, and **We** must approve **Your** request, *before* **You** receive the service, equipment or supplies.

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

If **You** do not get **Prior Authorization** when it is required, **We** will deny the claim. This will make **You** totally responsible for payment.

For more information about coverage rules and requirements, please refer to Section 2: General Provisions That Apply to All Benefits of this **Certificate**.

Advanced Imaging

Covered

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

Allergy Treatment

Covered

- Initial diagnostic evaluation, including:
    - Initial history;
    - Physical examination;
    - Relevant laboratory services; and
    - The following diagnostic tests:

        - Scratch tests or specified intradermal tests.
        - Specific laboratory tests to determine respiratory function and blood levels of the immune system.
        - Blood allergy testing when:
            - Skin testing is not conclusive;
            - The patient has a condition that precludes the use of scratch testing or intradermal tests; or
            - Being used instead of scratch or intradermal testing.
- Immunotherapy (injection of antigens) to build up immunities.

Not Covered

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

Ambulance Services

Covered

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

Not Covered

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

Autism Spectrum Disorder Treatment

Covered

- Diagnostic testing and evaluation by a **Qualified Provider** (as defined by state law).
- **Intensive-Level Services**:
    - **We** cover up to four (4) cumulative years of **Intensive-Level Services**.
    - The **Member** with autism must have a verified diagnosis of **Autism Spectrum Disorder**.
        - The diagnosis must have been made by a **Health Care Provider** skilled in testing and in the use of empirically-validated tools specific for **Autism Spectrum Disorders**.
    - **Intensive-Level Services** must begin after the **Member** with autism turns two years old, but before the **Member** with autism turns nine years old.
    - **Intensive-Level Services** must:
        - Be provided at least 20 hours per week over a six-month period of time.
        - Be based on a treatment plan developed by an individual who at least meets the requirements of a **Qualified Intensive-Level Provider** or a **Qualified Intensive-Level Professional**.

- The treatment plan must require that the **Member** with autism be present and engaged in the intervention.
- Be provided by a **Qualified Intensive-Level Provider** or **Qualified Intensive-Level Professional** who directly observes the **Member** at least once every two months.
- Be implemented by **Qualified Provider**s, **Qualified Professional**s, or **Qualified Therapist**s, or **Qualified Paraprofessional**s.
- Consist of intensive, Behavioral **Evidence-Based Therapy**, treatment and services with specific cognitive, social, communicative, self-care or behavioral goals.
- **Intensive-Level Services** must:
  - Address the characteristics of **Autism Spectrum Disorders**;
  - Be clearly defined;
  - Be directly observed;
  - Be continually measured;
  - Be provided in an environment most conducive to achieving the goals of the **Member** with autism's treatment plan.
  - Be provided a majority of the time in the presence of an engaged parent or legal guardian; and
  - Implement identified therapeutic goals developed by the team, including:
    - Training and consultation;
    - Participating in team meetings; and
    - Active involvement of the **Member**'s **Immediate Family**.

- The **Member** with autism's progress must be assessed and documented throughout the course of treatment. **We** reserve the right to review the **Member** with autism's treatment plan and a summary of progress on a periodic basis.

- **Non-Intensive Level Services**:
  - The **Member** must have a verified diagnosis of **Autism Spectrum Disorder**.
    - The diagnosis must have been made by a diagnostician skilled in testing and in the use of empirically-validated tools specific for **Autism Spectrum Disorders**.
  - **Non-Intensive Level Services** must:
    - Be provided in either of the following circumstances:
      - After the completion of **Intensive-Level Services** and designed to sustain and maximize gains made during **Intensive-Level Services** treatment.
      - To a **Member** with autism who has not and will not receive **Intensive-Level Services**, but for whom **Non-Intensive Level Services** will improve the **Member** with autism's condition.
    - Be based upon a treatment plan developed by an individual who at least meets the requirements of a **Qualified Provider**, a **Qualified Professional**, or a **Qualified Therapist**.
    - Be implemented by a person who is at least a **Qualified Provider**, **Qualified Professional**, **Qualified Therapist**, or a **Qualified Paraprofessional**.
    - Consist of specific **Evidence-Based Therapy** goals that are:
      - Clearly defined;
      - Directly observed;
      - Continually measured; and
      - That address the characteristics of **Autism Spectrum Disorders**.
    - Be provided in an environment most conducive to achieving the goals of the **Member** with autism's treatment plan.
    - Implement identified therapeutic goals developed by the team including:
      - Training and consultation,
      - Participation in team meetings; and
      - Active involvement of the **Member**'s Immediate **Family**.
    - May include direct or consultative services when provided by **Qualified Provider**s, **Qualified Supervising Provider**s, **Qualified Professional**s, **Qualified Therapist**s, or **Qualified Paraprofessional**s.
  - The **Member** with autism's progress must be assessed and documented throughout the course of treatment.
  - **We** reserve the right to review the **Member** with autism's treatment plan and a summary of progress on a periodic basis.

Not Covered

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

Behavioral Health and Substance Abuse Disorder Services

Covered

- Inpatient treatment, as described below:
    - Inpatient treatment **You** receive from a **Qualified Behavioral Health and/or Substance Use Treatment Provider** while **You** are confined in a **Behavioral Health and/or Substance Abuse Treatment Facility**.
- Transitional treatment, as described below:
    - Transitional treatment **You** receive from a **Qualified Behavioral Health and/or Substance Use Treatment Provider** in a **Qualified Behavioral Health and/or Substance Abuse Treatment Facility**.
        - Transitional treatment is more intensive than traditional **Outpatient Care** but less restrictive than traditional inpatient care. It includes:
            - Services at a residential treatment facility;
            - Partial hospitalization/day or evening treatment programs; or
            - Intensive outpatient treatment.
        - A qualified residential treatment facility program provides specialized 24-hour per day treatment and meets the following criteria:
            - The treatment program must be staffed by a multi-disciplinary team of **Qualified Behavioral Health and/or Substance Use Treatment Providers** who provide transitional treatment;
            - For each patient, within 72 hours of admission the team must complete a personalized, problem-focused treatment plan.
            - A psychiatrist must observe and assess each patient at least weekly.
- Outpatient treatment, as described below
    - Outpatient treatment **You** receive from **Qualified Behavioral Health and/or Substance Use Treatment Provider** in a **Behavioral Health and/or Substance Abuse Treatment Facility** while not receiving inpatient or transitional treatment.
        - Psychological and neuropsychological testing is covered **only if all** of the following apply:
            - A thorough clinical assessment by a **Qualified Behavioral Health and/or Substance Use Treatment Provider** has been conducted. It must include:
                - A review of mental status, social functioning, applicable medical information, history, and applicable collateral information.
            - There is significant uncertainty about a diagnosis that affects the choice of treatment interventions;

- The patient's symptoms are complex or unusual so that diagnosis and clarification of symptoms can be accomplished only through such testing;
- There are distinct treatment options based on the differential diagnosis that is clarified through the testing.
- The testing is likely to produce the required diagnosis and clarification necessary for Planning treatment.

▪ Nutritional counseling is covered when it is:
- Part of an approved treatment plan prescribed by a **Physician**;
- Provided by a certified or registered dietician or nutritionist; and
- Necessary for the effective treatment of a life-threatening **Illness** (e.g. anorexia nervosa or bulimia).

▪ For **Full-Time Students** attending school in Wisconsin, but outside the **Service Area**:
- A clinical assessment by an **Out-of-Network Provider** and five (5) visits for outpatient behavioral health or substance use treatment.
  - **We** retain the right to choose the provider.
  - **You** must get **Prior Authorization** for the clinical assessment and the five (5) outpatient visits described above. **You** must also get **Prior Authorization** for any additional treatment or services **You** receive from this, or another, **Out-of-Network Provider**.
  - **We** will not cover these services after **Your** school enrollment terminates, or otherwise ends.

- Services provided pursuant to an **Emergency Detention**, court order or commitment:
  - These services may be provided by any **Health Care Provider** according to the terms and conditions of this **Plan**, including an **Out-of-Network Provider**.
  - If services are provided by an **Out-of-Network Provider**, **We** must be notified within 72 hours so that **We** can arrange for continuing care with an **In-Network Provider**.
    - **We** will not continue to cover services provided by an **Out-of-Network Provider** once **We** have arranged for services from an **In-Network Provider**.

Not Covered

- **Custodial** or **Long Term Care**
- Residential treatment for the sole purpose of preventing relapse, for legal purposes, or for respite for the **Immediate Family**.
- Wilderness and camp programs, boarding schools, and academy-vocational programs.
- Psychological testing and assessments that are not likely to yield additional information that is useful for healing and curing or planning medical treatment. Examples include, but are not limited to:
  - Testing to assist with custody placement;
  - Vocational assessments; and
  - Academic assessments.
- Services for academic problems in the absence of a diagnosed mental health **Illness**, or for which the child's school is legally obligated to provide. This applies whether or not the school actually provides these services, and whether **You** choose to use those services.
- Treatment for a behavioral or psychological problem that was not caused by a clinically-diagnosed mental health **Illness**, even if it may be appropriate to seek professional help. Examples include, but are not limited to:
  - Antisocial behavior;
  - Uncomplicated bereavement;
  - Codependency;
  - Occupational problems such as job dissatisfaction or uncertainty about career choices;
  - Parent-child problems such as impaired communication or inadequate discipline;
  - Marital problems; and
  - Other interpersonal problems.
- Services related to or for the treatment of compulsive gambling or nicotine addiction, except as described under this **Plan's** "Tobacco Cessation Benefit."
- Behavioral or mental health services for, or connected to, developmental delays (e.g. Rett Syndrome).

- Inpatient treatment that continues after inpatient treatment is no longer **Medically Necessary**. This includes, but is not limited to, patients awaiting placement in or transfer to another facility or level of care.
- Inpatient treatment of a chronic behavioral health or substance use disorder, unless:
    - Clinical records document significant physical or mental decline; or
    - The patient is an active danger to herself, himself, or others.

Chiropractic Services

Covered

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

Not Covered

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

Dental Services and Oral Surgery

Covered

- Services related to the initial repair and restoration of an injured Sound Natural Tooth.
    - "Injured" does not include damage caused by eating, biting, disease or decay.

- Oral surgery:
    - Must be performed by a Doctor of Dental Surgery (D.D.S.) or a Doctor of Medical Dentistry (D.M.D.).
    - Coverage is limited to the following procedures:
        - Excision of partially or completely unerupted, impacted teeth;
        - Excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth;
        - Surgical procedures required to correct Accidental injuries to the jaw, cheeks, lips, tongue, roof and floor of the mouth;
        - Reduction of fractures and dislocations of the jaw;
        - External incision and drainage of cellulitis;
        - Incision of accessory sinuses, salivary glands or ducts;
        - Frenectomy (the cutting of the tissue in the midline of the tongue);
        - Functional osteotomy;
        - Osseous surgery;
        - Gingivectomy (the excision of diseased gum tissue to eliminate infection);
        - Gingival flap surgery;
        - Apicoectomy (the excision of the apex of the tooth root);
        - Alveolectomy (the leveling of the structures supporting the teeth when performed for reasons other than preparation for dentures)
- **Hospital** and ambulatory surgery center charges, including anesthesia, when:
    - **You** have a chronic **Disability**; or
    - **You** have a medical condition that requires hospitalization or general anesthesia for dental care.

Not Covered

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

Diabetes Supplies and Equipment

Covered

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

Not Covered

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

Durable Medical Equipment and Supplies

Covered

- Durable Medical Equipment, as described below:
    - Coverage includes, but is not limited to, the following:
        - Durable medical equipment for home use, including:
            - Morphine pumps.
            - Oxygen regulators.
            - Infusion pumps.
            - Specialized feeding equipment.
        - **Prosthetic** devices to replace a missing body part, including:
            - Artificial limbs;
            - Artificial eyes; and
            - Full cranial hair prostheses:
                - When sudden onset baldness occurs due to a disease, accident or medical treatment for which services are covered under this **Plan**; and
                - The sudden onset baldness is so extensive that it significantly alters the **Member**'s appearance.
                - Neither wigs nor other methods of hair restoration are covered for alopecia or other causes of hair loss.
        - Functional repair of durable medical equipment.
        - Durable mechanical equipment, such as a wheelchair or **Hospital** bed.
    - **We** reserve the right to decide whether to rent or purchase Durable Medical Equipment.

- Supplies, including:
    - Custom made orthotics prescribed by a **Physician**.
    - Casts, splints, trusses, braces and crutches for short-term or long-term use.
    - Supplies needed to properly operate covered Durable Medical Equipment.
    - Ostomy care items and catheter maintenance supplies.

Not Covered

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

Emergency Care

Covered

- **Emergency Care** for an **Emergency Medical Condition**, as described below:
    - Examples of situations for which **Emergency Care** is appropriate include, but are not limited to:
        - Suspected heart attack.
        - Loss of consciousness.
        - Suspected or actual poisoning.
        - Acute appendicitis.
        - Convulsions.
        - Heat exhaustion.
        - Uncontrollable bleeding.
        - Fractures.
        - Other acute conditions that are of sufficient severity to warrant immediate medical care.
    - **Prior Authorization** is not required for **Emergency Care**.
    - If **You** are admitted as an inpatient after seeking **Emergency Care**, **You** must still notify **Us** within 72 hours of **Your** admission, or as soon as it is medically feasible.
    - **Your** emergency room **Copayment** will be waived if, after seeking **Emergency Care**, **You** are admitted as an inpatient for at least 24 hours.
    - **We** cover **Emergency Care** provided by an **Out-of-Network Provider** as described below:
        - If **You** seek **Emergency Care** from an **Out-of-Network Provider**, once **You** are **Stabilized We** may request to transfer **You** to an **In-Network** facility. If **You** do not wish to be transferred to a Network facility, **You** will have to pay **Out-of-Network Cost-Sharing Amounts** for any additional care **You** receive.
        - Payment for **Emergency Care** from an **Out-of-Network Provider**:
            - **You** will only owe the **Deductible**, **Coinsurance** and/or **Copayment** amounts that apply to **Emergency Care** provided by an **In-Network Provider**.
            - **We** pay for **Emergency Care** provided by an **Out-of-Network Provider** based on the **Maximum Allowable Fee**. If what **We** pay is less than what the **Out-of-Network Provider** bills, **You** may have to pay the remaining amount.

Genetic Testing / Counseling

Covered

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

Not Covered

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

Hearing Services and Hearing Aids

Covered

- Diagnostic tests to establish or confirm hearing loss and determine the cause.
- Treatment of hearing impairment and hearing loss caused by an **Illness** or **Injury**.
- Surgery to repair malformed ear anatomy or malfunctioning hearing-related structures.
- **Cochlear Implants**, as described below:
    - A **Physician** or licensed audiologist must certify **You** as deaf or hearing impaired.
    - Covered devices and services:
        - The cost of the **Cochlear Implant** prescribed by a **Physician** or licensed audiologist;
        - Initial evaluation by an audiologist and otolaryngologist;
        - **Physician** and **Hospital** services; and
        - Aural and speech therapy following **Cochlear Implant** surgery.
- **Bone-Anchored Hearing Aid**, as described below:
    - A **Physician** or licensed audiologist must certify **You** as deaf or hearing impaired.
    - Covered devices and services:
        - Initial evaluation by an audiologist and otolaryngologist;
        - **Physician** and **Hospital** services;

        - Surgical placement of the device is covered under benefit, including any applicable limitations or exclusions.
    - Replacement parts or upgrades necessary due to inadequate or non-functioning components.
        - Any replacement parts or upgrades to existing **Bone-Anchored Hearing Aid** components are covered under this **Plan's** Hearing Services and **Hearing Aids** benefit.
- **Hearing Aids**, as described below:
    - A **Physician** or licensed audiologist must certify that **You** are deaf or hearing impaired.
    - Covered devices and services:
        - For children under the age of 18, one **Hearing Aid** per ear in each three-year period.
        - For adults, one **Hearing Aid** per ear, per lifetime.
        - Examinations, tests or services for prescribing and fitting a **Hearing Aid** or device.

Not Covered

- Batteries, cords and other accessories.

Home Health Care

Covered

- The evaluation of the need for home health care services and development of a home care plan by a registered nurse or medical social worker.
    - The attending **Physician** must request or approve the home care plan and certify that:
        - Hospitalization or **Confinement** in a **Skilled Nursing Facility** would otherwise be required if home care was not provided.
        - **Immediate Family** members, or other people living with **You**, cannot provide necessary care and treatment without suffering undue hardship.
        - The home health care services will be provided or coordinated by a:
            - State-licensed or Medicare-certified home health care agency;
            - Certified rehabilitation agency; or
            - Home health care agency that meets **Our** standards.
- The following services when provided during a **Home Health Care Visit**:
    - Part-time or intermittent **Skilled Nursing Services** provided or supervised by a registered nurse or licensed practical nurse.
        - The registered nurse or licensed practical nurse cannot:
            - Be the **Subscriber** or a **Dependent** covered under this **Plan**; or
            - Ordinarily reside with **You** in **Your** home.
    - Part-time or intermittent **Home Health Aide Services** that are supervised by a registered nurse or medical social worker.
        - When provided by a home health aide, **We** cover help with the normal **Activities of Daily Living** that are connected with or incidental to covered medical services.
    - Physical, respiratory, occupational or speech therapy.
        - When provided in the home, charges for these services are included with this home health care benefit. **You** do not have to pay for these services separately.
    - Prescribed medical supplies, drugs, medications, and laboratory services.
    - Home infusion services.
    - Prescribed intravenous (parenteral) or feeding tube (enteral) nutritional support systems.
        - **We** cover food substitutes for enteral nutrition when they provide at least 60% of the **Member**'s nutrition, and the need is medically documented.
    - Nutritional counseling provided or supervised by a certified or registered dietitian.

Not Covered

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

Hospice Care

Covered

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

Not Covered

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

Hospital Services

Covered

- Room and board charges.
- Inpatient and outpatient services ordered by a **Health Care Provider** that are essential for diagnosis or treatment, including:
    - Services provided by the attending **Health Care Provider**; and
    - Services provided by an additional **Health Care Provider** that are necessary due to medical complexity.
- Diagnostic tests and services that are ordered by a **Health Care Provider** and expected to reveal new information that will be useful for diagnosis or treatment.
- **Hospital** or ambulatory surgery center services for dental care, including anesthesia when:
    - **You** have a chronic **Disability**; or
    - **You** have a medical condition that requires hospitalization or general anesthesia for dental care.
- Covered drugs and medications **You** take during **Your Hospital** stay.
    - Coverage does not include take-home drugs, even if the **Hospital** pharmacy fills the prescription.
    - Take-home drugs are covered as described in Section 4: **Prescription Drug** Benefits of this **Certificate**. To avoid high out-of-pocket costs, **You** should fill **Your** prescription at a Network Pharmacy.

Not Covered

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

Kidney Disease Treatment

Covered

- Inpatient and outpatient services directly related to kidney disease treatment, as described below:
    - **Covered Services** include, but are not limited to:
        - Dialysis services, including:
            - Inpatient **Hospital** dialysis services;
            - Inpatient, outpatient or self-dialysis services at a renal dialysis facility; and
            - Dialysis when performed at home by a trained End-Stage Renal Disease (ESRD) patient or helper, or both.
        - **Hospital** and **Physician** charges.
        - Kidney transplantation
            - For information about coverage for kidney transplantation, please see "Surgical Services" later in this section.
    - **We** are not required to duplicate coverage available to a **Member** under Medicare or any other insurance coverage the **Member** may have.
        - An individual can become eligible for Medicare due to ESRD. If or when that happens, **We** will coordinate benefits with Medicare at the time **You** become eligible for Medicare.
        - Please refer to Section 8: Coordination of Benefits for more information about:
            - When **You** should enroll in Medicare Parts A and B;
            - The consequences of not enrolling in Medicare Parts A and B when **You** become eligible; and
            - When, and the circumstances under which, this group health plan is primary or secondary to Medicare.

Maternity and Newborn Care

Covered

- Maternity care, as described below:
    - Prenatal care, including:
        - Physical examination;
        - Pap test;
        - Laboratory tests; and
        - HIV antibody test.
    - **Hospital** care, including:
        - A minimum of 48 hours of inpatient care for the mother and the newborn following a vaginal delivery.
        - A minimum of 96 hours of inpatient care for the mother and the newborn following delivery by caesarean section.
    - **Physician** services for labor, delivery and postpartum care.
    - Nurse-midwife services for prenatal care, labor and delivery, and postpartum care:
        - Nurse-midwife care must be provided by:
            - A registered nurse certified to practice as a nurse-midwife by the American College of Nurse-Midwives and the State of Wisconsin; or
            - A licensed registered nurse certified as a nurse-midwife in the state in which he or she practices.
        - Except during an emergency, **You** must receive nurse-midwife services in a healthcare facility approved by the state in which it is located to offer nurse-midwife care.
- Newborn care, as described below:
    - Nursery room, board and care.
    - After birth and while the newborn is still in the **Hospital**:
        - A routine well-baby or Preventive exam; and
        - Other related routine or Preventive professional services.
    - Care and treatment a newborn may need immediately after birth for health concerns, including but not limited to:

        - Pre-term or premature birth;
        - Low birth weight;
        - Respiratory Distress Syndrome (RDS);
        - Failure to thrive; or
        - Inadequate liver function.
    - Treatment of congenital defects and birth abnormalities, including functional repair which is needed to achieve normal bodily function.
        - **Cosmetic Surgery** performed only to improve a newborn's appearance is not covered.
        - See "Surgical Services" later in this section for more information regarding surgery to treat congenital heart conditions.

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

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

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

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

Not Covered

- Midwife labor and delivery services **You** get outside of a **Hospital**.
- Unless the mother needs and concurrently gets care for a medical condition, an extended **Hospital** stay beyond:
    - 48 hours following a vaginal delivery; or
    - 96 hours following a cesarean section.
- Amniocentesis or ultrasound performed to alleviate anxiety or to determine the gender of the fetus.
- Childbirth education or preparation courses (e.g. Lamaze).

Physical, Speech and Occupational Therapy

Covered

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

- Must be prescribed by a **Physician** in a treatment plan that identifies:
  - The delayed or impaired skill and/or functional ability;
  - The specific goals the **Physician** has for treatment;
  - How often treatment is necessary (frequency); and
  - How long treatment should last (duration).
- Therapy treatments must be:
  - Reasonably expected to promptly result in significant, meaningful progress toward treatment goals.
  - Provided according to the treatment plan; and
  - Provided by a therapist who is:
    - Licensed or certified by the state in which he or she is working; and
    - Practicing within the scope of his or her license or certification.

Not Covered

- Any **Rehabilitative Service** that does not meet the coverage criteria described above, including:
  - According to **Our** judgment, any services **You** get after **You** have reached a point that it is unlikely **You** will make any further meaningful progress toward **Your** treatment goals.
  - Any services **You** get after **Your** health condition has stabilized and **You** have reached **Your** expected level of improvement or resolution.
  - Any services **You** get to prevent **Your** health condition from worsening, relapsing or reversing.
  - Any services **You** routinely get that do not meet the definition **Rehabilitative Services**. This exclusion applies even if these services are intended to help **You** maintain **Your** body's highest level of functioning.
  - Group therapy.
  - Equipment or services to help prevent **Injury** or to help **You** participate in physical activity or sports.
  - General observation of exercises **You** can perform at home or in a health club or similar setting.
  - Services which help **You** perform actions or exercises that **You** have already learned and have shown **You** can adequately perform without help.
  - Services and materials designed to help **You** make lifestyle changes, even if they will help enhance therapy. This includes, but is not limited to:
    - Chronic pain management classes;
    - Stress management classes
    - Behavior modification classes;
    - **Immediate Family** member education;
    - Physical fitness lessons or guidance;
    - Nutritional counseling; and
    - Books and other materials related to health conditions.
- Any **Habilitative Service** that does not meet the coverage criteria described above, including:
  - Any services **You** get after, in **Our** opinion, **You** have reached a point that it is unlikely **You** will make any further meaningful progress toward **Your** treatment goals.
  - Any services **You** get after **You** have reached the level of functioning which is appropriate for **Your** age and/or level of maturity.
  - Services which help **You** perform actions or exercises that **You** have already learned and have shown **You** can adequately perform without help.
  - Services that a school is legally obligated to provide. This exclusion applies whether the school actually provides these services, and whether **You** choose to use them.
  - Services to help develop or enhance a child's ability to perform school-related tasks. These include, but are not limited to:
    - Grasping a pencil;
    - Writing;
    - Using scissors;
    - Accessing playground equipment;
    - Developing play skills; or
    - Understanding reading materials.
  - Auditory processing evaluation and treatment.
    - This includes, but is not limited to:

                - Auditory integration training;
                - Aural rehabilitation; and
                - Auditory training.
            - This does not include an auditory processing evaluation and treatment related to and performed after you get a **Cochlear Implant**.
    - Services designed to help with social awareness and social skills that do not help **Your Habilitative Services** therapy goals.
    - Services that **You** can get from a governmental entity or another public or private organization.
    - Services that **Immediate Family** members can perform without suffering undue hardship.

Office Visits and Outpatient Care

Covered

- Services by qualified **Health Care Providers** in a **Physician**'s office or other outpatient setting, including:
    - Examination, diagnosis and treatment of an **Illness** or **Injury**.
    - Routine physical examination.
        - **We** cover one each **Benefit Period**.
    - Preventive Services that **We** are required by law to cover.
        - Please see "Preventive Care" later in this section for more information.
    - **Medically Appropriate** diagnostic services.
        - Diagnostic procedures are **Medically Appropriate** when they meet all of the following conditions:
            - Contemporary medical consensus considers them reliable and effective;
            - They are performed by **Qualified Provider**s;
            - They are safe and indicated for **Your** individual medical history and risk group.
                - **Your** risk group is defined by **Your** age, sex, and risk factors such as family history, lifestyle, and tobacco and alcohol use.
            - They will provide new and relevant information about **Your** health and will not duplicate information provided by other procedures that have been or are performed.
        - Coverage includes, but is not limited to:
            - Complete Blood Count;
            - Total blood cholesterol count;
            - Thyroid function test;
            - HIV antibody test;
            - Urinalysis;
            - Colorectal cancer screening procedures;
            - Mammogram;
            - Clinical breast examination;
            - Pap test; and
            - Pelvic examination.
        - **We** generally only cover one of each diagnostic service per **Benefit Period**. However, **We** may cover them in more frequent intervals if they are:
            - Being performed to treat a diagnosed **Illness**;
            - Warranted by family history; or
            - **Medically Necessary** due to other risk factors.
    - Prenatal and maternity care.
        - Please see "Maternity and Newborn Care" earlier in this section for more information.
    - Well baby and well child care.
        - Coverage includes, but is not limited to:
            - Routine hearing screenings or tests;
            - Vision tests;
            - Hemoglobin and hematocrit tests; and
            - Blood tests to detect lead exposure.
    - Immunizations required by law or deemed appropriate by a **Physician**.
    - Routine hearing screenings for adults.

Not Covered

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

Preventive Care

Covered

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

Reproductive Health and Infertility Services

Covered

- Contraceptive methods, as described below:
    - Medical contraceptive methods, including but not limited to:
        - Diaphragm;

        - Cervical cap;
        - Intrauterine device (IUD);
        - Depo Provera shot;
        - Implantable birth control device;
        - Tubal ligation; and
        - Vasectomy;
    - Contractive methods available through the pharmacy, including birth control pills, are covered under the **Prescription Drug** benefit. See Section 4: **Prescription Drug** Benefits of this **Certificate** for more information.
- Surgical sterilization methods, such as tubal ligation and vasectomy.
- Infertility services, as described below:
    - **We** only cover the following infertility-related services:
        - Services performed exclusively to diagnose the cause of infertility.
            - Once a diagnosis has been found, **We** will not cover any further diagnostic tests, unless they are reasonably expected to reveal another clinical cause for infertility.
        - To enable natural conception, surgical correction of a malformed or malfunctioning body part causing infertility.
            - This does not include reversal of a tubal ligation or vasectomy.

Not Covered

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

Skilled Nursing Care

Covered

- **Skilled Nursing Facility** care during a **Confinement Period**, as described below:
    - **We** only cover **Skilled Nursing Facility** care when:
        - **You** enter the **Skilled Nursing Facility** within 24 hours of being discharged from a general **Hospital**;
        - **You** are recuperating or rehabilitating from an **Injury** or **Illness**; and
        - **You** require daily Skilled Nursing or **Skilled Rehabilitation Services**.
    - Coverage includes, but is not limited to:
        - Room and board.
        - **Physician** services, **Skilled Nursing Services**, and **Skilled Rehabilitation Services**.

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

Not Covered

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

Skilled Rehabilitation Care

Covered

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

Not Covered

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

Surgical Services

Covered

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

        - Tetralogy of fallot
        - Transposition of the great vessels
        - Hypoplastic left or right heart syndrome.
- Surgery may be performed as an open or closed surgical procedure, or through interventional cardiac catheterization.

Not Covered

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

Temporomandibular Disorder (TMD) Services

Covered

- Temporomandibular Disorder (TMD) Treatment:
    - Initial diagnostic evaluation, including:
        - Initial history and physical examination.
        - Panoramic or TMD tomography.
        - Magnetic Resonance Imaging (MRI) if there is evidence of joint disease.
        - Limited psychosocial assessment.
        - Blood testing and urinalysis.
        - Diagnostic injections, such as nerve blocks.
    - Surgical or nonsurgical treatment, including:
        - Reversible intraoral **Prosthetic** devices and appliances, such as removable splints.
        - Physical therapy.
        - Steroid joint injections.
        - Open surgical procedures and surgical arthroscopy to rehabilitate a functional deficit or impairment cause by specific joint disease that has been resistant to other medical treatment.

Not Covered

- Any TMD diagnosis services that general medical consensus considers unproven or unconventional. This includes, but is not limited to, the following:
    - Electromyography (EMG) or muscle testing.
    - Electronic jaw-tracking systems.
    - Thermography and kinesiography.

- Ultrasonography.
- Radiography or regular dental X-rays.

- Any TMD treatment services that general medical consensus considers unproven or unconventional. This includes, but is not limited to, the following:
  - Orthodontic braces or orthognathic surgery to change the bite.
  - Occlusal adjustment or modification of a dental surface to change the bite.
  - Restorative therapy or prosthodontic treatment, such as the use of crowns and bridges to balance the bite.
  - Ultrasonic treatment, electrogalvanic stimulation, iontophoresis, and biofeedback.
  - Transcutaneous electrical nerve stimulation (TENS).
  - Nutritional counseling and home therapy programs.
  - Services which are not expected to lead to a prompt and predictable improvement in health status.
  - Services that continue after **You** reach the expected state of improvement, resolution, or stabilization of **Your** health condition.

Tobacco Cessation

Covered

- Tobacco use screening for all adults who are age 18 and over, and tobacco cessation interventions for identified tobacco users.
  - **We** will cover up to two cessation attempts every twelve months. During each cessation attempt **You** will get:
    - Up to four 10-minute tobacco cessation counseling sessions, including:
      - Telephone counseling;
      - Individual counseling; and
      - Group counseling; and
    - Up to 90 days of FDA-approved tobacco cessation medications.
      - A **Physician** must prescribe this medication.
      - **You** can only fill the prescription to receive a 30-day supply at a time. This gives **You** the opportunity to try different tobacco cessation aids to decide which one is most effective for **You**.
- Tobacco cessation aids, including both **Prescription Drugs** and over-the-counter aids.
  - Please visit **Our** website, weatrust.com for a list of covered tobacco cessation aids, or **You** can call **Us** at (800) 279-4000 (TTY 711)**.**

Urgent Care

Covered

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

Virtual Visit

Covered

- **Virtual Visit,** with an **In-Network Provider,** to address acute medical symptoms.
  - Can be used to address both physical and behavioral health symptoms.
  - In some instances, the **Virtual Visit Health Care Provider** may recommend that **You** seek services in a clinic setting to receive the most appropriate treatment.

Not Covered

- **Virtual Visits** with **Out-of-Network Providers.**
- Any other remote electronic communication or interaction between a **Health Care Provider** and a **Member**, or a **Member**'s **Immediate Family**, **Authorized Representative**, or other individual, that does not meet the definition of **Virtual Visit.** This includes, but is not limited to:
    - Telephone-only communication
    - Text message
    - Email
    - Exchanging messages through an electronic health record website or app, or through a patient portal
    - Remote patient health monitoring.
- Communication between **Health Care Providers**, including but not limited to:
    - Email, communication through electronic health records, and other asynchronous transmission of patient health information
    - Telephone calls
    - Text messages

Vision Services

Covered

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

Not Covered

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

Walk-In Retail Clinic Services

Covered

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

SECTION 4: PRESCRIPTION DRUG BENEFITS
THREE TIER DRUG PLAN

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

Important Notes

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

How to Access

- To make the best and most knowledgeable use of **Your Prescription Drug** benefits, always get **Your Prescription Drugs** from an **In-Network** pharmacy.
    - **In-Network** pharmacies have up-to-date information about whether a specific drug is a covered **Formulary** drug.
    - They can tell **You** about **Cost-Sharing Amounts You** must pay, **Prior Authorization** requirements, and dispensing limitations. This helps **You** keep **Your** out-of-pocket costs as low as possible.
    - To locate **In-Network** pharmacies, visit **Our** website at weatrust.com or call **Our** Customer Service department.
    - You can also get up to a 90-day supply of **Your Prescription Drugs** through **Our** Home Delivery Program.
        - You can find more information about **Our** Home Delivery Program on **Our** website at weatrust.com.
        - Over-the-counter drugs are not available through the Home Delivery Program.
- Getting drugs at an **Out-of-Network** pharmacy will usually result in high out-of-pocket costs.

Formulary and Drug Tiers

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

    - Share this information with **Your Health Care Providers** so that **You** can make informed decisions about **Your** treatment and how much it will cost **You**.
- The drug **Formulary** includes a comprehensive range of covered **Prescription Drugs**, but it does not include all **Prescription Drugs**.
    - **We** only cover a prescribed drug if it is:
        - **Medically Necessary**;
        - **Medically Appropriate**; and
        - **Cost Effective**.
    - **We** do not cover drugs that are not included on the **Formulary**, even if the drug may be beneficial and prescribed by a **Health Care Provider**.
    - **We** have the right to deny coverage for new drugs until **We** have investigated them and found them to be **Medically Appropriate**.
    - Coverage exceptions for drugs not included on the **Formulary**:
        - **We** will consider a coverage exception only if ALL of the following apply:
            - **You** have tried all the covered drugs in the appropriate therapeutic category.
            - **Your Health Care Provider** provides **Us** with compelling, contemporaneous clinical evidence that either:
                - None of the covered drugs is effective for you; or
                - For a documented medical reason, **You** are unable to take any of the covered drugs.
            - The substitute drug **You** are requesting is the most **Cost-Effective** of the safe and effective alternative drugs in **Your** specific medical circumstances.
        - **Your Health Care Provider** must submit an exception request to **Us**, and **We** must approve it, before **You** fill **Your** prescription.
- Three Drug Tiers
    - Prescription drugs on the **Formulary** are placed in one of three categories, or tiers. The tier in which **We** place a specific drug affects the amount **We** reimburse.
    - Tier 1:
        - Includes most, but not all, generic drugs.
        - It may also include some brand name drugs and a few over-the-counter drugs.
            - Tier 1 brand name drugs and over-the-counter drugs are therapeutically equivalent to drugs in Tier 2 or Tier 3.
    - Tiers 2 and 3:
        - Include all other generic and brand name drugs, based on cost, therapeutic efficacy, and the recommendations of **Our** Pharmacy and Therapeutics Committee.

Coverage Limitations

- Dispensing limitations
    - Dispensing is limited in quantity to a **Medically Appropriate** dosage, or what **We** have established as a 30-day supply. **We** reimburse only for the quantity that **We** consider a 30-day supply.
        - A 30-day supply may be either more or less than 30 unit dosages.
        - If **Your Health Care Provider** prescribes a quantity that exceeds **Our** established 30-day supply, the pharmacist at an **In-Network** pharmacy will inform **You** before filling the prescription.
        - Covered dispensing amounts may be different under the Home Delivery Program. See below for more information.
    - **We** will only consider an exception to the dispensing limitation when compelling clinical evidence indicates a larger dosage is **Medically Necessary** and **Medically Appropriate** for **Your** specific medical needs.
    - If **Your** coverage will be terminating within 90 days, **We** have the right to limit dispensing to a 30-day supply.
    - Over-the-counter drugs are not available through the Home Delivery Program.
- Specialty drugs
    - Specialty drugs are prescription medications that require special handling, administration or monitoring. They are used to treat complex, chronic conditions.
    - Specialty drugs are limited to a 30-day supply, even if **You** get them through **Our** Home Delivery Program. **You** will be charged one **Cost-Sharing Amount** per 30-day supply.

- **We** may require that **You** get specialty drugs through **Our** specialty drug program for maximum reimbursement.

- **Prior Authorization** and medical monitoring
  - **We** may require that **You** get **Prior Authorization**, or undergo medical review and monitoring, for any drugs:
    - With a high potential for drug-related toxicity;
    - For which a step-therapy approach is appropriate; or
    - With unique prescribing or monitoring indications.
  - The list of drugs that meet these criteria is small, but will change frequently with new developments. **You** can view the most current list on **Our** website at weatrust.com.
    - If **Your Health Care Provider** prescribes one of these drugs, the pharmacist at an **In-Network** pharmacy will inform **You** before filling the prescription. **You** can call **Us** to start any required review.
    - If **You** take **Your** prescription to an **Out-of-Network** pharmacy, **You** will need to pay, in advance, the entire bill for the prescription.
      - **You** take the risk that **We** will not reimburse **You** for the drug. This could happen, for example, if **We** would have denied **Your Prior Authorization** request for that drug based on **Your** particular medical circumstances.
      - If **We** do reimburse **You**, **Your** out-of-pocket costs will be higher than if **You** go to an **In-Network** pharmacy.
  - Penalties for failing to get **Prior Authorization** when required do not count toward **Your Maximum Out-of-Pocket Limit**.

Cost Sharing and Reimbursement

- **We** may reimburse covered **Prescription Drug** expenses in either of the following ways:
  - **You** may show **Your** insurance identification card to an **In-Network** pharmacy and pay the applicable **Cost-Sharing Amount**, plus any additional cost for brand name drugs. **We** will then reimburse the pharmacy directly.
  - **You** may pay the entire cost of a Prescription drug at any pharmacy. To get reimbursed, **You** would submit to **Us** a **Prescription Drug Claim** form with the required information. **We** would then reimburse **You** for the appropriate amount.
    - **You** can get a **Prescription Drug** claim form by printing it from **Our** website at weatrust.com, or by calling **Our** Customer Service Department.
    - **We** will only reimburse the amount that is charged by an **In-Network** Pharmacy, minus the applicable **Cost-Sharing Amount**. If use an **Out-of-Network** pharmacy, **Our** reimbursement may be much less than **You** were charged.
- The amount **We** reimburse and the amount **You** must pay for **Your** covered **Prescription Drugs** depends on three factors:
  - The **Cost-Sharing Amounts** that apply to **Your Prescription Drugs**.
    - The amounts are different depending on whether **You** purchase a **Prescription Drug** from Tier 1, Tier 2, or Tier 3.
    - **You** can find the **Cost-Sharing Amount** for each tier in **Your Benefit Summary**. That amount applies separately to each prescription or refill.
  - Whether **You** select an **In-Network** or an **Out-of-Network** pharmacy.
    - **We** limit **Our** reimbursement to the amount an **In-Network** pharmacy charges.
    - **You** can find the list of **In-Network** pharmacies in **Your** area on **Our** website at weatrust.com, or by calling **Our** customer service department.
  - Whether **You** get a **Cost-Effective** drug.
    - There may be more than one drug that is appropriate to treat **Your** medical condition. However, **We** will only cover drugs that **We** have determined are **Cost-Effective**.
    - If **You** get a brand name drug, **We** may limit **Our** reimbursement to the amount an **In-Network** pharmacy charges for the FDA-approved generic equivalent drug.
      - If this happens, **You** must pay the drug's applicable **Cost-Sharing Amount**. **You** must also pay the difference between the amount the pharmacy charged and the amount of **Our** reimbursement. You will likely end up paying a lot out-of-pocket.
      - A note from **Your Health Care Provider** on **Your** prescription that a drug must be dispensed as written is not, by itself, enough evidence for **Us** to reimburse for that drug.

    - To get reimbursement, before **You** fill **Your** prescription **Your Health Care Provider** must submit to **Us** an exception request, and **We** must approve it. **We** will base **Our** decision upon the medical documentation **Your Health Care Provider** submits with the exception request.
- If **You** buy **Prescription Drugs** from an **Out-of-Network** pharmacy, **You** will be required to pay the full cost of the drug and submit a claim form.
    - **You** can get a claim form by printing it from **Our** website or by calling **Our** customer service department.
    - **We** will reimburse **You** the amount **We** would have paid to an **In-Network** pharmacy, minus the Cost-Sharing amount **You** owe. **Your** out-of-pocket costs will usually be much higher when **You** use an **Out-of-Network** pharmacy.
        - Note: Most **Hospital** pharmacies are not **In-Network** pharmacies. If **Your Health Care Provider** gives **You** a prescription when **You** leave the **Hospital**, **You** may want to go to an **In-Network** pharmacy to have it filled.

Benefits

Covered

- Drugs that are required to carry the legend, "Federal law prohibits dispensing without prescription."
- Drugs that may be dispensed only with a **Health Care Provider's** written prescription, as required by state law.
- Drugs for the treatment of HIV infection.
- Insulin and other **Prescription Drugs** and medications prescribed for the treatment of diabetes.
- Specified prescription and over-the-counter tobacco cessation aids, as described in the "Tobacco Cessation" subsection of Section 3: Medical Benefits of this **Certificate**.

Not Covered

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

- Drugs or medications prescribed for, or in connection with, infertility or conception.
    - Examples include, but are not limited to, Clomiphene Citrate, Pregnyl and Repronex.
- Drugs or medications for the treatment of impotence or erectile dysfunction.

- Refills, as follows:
    - Early refills;
        - **We** do not reimburse for early or additional refills if **Your** medications are lost, stolen, damaged, expired, misplaced, missing, or otherwise compromised.
    - Refills beyond number of refills your **Health Care Provider** has prescribed; or
    - Any refill dispensed more than one year after the **Health Care Provider** originally prescribed it.
- Drugs or medications provided in connection with any medical service not covered by this **Plan**.

SECTION 4: PRESCRIPTION DRUG BENEFITS
VALUE CHOICE DRUG PLAN

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

Important Notes

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

How to Access

- To make the best and most knowledgeable use of **Your Prescription Drug** benefits, always get **Your Prescription Drugs** from an **In-Network** pharmacy.
    - **In-Network** pharmacies have up-to-date information about whether a specific drug is a covered **Formulary** drug.
    - They can tell **You** about **Cost-Sharing Amounts You** must pay, **Prior Authorization** requirements, and dispensing limitations. This helps **You** keep **Your** out-of-pocket costs as low as possible.
    - To locate **In-Network** pharmacies, visit **Our** website at weatrust.com or call **Our** Customer Service department.

    - You can also get up to a 90-day supply of **Your Prescription Drugs** through **Our** Home Delivery Program.
        - You can find more information about **Our** Home Delivery Program on **Our** website at weatrust.com.
        - Over-the-counter drugs are not available through the Home Delivery Program.
- Getting drugs at an **Out-of-Network** pharmacy will usually result in high out-of-pocket costs.

Formulary and Drug Tiers

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

Coverage Limitations

- Dispensing limitations
    - Dispensing is limited in quantity to a **Medically Appropriate** dosage, or what **We** have established as a 30-day supply. **We** reimburse only for the quantity that **We** consider a 30-day supply.
        - A 30-day supply may be either more or less than 30 unit dosages.
        - If **Your Health Care Provider** prescribes a quantity that exceeds **Our** established 30-day supply, the pharmacist at an **In-Network** pharmacy will inform **You** before filling the prescription.
        - Covered dispensing amounts may be different under the home delivery program, or at pharmacies participating in the 90-Day Retail Benefit. See below for more information.
    - **We** will only consider an exception to the dispensing limitation when compelling clinical evidence indicates a larger dosage is **Medically Necessary** and **Medically Appropriate** for **Your** specific medical needs.
    - If **Your** coverage will be terminating within 90 days, **We** have the right to limit dispensing to a 30-day supply.
- 90-day retail benefit
    - This **Plan** offers a 90-day supply of some drugs from a specific subgroup of **In-Network** retail pharmacies.
        - **You** can get the names of these pharmacies in **Your** area by visiting **Our** website, weatrust.com, or by calling **Our** Customer Service department.
    - A 90-day retail prescription is subject to a Cost-Sharing amount equal to what **You** would pay for three separate 30-day refills of the prescription.
- Specialty drugs
    - Specialty drugs are prescription medications that require special handling, administration or monitoring. They are used to treat complex, chronic conditions.
    - Some of **Our** health plans have a Tier 4 for certain specialty drugs. With these plans, certain high-cost specialty drugs are placed into Tier 4.
        - If this applies to **Your** plan, **Your Benefit Summary** will show cost-sharing information for Tier 4.
        - **Our** website includes the most current list of Value Drugs and other covered drugs, indicating the tier in which they have been placed. It also includes a separate list of the specialty drugs that are placed into Tier 4, if Tier 4 applies to **Your** plan.
            - **We** encourage **You** to share this information with **Your Health Care Provider** so that **You** can make informed decisions about **Your** treatment and its cost to **You**.
            - These lists may change frequently, so if **You** have a question about reimbursement for a certain **Prescription Drug**, please visit **Our** website at weatrust.com.
    - **We** may require that **You** get specialty drugs through **Our** specialty drug program for maximum reimbursement.
    - Specialty drugs are limited to a 30-day supply even if **You** get them through the Home Delivery Program. You will be charged one **Cost-Sharing Amount** per 30-day supply.
- **Prior Authorization** and medical monitoring
    - **We** may require that **You** get **Prior Authorization**, or undergo medical review and monitoring, for drugs:
        - With a high potential for drug-related toxicity;
        - For which a step-therapy approach is appropriate; or
        - With unique prescribing or monitoring indications.
    - The list of drugs that meet these criteria is small, but will change frequently with new developments. **You** can view the most current list on **Our** website at weatrust.com.
        - If **Your Health Care Provider** prescribes one of these drugs, the pharmacist at an **In-Network** pharmacy will inform **You** before filling the prescription. **You** can call **Us** to start any required review.
        - If **You** take **Your** prescription to an **Out-of-Network** pharmacy, **You** will need to pay, in advance, the entire bill for the prescription.
            - **You** take the risk that **We** will not reimburse **You** for the drug. This could happen, for example, if **We** would have denied **Your Prior Authorization** request for that drug based on **Your** particular medical circumstances.
            - If **We** do reimburse **You**, **Your** out-of-pocket costs will be high.
    - Penalties for failing to get **Prior Authorization** when required do not count toward **Your Maximum Out-of-Pocket Limit**.

Cost Sharing and Reimbursement

- We may reimburse covered **Prescription Drug** expenses in either of the following ways:
    - **You** may show **Your** insurance identification card to an **In-Network** pharmacy and pay the applicable **Cost-Sharing Amount**, plus any additional cost for brand name drugs. **We** will then reimburse the pharmacy directly.
    - **You** may pay the entire cost of a Prescription drug. To get reimbursed, **You** would submit to **Us** a **Prescription Drug Claim** form with the required information. **We** would then reimburse **You** for the appropriate amount.
        - **You** can get a **Prescription Drug** claim form by printing it from **Our** website at weatrust.com, or by calling **Our** Customer Service Department.
        - **We** will only reimburse the amount that is charged by an **In-Network** Pharmacy, minus the applicable **Cost-Sharing Amount**. If use an **Out-of-Network** pharmacy, **Our** reimbursement may be much less than **You** were charged.
- The amount **We** reimburse and the amount **You** must pay for **Your** covered **Prescription Drugs** depends on three factors:
    - The **Cost-Sharing Amounts** that apply to **Your Prescription Drugs**.
        - The amounts are different depending on whether **You** purchase a Value Drug or other drug from Tier 1, Tier 2, Tier 3, or Tier 4 if applicable.
        - **You** can find the **Cost-Sharing Amount** for each tier in **Your Benefit Summary**. The specified amount applies separately to each prescription or refill.
    - Whether **You** select an **In-Network** or an **Out-of-Network** pharmacy.
        - **We** limit **Our** reimbursement to the amount an **In-Network** pharmacy charges.
        - **You** can find the list of **In-Network** pharmacies in **Your** area on **Our** website at weatrust.com, or by calling **Our** Customer Service department.
    - Whether **You** get a **Cost-Effective** drug from among the viable alternatives.
    - There may be more than one drug that is appropriate to treat **Your** medical condition. However, **We** will only cover drugs that **We** have determined are **Cost-Effective**.
        - If **You** get a brand name drug, **We** may limit reimbursement to the amount an **In-Network** pharmacy charges for the FDA-approved generic equivalent drug.
            - If this happens, **You** must pay the drug's applicable **Cost-Sharing Amount**. **You** must also pay the difference between the amount the pharmacy charged and the amount of **Our** reimbursement. You will likely end up paying a higher out-of-pocket amount.
            - A note from **Your Health Care Provider** on **Your** prescription that a drug must be dispensed as written is not, by itself, enough evidence for **Us** to reimburse for that drug.
                - To get reimbursement, before **You** fill **Your** prescription **Your Health Care Provider** must submit to **Us** an exception request, and **We** must approve it. **We** will based **Our** decision upon the medical documentation **Your Health Care Provider** submits with the exception request.
- If **You** buy **Prescription Drugs** from an **Out-of-Network** pharmacy, **You** will be required to pay the full cost of the drug and submit a claim form.
    - **You** can get a claim form by printing it from **Our** website or by calling **Our** customer service department.
    - **We** will reimburse **You** the amount **We** would have paid an **In-Network** pharmacy, minus the applicable Cost-Sharing amount **You** owe. **Your** out-of-pocket costs will usually be much higher when **You** use an **Out-of-Network** pharmacy.
        - Note: Most **Hospital** pharmacies are not **In-Network** pharmacies. If **Your Health Care Provider** gives **You** a prescription when **You** leave the **Hospital**, **You** may want to go to an **In-Network** pharmacy to have it filled.

Benefits

Covered

- Drugs labeled with "Federal law prohibits dispensing without prescription."
- Drugs that may be dispensed only with a **Health Care Provider's** written prescription as required by state law.
- Drugs for the treatment of HIV infection.
- Insulin and other **Prescription Drugs** and medications prescribed for the treatment of diabetes.
- Specified prescription and over-the-counter tobacco cessation aids, as described in the "Tobacco Cessation" subsection of Section 3: Medical Benefits of this **Certificate**.

Not Covered

- Drugs and medications that you can legally get without a prescription, even if **Your Health Care Provider** prescribes them.
    - The only exception to this is an over-the-counter drug that **We** have listed on the **Formulary**.
        - **We** add these drugs to the **Formulary** when **We** have decided that they are a **Cost-Effective**, comparably equivalent alternative to a **Prescription Drug**.
    - Such over-the-counter drugs require a prescription from **Your Health Care Provider**.
- Drugs or medications that **We** have decided are ineffective or only marginally effective.
- A drug or medication that has not been proven to be more effective than a less expensive, therapeutically equivalent drug.
- Any drug or medication labeled "Caution – limited by federal law to investigational use."
    - This exclusion does not apply to drugs for the treatment of HIV infection that this **Plan** is required by law to cover.
- Any drug that has not been approved by the FDA for at least six months for the purpose that **Your Health Care Provider** is prescribing it, or it is otherwise being used.
- Drugs or medications for the treatment of alopecia or hair loss.
    - Examples include, but are not limited to, minoxidil or Rogaine.
- Drugs or medications primarily to improve appearance.
    - This includes all dosage forms of tretinoin (for example, Retin-A) for individuals who are 36 years of age or older, except for the treatment of acute acne.
- Tobacco cessation aids, except for specified prescription and over-the-counter aids as described in this **Certificate**.
- Drugs or medications prescribed for, or in connection with, weight loss or weight control.
    - Examples include, but are not limited to, Dexedrine and Xenical.
- Drugs or medications prescribed for, or in connection with, infertility or conception.
    - Examples include, but are not limited to, Clomiphene Citrate, Pregnyl and Repronex.
- Drugs or medications for the treatment of impotence or erectile dysfunction.
- Refills, as follows:
    - Early refills;
        - **We** do not reimburse for early or additional refills if **Your** medications are lost, stolen, damaged, expired, misplaced, missing, or otherwise compromised.
    - Refills beyond the number of refills your **Health Care Provider** has prescribed; or
    - Any refill dispensed more than one year after the **Health Care Provider** originally prescribed it.
- Drugs or medications provided in connection with any medical service not covered by this **Plan**.

SECTION 5: GENERAL EXCLUSIONS AND LIMITATIONS

We will not cover any of the following services:

General Exclusions and Limitations: Medical

Testing, Services and Procedures

- **Experimental/Investigational** treatments and services
- Bariatric surgery, including gastric restrictive, bypass, and other similar surgeries, and treatment of any related complications.
    - This exclusion applies regardless of **Your** diagnosis or the reason for the surgery.
- Weight loss or weight control programs, services and surgeries for the treatment of obesity, including bariatric surgery.
    - **We** also exclude coverage for complications that are related to any of these programs, services, treatments or surgeries.
    - This exclusion does not include any weight loss or weight control services that **We** are required by law to cover.
- **Routine Foot Care**
    - This exclusion does not apply to **Routine Foot Care** provided to **Members** with a confirmed diagnosis of:
        - Diabetes;
        - Peripheral neuropathies (as determined by **Us**);
        - Arteriosclerosis; or
        - Chronic Thrombophlebitis
- Private duty nursing services.
- Services or equipment to prevent **Injury**.
- Services or equipment to help or make physical activity or sports possible.
- Services to prevent **Illness**, except those services expressly listed in the "Preventive Care" subsection of Section 3: Medical Benefits of this **Certificate**, or that **We** are otherwise required by law to cover.
- Services or items for physical fitness, wellness, health education or personal hygiene.
- Services to educate **You** or help **You** adapt to a diagnosis or a chronic physical or mental condition. Examples include:
    - Stress management classes; and
    - Classes, education and awareness training for individuals suffering from chronic pain.
- In the absence of an **Illness** or **Injury**, services to help **You** improve **Your** existing physical or mental health and sense of wellbeing.
- Services to treat impotence and erectile dysfunction.
- Removal and treatment of skin tags.
- Services for which the sole purpose is to improve appearance. Examples include, but are not limited to:
    - Services to improve skin appearance;
    - **Cosmetic Surgery**;
    - Services to treat and/or remove keloids;
    - Services to repair scarring or disfigurement caused by body piercing, tattooing, implants or other services or procedures which were:
        - Not **Medically Necessary**;
        - Not **Medically Appropriate**; or
        - Not performed by a licensed medical professional.
- Services for male or female baldness or hair loss, regardless of the cause. This includes, but is not limited to:
    - Hair restoration;
    - Hair transplants; and
    - Hair implants.
- Services or supplies intended primarily for convenience or the personal preference of:
    - **You**;
    - **Your Immediate Family**;
    - The **Health Care Provider**; or
    - Any other person.
- Services or interventions that have not been documented as being safe and effective for a specific **Illness** or **Injury**.

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

Prescription Drugs and Other Equipment, Devices or Items

- Prescription drugs and other devices or items for the treatment of obesity.
- Replacement of **Prescription Drugs** or medications, orthotics, or equipment that are:
    - Lost;
    - Stolen;
    - Damaged;
    - Misplaced;
    - Missing; or
    - Otherwise compromised.
- Augmentative and/or alternative communicative devices and systems.
- Tobacco cessation aids, except for the specific prescription and over-the-counter aids described in the "Tobacco Cessation" subsection of Section 3: Medical Benefits of this **Certificate**.
- Enuresis alarms.
- Appliances for snoring.

- Continuous passive motion (CPM) machine.
- Equipment or services to prevent **Injury** or to help or make physical activity or sports possible.
- Any immunizations **You** get for the sole purpose of traveling outside of the United States.
- Items or services for physical fitness, wellness, health education or personal hygiene.
- Vitamins.
- Nutritional or diet supplements, except for those **We** are required by law to cover.
- **Prescription Drugs**, equipment, devices or other items to treat impotence and/or erectile dysfunction.
- Drugs and injections for male or female baldness or hair loss regardless of the cause. This includes, but is not limited to:
    - Hair restoration;
    - Hair transplants; and
    - Hair implants.
- Holistic or homeopathic remedies and preparations.
- Any supplies or equipment **You** can buy over-the-counter without a prescription. This includes, but is not limited to, items such as gauze, bandages and tape.

Therapies

- Vocational rehabilitation, including work-hardening programs.
- Gene therapies, treatments or enhancements.
    - While **We** never reimburse for gene therapies, treatments or enhancements, **We** reimburse for the **Genetic Testing** and/or genetic counseling described in the "**Genetic Testing**/Counseling" subsection of Section 3: Medical Benefits of this **Certificate**.

General Exclusions and Limitations: Non-Medical

Appointments and Other Types of Visits

- Missed appointments.
- Office Visits, **Physician** charges, or any other service for or connected to a procedure or service that this **Plan** does not cover.
    - This exclusion applies even if **You** were not covered under this **Plan** when the noncovered procedure or service was performed.
    - This exclusion includes, but is not limited to:
        - Follow-up **Physician** and/or **Surgeon** visits;
        - Diagnostic tests which are primarily related to (or only necessary because) of a noncovered procedure or service;
        - Services to treat or resolve complications caused by a noncovered procedure or service;
        - Services or procedures to repair a failed noncovered procedure or service;
        - Services to repair scarring caused by a noncovered procedure, service or surgery;
        - Home health care required as a result of a noncovered procedure or service.
    - This exclusion does not apply when the law otherwise requires reimbursement.
- Charges related to the supervision of laboratory services that do not involve written consultation by a Health Care Provider including, but not limited to, laboratory interpretation.

Services, Treatments and/or Supplies

- Charges for which our liability cannot be determined because a Covered Person, Health Care Provider, facility or other individual or entity within 30 days of our request, failed to:
    - Authorize the release of all medical records to **Us** and other information **We** requested.
    - Provide **Us** with information **We** requested about pending **Claims** or other insurance coverage.
- Services that are for treatment of complications arising from non-**Covered Services**
- Legal Services
- Copying and providing medical or any other type of information to support a **Claim**.
- **Prescription Drugs** and medications for **Members** who are eligible to enroll in the Medicare Part D program, regardless of whether they enroll. This exclusion does not apply to the following individuals, or in the following situations:
    - **Employees** who are covered **Actively-at-Work** and their covered **Dependents**.

    - **Members** who are covered by **Our** standard **Family** plan.
    - **Members** who are covered under state or federal continuation (COBRA) coverage, unless they choose to waive **Prescription Drug** coverage under this **Plan**.
    - Any **Member** for whom **We** are the primary payer according to Medicare Secondary Payer rules.
    - Any **Prescription Drugs** or medications that **We** are required by law to cover for all **Members**, including **Members** who are eligible to enroll in the Medicare Part D program.
- Services or items that are provided for free or for which **You** are not legally obligated to pay if **You** don't have insurance.
- Services that a child's school is legally obligated to provide. This exclusion applies regardless of whether the school actually provides the services, and whether **You** choose to use those services.
- Unless **We** are required by law to pay for them, services or items furnished or paid for by a governmental entity, facility, or program other than Medicaid.
- Services or items required by a third party. This includes, but is not limited to, services required for the purposes of insurance, employment or special licensing.
- Court-ordered treatment, unless:
    - It meets **Our** criteria for **Medical Necessity**, **Medical Appropriateness** and **Cost-Effectiveness**;
    - It is otherwise covered under this **Plan**; or
    - **We** are required by law to cover it.
- Services or treatment for a medical condition that arose from, or originated during, service in the armed forces.
- Services or treatment for an **Injury** or **Illness** caused by war, insurrection, riot or terrorism; or to which war, insurrection, riot or terrorism contributed.
- Services or treatment for an **Injury** or **Illness** that resulted from participating in a crime.
- Non-emergency services **You** get while **You** are outside the United States.
- Services ordered, directed, performed or provided to **You** by an **Immediate Family** member.
- Services or treatment eligible for worker's compensation benefits, or benefits from any other payment program established by a similar law.
    - This exclusion applies whether **You** apply for or get worker's compensation or similar benefits.
    - This includes amounts **You** get when a claim under worker's compensation or a similar law is settled by stipulation or compromise.

Charges and Expenses

- Travel and lodging.
- Charges or costs exceeding a benefit maximum or **Maximum Allowable Fee**, where applicable.
- Charges or costs for services **You** got while **You** were not covered under this **Plan**.

SECTION 6: ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

General

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

Employee Eligibility

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

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

Dependent Eligibility

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

- The employee's legal **Spouse**.
- The employee's or **Dependent Spouse's** biological child, legally adopted child, or stepchild who is under the age of 26.
- A child for whom the employee or **Dependent Spouse** is a legal guardian or as otherwise required by law.
- A child for whom the employee or **Dependent Spouse** has a Qualified Medical Child Support Order (QMCSO).
- A **Dependent** child's child (ie. grandchild of employee or **Spouse**) until the **Dependent** child turns 18 or marries, whichever occurs first.
- An unmarried disabled child age 26 or older whom meets all of the following circumstances:
    - S/He is permanently mentally or physically disabled.
    - S/He is incapable of self-sustaining employment.
    - S/He is chiefly **Dependent** on the employee or **Dependent Spouse** for at least 50% of support.
        - **You** must provide written documentation that the above-listed criteria are met within 30 days of the date that **Your Dependent** is initially eligible to enroll or within 30 days of that date s/he reaches the age of 26. **We** may request, and **You** must provide, documentation of continued disability at any time during the 2 years following the initial eligibility date. Thereafter, **You** may be required to provide proof of continued disability on an annual basis.
- A child who is age 26 or older, a full-time student and meets all of the following circumstances:
    - Was called to active duty in the National Guard or in a reserve component of the United States armed forces prior to age 27 while s/he was a full-time student.
    - Returns to full-time student status within 12 months of completing the active duty obligation.
    - Remains a full-time student.
        - **We** may require **You** to provide documentation of continued full-time student status for any enrolled child as frequently as every 6 months. **Your** failure to give this information could result in termination of a child's coverage.

Initial Enrollment and Effective Dates

Employees eligible for coverage must submit a completed enrollment form within 30 days of becoming eligible for coverage under this **Plan**. If **You** do not submit **Your** enrollment form within 30 days, **You** will be subject to the rules applicable to Late Enrollees, described below.

If **You** submit **Your** enrollment form on time, **Your** coverage effective date will be as follows:

- **Active Status Employees** on the **Plan's** effective date:
  - The date the **Plan** is effective for **Your** employer..
- Newly-hired or newly-**Eligible Employees**
  - If Your employer imposes a probationary or waiting period (not to exceed 90 days), the date You complete the probationary or waiting period.
  - If You are not subject to a waiting period, the date You begin actively performing Your regular job duties.
- **Employees** rehired after layoff (if allowed by **Your** employer)
  - If **Your** employer imposes a waiting period, the date **You** complete the waiting period. No waiting period will exceed 90 days.
  - If **You** are not subject to a waiting period, the date **You** begin actively performing **Your** regular job duties.

Late Enrollees

If **You** waive or decline coverage for yourself and/or **Your Dependents** when first eligible, **You** and/or **Your Dependents** will not be able to enroll until **Your** employer's next open enrollment period.

Similarly, if **You** do not enroll yourself and/or **Your Dependents** during a special enrollment Period, **You** will not be able to enroll yourself and/or **Your Dependents** until **Your** employer's next open enrollment period.

Open Enrollment Period

Open enrollment refers to a period of time during which **Eligible Employees** and **Dependents** can apply for or change coverage. Open enrollment happens only once per year. Your employer will notify **You** when Open Enrollment is available.

Special Enrollment Period

If **You** did not enroll in this **Plan** when **You** were first eligible, **You** may be able to enroll before **Your** employers next open enrollment period if you qualify for a special enrollment period. This also applies if **You** did not enroll **Your Dependents** when they were first eligible.

Except as otherwise described below, you or **Your Dependents** must submit a completed enrollment form requesting special enrollment within 30 days of a qualifying event. The effective date of coverage when enrolling during a special enrollment period will be the date of the event triggering the availability of special enrollment.

Special enrollment is available for eligible individuals who:

- Lost eligibility under a prior health plan for reasons other than non-payment of **Premium** or due to fraud or intentional misrepresentation of a material fact.
- Exhausted COBRA continuation coverage.
- Lost employer contributions towards the cost of other health plan coverage.
- Are now eligible for coverage due to marriage, birth, adoption, or placement for adoption.
- Lost eligibility for coverage under Medicaid or BadgerCare Plus.
  - If You are eligible for a special enrollment period for this reason, You must submit Your enrollment form within 60 days of losing Medicaid or BadgerCare Plus coverage.
- Are newly eligible for Wisconsin's Premium assistance subsidy under Medicaid or BadgerCare Plus.
  - If You are eligible for a special enrollment period for this reason, You must submit Your enrollment form within 60 days of becoming eligible for premium assistance.

Enrolling Dependent Children: Newborn Children

Newborn children are covered automatically from the moment of birth. Following the birth of a child, **You** must submit an enrollment form within 60 days to add the newborn to **Your Plan**.

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

Enrolling Dependent Children: Adopted Children

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

- The date that a court makes a final order granting adoption.
- The date that a child is legally placed with **You** for adoption.

If **You** send **Us** a completed enrollment form within 60 days of the event, coverage will be effective as of the date of the adoption or placement for adoption.

Legal Custody or Guardianship

A child becomes eligible for coverage on the date a court awards **You** or **Your Dependent Spouse** legal custody or guardianship. If **You** send **Us** a completed enrollment form within 30 days of the date the court awards legal custody or guardianship, coverage will be effective as of the award date.

Qualified Medical Child Support Order

If **You** or **Your Dependent** spouse is required by a Qualified Medical Child Support Order or other court order (as defined by ERISA and/or applicable state or federal law) to enroll a child in this **Plan**, **You** can enroll the child at any time without regard to any Open Enrollment or Special Enrollment limits. **We** will provide the benefits of this **Plan** according to the order's applicable requirements.

- You must submit a completed enrollment form as well as a copy of the Order.
- The coverage effective date will be the date the court order specifies.
- Coverage under this provision will be provided as long as:
  - The **Employee** or **Dependent Spouse** remain covered under the **Plan**;
  - The court order remains in effect;
  - The child is not covered under another group or individual policy that provides comparable coverage;
  - The child continues to meet the **Plan's** definition of **Dependent**.

Duty to Provide Information

You are required to provide the information **We** need to accurately determine eligibility and to notify your employer of any changes that affect your coverage eligibility or the eligibility of **Your Dependents**.

You must notify **Us** immediately when one of **Your** covered **Dependents** is no longer eligible for coverage.

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

- Address changes;
- Marriage or divorce;
- Death of an enrolled **Family** member (a different type of coverage may be necessary);
- Enrollment in another health plan or in Medicare;
- Eligibility for Medicare;
- **Dependent** child reaching the **Dependent** Age Limit;
- Enrolled **Dependent** child either becomes totally or permanently **Disabled** or is no longer **Disabled**.

If **You** fail to notify **Us** of individuals who lose eligibility for coverage, **We** will not be obligated to cover any services or items he or she gets after losing eligibility. This is true even if **We** get premium payments for that individual. **You** must submit all notifications in writing and on approved forms.

The **Subscriber** must provide evidence of eligibility of **Dependents** upon request by the **Plan**. Failure to provide such evidence either when **Your Dependent** is no longer eligible or when requested is considered intentional material misrepresentation. Failure to provide evidence of eligibility may result in the termination of coverage for the **Dependent**. Such termination may be retroactive to the date the **Dependent** became ineligible for coverage under the **Plan** pursuant to applicable Department of Labor regulations, depending on the facts and circumstances.

If **Your Dependent**'s coverage is terminated retroactive to the date of ineligibility, **You** have the right to submit a **Grievance** under the **Grievance** provisions of this **Plan**, described below. Per the **Grievance** provisions, the Committee will review the facts and circumstances surrounding the ineligibility and the information that **You** were required to provide.

Termination of Coverage

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

- The date this **Plan** terminates for **Your** employer for any reason.
- The end of the period for which the last **Premium** was paid in full for the **Subscriber** and/or any **Dependents**.
- When **Subscriber** or any **Dependent** enters the military forces of any state or country, including the United States, on active duty or as a **Member** of a reserve unit of the armed forces for at least 30 consecutive days, coverage will end on the last day of the month.
- The last day of the month in which the **Subscriber** ceases to be a member of the class of **Eligible Employees** specified by **Your** employer on the Agreement for coverage under this **Plan**. For example, a change in job duties or in the number of hours worked that renders the **Subscriber** ineligible for coverage.
- The last day of the month in which the **Subscriber**'s occupational group ceases to be part of the class of **Eligible Employees** specified by employer on the Agreement as being part of an insured group.
- The last day of the month in which the **Subscriber** becomes ineligible because of the termination of employment, whether voluntary or involuntary.
- The date on which the **Subscriber** fails to comply with any provision of this **Plan**.
- The date of the **Subscriber**'s death.
- In the event of the death of the **Subscriber**, coverage for **Dependents** will end on the last day of the month of **Subscriber**'s death.
- In the case that divorce or annulment of marriage terminates the spousal relationship, coverage for the **Dependent** spouse will terminate on the last day of the month in which the divorce or annulment is final.
- The last day of the month in which a **Dependent** child no longer meets the criteria to be covered under this **Plan**.
- Coverage will terminate for any **Dependent** as of the date of their death.
- When the **Subscriber** provides written notice requesting termination of coverage, the coverage will end on the last day of the month notice was received or the last day of the month in which the **Subscriber** requests coverage to terminate, whichever is later.

Extension of Benefits

If **You** are **Totally Disabled** on the date this **Plan** terminates for all employees, **We** will temporarily continue to reimburse for **Covered Services** related to the **Illness** or **Injury** causing **Your Total Disability**. This extension will end on the earliest of the following:

- The date **Your Total Disability** ends;
- The end of twelve (12) consecutive months immediately following the date this **Plan** terminated;
- The **Maximum Benefit Amount** is paid; or
- The date coverage begins under another group health plan for the **Illness** or **Injury** causing **Your** total disability.

Coverage Ending Due to Fraud or Intentional Misrepresentation

If **We** find that you, **Your Dependent**(s) or **Your** employer has performed an act, practice, or omission that constitutes fraud or intentional misrepresentation of fact, **We** have the right to terminate coverage and the termination may be retroactive. This includes knowingly providing incorrect information regarding the **Subscriber** or **Dependents**' coverage eligibility. When this happens, **We** will provide **You** with a 30-day advance written termination notice. Coverage will end on the date **We** specify in the notice, which may be retroactive pursuant to Department of Labor regulations and in accordance with other provisions in this **Plan**.

Continuation of Coverage

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

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

COBRA Continuation

If **Your** employer is subject to the requirements of COBRA, **You** and **Your** covered **Dependents** may be eligible for continuation coverage if a designated "qualifying event" has occurred. The duration of COBRA coverage is governed by federal law and will vary based upon **Your** coverage class and the qualifying event leading to the loss of coverage. Individuals electing coverage under COBRA are responsible for paying the premium for this coverage.

For additional information about **Your** rights, eligibility and responsibilities related to continuation coverage under COBRA contact **Your** employer.

Wisconsin Continuation

In certain circumstances, Wisconsin law provides continuation rights, of up to 18 months, to **You** and/or **Your** covered **Dependents**. **You** and/or **Your** covered **Dependents** are eligible for continuation coverage if the individual was covered under the **Plan** for a period of at least three months. Continuation coverage is terminated when one of the following circumstances happens:

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

Your employer must give **You** written notice of **Your** right to elect continuation coverage within five days of coverage termination. **You** and/or **Your** covered **Dependents** must elect continuation of coverage within 30 days of getting this notice. You and/or **Your** covered **Dependents** are responsible for paying the premium for continuation coverage.

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

USERRA Continuation

USERRA grants rights to individuals who take a leave of absence for service in the armed forces of the United States, including Reserve services. USERRA gives **You** the right to elect to continue employer-sponsored coverage for up to 24 months during a period of an armed forces leave of absence. If **You** elect to continue coverage based on **Your** rights under USERRA, **You** are responsible for paying the premium associated with this coverage.

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

SECTION 7: CLAIMS PROCEDURES

To get reimbursed, **You** must send **Us** within 90 days a written **Claim** and proof that **You** have incurred a covered loss. Wisconsin law extends this period to 12 months beyond the 90 days required by this **Plan**. However, this extension only applies if **We** are not prejudiced by the delay and it was not reasonably possible for **You** to meet **Our** 90-day limit. **You** can get a **Claim** form from **Your** employer or from **Us**. The identification card **We** sent **You** after enrollment gives the address where **Claims** must be sent.

Most **Health Care Providers** submit **Claims** as a service to their patients. **We** are happy to accept **In-Network** Provider-submitted **Claims** that meet industry-accepted standards. This will fulfill **Your** obligation if the **Claim** contains all the information, **We** need to evaluate it. **We** reserve the right to require that **You** submit **Claims** for services from **Out-of-Network Providers** that satisfy **Our** requirement to prove that **You** have incurred a covered loss. **We** also may, at **Our** discretion, pay **You** directly for **Covered Services** you get from **Out-of-Network Providers**. If **We** pay **You** directly, **You** must in turn pay the **Out-of-Network Provider**.

Claim for Health Care Services

Your Claim must include this information:

- The name and address of the **Subscriber**.
- The employer's group number (this is listed on **Your** insurance identification card).
- The **Member**'s name, address, date of birth, and **Subscriber** number. The **Subscriber** number is listed on **Your** insurance identification card.
- The name of the primary insurer, if it is not WEA Trust.
- Information regarding any other group insurance coverage.
- The **Health Care Provider's** name, complete address, telephone number, federal tax identification number, and national provider identifier.
- The name and telephone number of the individual practitioner who performed the service(s).
- The place and date of service or, for **Hospital** claims, admission and discharge dates.
- The **Member**'s diagnosis and the appropriate procedure or billing code for each service the **Member** got, with an itemization of charges for each service.

We rely on medical documentation to decide if the procedure or billing codes the **Health Care Provider** listed are appropriate. If the documentation indicates another code is more appropriate, **We** have the right to base **Our** reimbursement on the service(s) the documentation supports. **We** also have the right to deny charges for services that are billed inconsistently with industry-accepted coding standards.

Claim for Prescription Drugs

If **Your** employer's **Plan** includes **Prescription Drug** coverage, **You** may get covered **Prescription Drug** expenses reimbursed in either of two ways:

1. **You** may show **Your** insurance identification card to an **In-Network** pharmacy and pay the applicable **Cost-Sharing Amount** plus any additional cost for brand name drugs. **We** will then reimburse the pharmacy directly.

2. **You** may pay the entire cost of a **Prescription Drug** at any pharmacy and then submit a **Prescription Drug Claim** form with the required information. **We** will then reimburse **You** for the appropriate amount. **You** can get a **Prescription Drug Claim** forms from **Your** employer or from **Us**. **We** will reimburse **You** for the amount an **In-Network** pharmacy charges, minus the applicable Cost-Sharing Amount. If **You** go to an **Out-of-Network** pharmacy, **Our** reimbursement to **You** may be significantly less than **You** were charged. **Note:** Most **Hospital** pharmacies are not **In-Network** pharmacies. If **Your Health Care Provider** gives **You** a prescription when **You** leave the **Hospital**, **You** may want to go to an **In-Network** pharmacy to have it filled.

Proof of Loss

You must give **Us** satisfactory proof that **You** have incurred a covered loss, as well as 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 to show **Us** that the services **You** got fulfill **Our** coverage criteria. When **We** have questions about whether a **Claim** meets **Our** coverage criteria or whether reimbursement limits apply, **We** rely on objective, contemporaneous medical documentation and records, as well as 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** will help **You** in any way **We** can, but **You** are responsible for gathering and sending **Us** this information.

Some **Health Care Providers** charge for copying and/or submitting medical documentation. **We** do not pay for or reimburse these charges. **You** must pay these costs.

When necessary to establish proof of loss and evaluate a claim, **We** have the right to require that **You** be examined by a Health Care Provider of **Our** choice. We will pay the cost of this examination.

How and When Claims Will Be Paid

We pay benefits within 30 days of receiving a **Claim** and the required proof of loss. **We** directly reimburse **In-Network Health Care Providers** from whom **You** received services. **We** may also, at **Our** discretion, pay **You** for **Covered Services You** receive from **Out-of-Network Providers**. **You** must then pay the **Out-of-Network Provider**.

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

Our Right of Review and Recoupment

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

If **We** pay benefits that exceed those **You**'re entitled to, **You** must repay the excess as soon as **We** notify **You** of the overpayment. **We** may, at **Our** option, recover some or all of the overpayment by reducing a later **Claims** payment or **Premium** refunds we may owe **You**. **We** have the right to charge reasonable interest on the delinquent amount.

If we determine that **We** erroneously but in good faith made a benefit payment to a **Health Care Provider** that **We** should not have made, we reserve the right to seek recovery of that benefit payment from the **Health Care Provider**. We reserve the right to offset later benefit payments to the **Health Care Provider** by the amount of any such overpayments.

If **We** paid benefits under this **Plan** and **You** or **Your** covered **Dependent** receives worker's compensation benefits through settlement, compromise, judgment, award, or other arrangement, **You** must promptly repay **Us**. If **You** do not, **We** may recover some or all of the amount **You** owe **Us** by reducing later benefit payments payable, by filing suit against **You**, or by taking lesser legal action.

When **We** determine that **You** are eligible for, or have received, worker's compensation benefits, this **Plan** obligates **You** to cooperate with **Us** in **Our** attempts to recover payments **We** have made on **Your** behalf. 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 **Plan**, **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 8: COORDINATION OF BENEFITS

Applicability

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

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

Order of Benefit Determination Rules

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

General Rules

- **No coordination of benefits provision**
    - If the other plan does not have a coordination of benefits provision, it will be primary and the benefits available under this **Plan** will be secondary.

- **Non-Dependent/Dependent**
    - The plan that covers an individual as an employee, **Member**, or **Subscriber** (other than as a **Dependent**) is primary.
        - If a **Member** is covered by more than one **Plan** as an employee, **Member** or **Subscriber** (other than as a **Dependent**), the plan with the earlier effective date is primary.
    - The **Plan** that covers an individual as a **Dependent** is secondary.
- **Active Status/Inactive Employee**
    - The **Plan** that covers an individual as an employee who is neither laid off nor retired or as that employee's **Dependent** are primary to a **Plan** that covers a person as a laid-off or retired employee or as that employee's **Dependent**.
    - If the other **Plan** in question does not have this rule so that the Plans order of benefit determinations do not agree, this rule will be ignored.
- **Continuation coverage**
    - If an individual has continuation coverage provided pursuant to federal or state law and is also covered by another **Plan**, the **Plan** that covers the individual as an employee, **Member**, or **Subscriber** or as the **Dependent** of such individual will be primary.
- **No other rules apply**
    - If none of the above rules determines the order of benefits, the **Plan** that has covered the individual for the longer period of time will be primary.

Dependent Child/Parents Married, Not Separated or Divorced

- When a **Dependent** child is covered as a **Dependent** of both married persons who are parents of the **Dependent** which **Plan** is determined to be primary is as follows:
    - The plan of the parent whose birthday falls earlier in the **Calendar Year** is primary.
    - If both parents have the same birthday, the **Plan** that has covered a parent for the longer period of time is primary.
    - If the other **Plan** does not follow the above noted birthday rule and instead uses a rule based on gender of the parent, the rule based on gender will determine the order of benefits.

Dependent Child/Non-Married, Separated or Divorced Parents

- When two or more Plans cover a child of divorced or legally separated parents, benefits for the child will be determined in this order:
    - First, the **Plan** of the custodial parent.
    - Then, the **Plan** of the **Spouse** of the parent with the custody of the child; and
    - Finally, the **Plan** of the noncustodial parent.
- If a court decree states that parents share joint custody but does not identify which parent is responsible for providing healthcare coverage, the order of benefits will be determined as if the parents were married utilizing the birthday rule stated above.
- If the specific terms of a court decree state which parent is responsible to provide healthcare coverage, the **Plan** of the specified parent will be primary.
- When two or more plans cover an adult **Dependent** child (age 18 or above) of divorced or legally separated parents and there is no longer a custodial parent or an in-force court decree dictating which parent is responsible for providing healthcare coverage, the plan that has covered the adult **Dependent** child for the longer period of time will be primary.

Coordinating Benefits with Medicare

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

If **You** are eligible for Medicare Parts A and B but have not enrolled in that coverage, this **Plan** will estimate what Medicare would have paid an **In-Network Provider**. **We** will then coordinate benefits available under this **Plan** accordingly. **You** will be responsible for paying any amounts this **Plan** does not cover.

When this Plan is Primary to Medicare

- The employer has 20 or more employees
- The covered individual is eligible for Medicare due to End Stage Renal Disease and is in the first 30-month coverage coordination period (the first 30 months of eligibility or entitlement to Medicare based on having ESRD).
- The covered individual is eligible for Medicare due to disability (as defined by Medicare) and the employer has more than 100 employees.

When Medicare is Primary

- The employer has fewer than 20 employees.
- The covered individual has group continuation coverage (such as COBRA).
- The covered individual is retired.
- The covered individual is eligible for Medicare due to with End Stage Renal Disease and has complete the 30-month coverage coordination period.
- The covered individual is eligible for Medicare due to disability (as defined by Medicare) and the employer has fewer than 100 employees

Effect on Benefits when this Plan is Secondary

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

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

- The difference between the **Maximum Allowable Fee** and the amount paid by the Primary **Plan**; or
- Benefits that would have been paid under this **Plan** without regard to this Coordination of Benefits section.

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

Rights Under this Section

This **Plan** has the right to:

- Release or obtain **Claim** information from any benefit plan, individual or entity.
- Pay benefits to any other benefit plan or entity which has paid benefits which should have been paid by this **Plan**.
- Recover any overpayment made by this **Plan** from the person or entity to whom the payment was made.

We may obtain or release any information needed to carry out the intent of this section. **You** must tell **Us** if **You** or **Your** covered **Dependents** have coverage under any other benefit plan(s) when the covered individual makes a **Claim**.

SECTION 9:
COMPLAINTS, GRIEVANCES AND APPEALS PROCEDURES

Complaint and Grievance Procedures

You have the right to a full and fair review of any **Complaints You** may have about **Your Claims** or how **We** administer **Your** benefits.

This section explains **Your** rights to ask **Us** to explain **Our** decisions regarding **Your Claims**. It also explains **Your** rights to make a **Complaint**, file a formal **Grievance**, and appeal an adverse determination or decision.

Right to Information and an Explanation of Benefits

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

After **You** receive health care services, **Your Health Care Provider** will send **Us** a **Claim** for benefits. After **We** process that **Claim**, **We** will send **You** an Explanation of Benefits (EOB) form. The EOB form will contain the following information:

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

You may call **Us** and talk with one of **Our** Customer Service Representatives if **You** have questions about **Your** EOB form or how **We** determined **Your** benefits, or if **You** have a **Complaint**.

Questions or Complaints

Many questions or **Complaints** about benefits and **Claims** payments can be resolved informally by contacting **Our** customer service department at (800) 279-4000. A Customer Service Escalation Specialist will promptly investigate **Your Complaint** and keep **You** informed about the progress of the investigation.

If the Customer Service Escalation Specialist is unable to resolve **Your Complaint** to **Your** satisfaction, **You** have the right to file a formal **Grievance**.

Filing a Grievance

You can file a **Grievance** if **You** are dissatisfied with **Us** or how **We** administer this **Plan**. If **We** issue **You** an **Adverse Benefit Determination**, **You** can file a special type of **Grievance** known as an **Appeal**.

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

In addition to the Standard and **Expedited Grievance** rules, there is also a special set of rules **We** have to follow when **We** review an **Appeal**. **You** can find the additional rules that apply to **Appeals** after the sections discussing the Standard and **Expedited Grievance** procedures.

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

Standard Grievance Procedure

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

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

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

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

We will mail **You** an acknowledgement letter within five (5) business days of receiving **Your Grievance**.

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

Grievance Committee: If the **Grievance**/**Appeal** Manager is unable to resolve **Your Grievance** to **Your** satisfaction, it will go to the **Grievance** Committee for review. While not required, **You** have the right to attend the **Grievance** Committee meeting in person or over the telephone. **You** can also have someone else represent **You** in the meeting. If necessary, **We** will make reasonable accommodations to allow **You** and/or **Your** representative to participate.

At least seven (7) calendar days before the **Grievance** Committee meeting, **We** will notify **You** in writing of the meeting date, time and location. Before or during the **Grievance** Committee meeting, **You** have the right to present any of the following for the committee to consider:

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

The **Grievance** Committee will review all of the information and documentation **You** have provided. It will inform **You** in writing of its decision. If the Committee believes that WEA Trust did not reasonably handle **Your Grievance** according to the **Plan's** terms and the known facts, it will tell **Us** how to correct the issue.

Decision Timeframe: We will make every effort to resolve **Your Grievance** and notify **You** in writing within thirty (30) calendar days from the date **We** receive **Your Grievance**. However, if we cannot resolve **Your Grievance** within thirty (30) calendar days, **We** may extend the decision timeframe for up to another thirty (30) calendar days. If that happens, **We** will notify **You** in writing of the reason **We** need extra time and the date by which **We** will make a decision.

Expedited Grievance Procedure

Expedited Grievance Criteria: There may be times, when necessary due to an urgent medical need, **You** may need a faster response to **Your Grievance**. When that happens, **You** can file a **Grievance** and ask for it to be expedited.

You can ask for an **Expedited Grievance** when any of the following are true:

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

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

If **Your Grievance** is urgent and meets the **Expedited Grievance** criteria, **We** will investigate it as quickly as **Your** health condition requires. See Section 1: Definitions of this **Certificate** for more information about what qualifies as an **Expedited Grievance**.

Filing an Expedited Grievance: You, **Your Authorized Representative** or **Physician** can file an **Expedited Grievance** orally by calling **Us** at (800) 279-4000 (TTY 711). **You** can also file it in writing but **We** will be able to resolve it more quickly if **You** call.

Decision Timeframe: We will investigate, review and resolve **Your Expedited Grievance** within 72 hours of receiving it. **Our Grievance/Appeal** Manager will then call to inform **You** of **Our** decision and will also mail **You** a letter explaining **Our** decision.

Adverse Benefit Determination

A **Grievance** that involves an **Adverse Benefit Determination** is also known as an **Appeal**. The Standard and **Expedited Grievance** procedures described above apply to **Appeals**, but there are additional rules that also apply. They are as follows:

- **You** can ask for access to, and copies of, all documents, records, and other information relevant to **Your Appeal**. **We** must give **You** these copies free of charge.

- **You** can ask **Us** to identify any medical or vocational expert that **We** consulted when making **Our** initial **Adverse Benefit Determination**. **You** can ask regardless of whether **We** relied upon the expert's advice when **We** made **Our** decision.

- If **Your Appeal** is wholly or partially based on medical judgment, the **Grievance** Committee will consult with a health care professional who has appropriate training and experience. That training and experience must have been in the medical field involved in the medical judgment.
    - The health care professional will not be someone **We** consulted while making **Our** initial decision. It also will not be someone who works for that person.
    - Decisions based on medical judgment include, but are not limited to, whether a particular treatment, drug or other item is **Experimental**, **Investigational**, **Medically Necessary** or Appropriate.
- The **Grievance** Committee reviewing **Your Appeal** will not include anyone who:
    - Made the initial **Adverse Benefit Determination**; or
    - Works for any person who made the initial **Adverse Benefit Determination**.

- The **Grievance** Committee will consider all comments, documents, records and other information **You** submit with **Your Appeal**. It will do this regardless of whether **We** considered this information when **We** made **Our** initial decision.

- **Grievance** Committee members will be free to make an independent and impartial decision regarding **Your Appeal**.
    - We cannot make employment-related decisions for the people on the **Grievance** Committee based on the likelihood that they will support benefit denials.
        - Employment-related decisions include hiring, compensation, termination, promotion, or other similar matters.

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

- **We** will tell **You Our** decision as soon as possible, but no later than the following timeframes:
    - For a Pre-Service **Claim**, **We** will tell **You** in writing within thirty (30) calendar days after the date **We** get **Your Appeal**.
    - For a **Post-Service Claim**, **We** will make every effort to resolve **Your Appeal** and tell **You** in writing within thirty (30) calendar days after the date **We** get **Your Appeal**.
        - However, if **We** cannot resolve **Your Appeal** within thirty (30) calendar days, **We** may extend the decision timeframe for up to another thirty (30) calendar days.
        - If that happens, **We** will notify **You** in writing of the reason **We** need extra time, and the date by which **We** will make a decision.
    - For an **Urgent Claim**, **We** will notify **You** via telephone no later than 72 hours after **We** get **Your Appeal**. **We** will then mail **You** a written copy of **Our** decision letter.

Requesting an Independent External Review

If **You** are not satisfied with the outcome of **Your Grievance** or **Appeal**, **You** may have the right to seek an **Independent External Review**. There are two types of decisions that can be eligible for Independent External Review, an initial **Adverse Benefit Determination** and a **Final Adverse Benefit Determination**.

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

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

Independent External Review Criteria: You or **Your Authorized Representative** can ask for an Independent External Review when:

- The benefit at issue is otherwise covered under the **Plan**;
  AND
- The **Adverse Benefit Determination** or **Final Adverse Benefit Determination** was based on either of the following:
    - The use of medical judgment, including, but is not limited, to decisions about:
        - **Medical Necessity** and **Medical Appropriateness**;
        - Health care setting;
        - Level of care;
        - Effectiveness of a covered benefit;
        - A determination that a treatment is **Experimental** or **Investigational**;

        - A determination of whether a **Member** is entitled to a reasonable alternative standard for a reward under a wellness program; or
        - A determination of whether the **Plan** is complying with the nonquantitative treatment limitation requirements under federal mental health parity rules that require parity in the application of medical management techniques;
    - A **Rescission** of coverage, regardless of whether the **Rescission** had any effect on a particular benefit at the time the **Rescission** occurred.

AND

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

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

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

Standard Independent External Review Procedure

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

Initial Plan Review: When **We** get **Your** written request for an Independent External Review, **We** will review it to determine whether:

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

Within one (1) business day of completing **Our** initial **Plan** review, **We** will send to **You** written notification of the status of **Your** request.

- If **Your** request is incomplete, **We** will tell **You** what information or materials are needed to complete **Your** request, and by when **You** need to send them to **Us**.
- If **Your** request is complete but ineligible for Independent External Review, **We** will tell **You** why it is ineligible.
- If **Your** request is complete and eligible for Independent External Review, **We** will forward **Your** request to the **IRO**.

If **We** decide that **Your** request is eligible for Independent External Review, **We** will randomly assign an **IRO** from a list of **IRO**s approved by the Wisconsin Office of the Commissioner of Insurance (OCI) with whom **We** have contracted.

Within five (5) business days of receiving **Your** Independent External Review request, **We** will send to the **IRO** and copy **You**:

- **Your** written request;
- All supporting information **You** submitted to support **Your** request; and
- Any other relevant documents or information **We** used when deciding **Your Grievance** or **Appeal**.

IRO Review: When the **IRO** has received **Your** Independent External Review request it will do its own initial review. It will timely notify **You** of the results of its initial review, including the following information:

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

The **IRO** will review all of the provided information and documentation and inform both **You** and **Us**, in writing, of its decision.

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

Expedited Independent External Review Procedure

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

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

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

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

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

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

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

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

Requesting an Expedited Independent External Review: To ask for an **Expedited Independent External Review** of an Initial Benefit Determination, follow the process for filing an **Expedited Grievance** described above. In **Your** communication, tell **Us** that **You** want to go directly to **Independent External Review**.

To request an **Expedited Independent External Review** of a **Final Adverse Benefit Determination**, **You** must do it in writing. **You** can use any written format, such as a signed form or letter.

Initial Plan Review: When **We** get **Your** request, **We** will immediately review it to decide whether it meets the **Independent External Review** criteria. See the standard **Independent External Review** Initial **Plan** Review section for above for more information.

If **We** decide that **Your** request is eligible for **Independent External Review**, **We** will randomly assign an **IRO**. This process is described above in the standard **Independent External Review** Procedures section. We will then immediately, in the fastest way possible, send to the assigned **IRO Your** request for an **Expedited Independent External Review**. **We** will include all information and documentation **We** used to make **Our** initial decision, as well as any documentation or information **Your** provided with **Your** request.

IRO Review: Immediately upon receiving **Your** request for an **Expedited Independent External Review**, the **IRO** will review it to decide whether it meets the criteria for **Expedited Independent External Review**.

If the **IRO** decides that **Your** request does not meet the criteria for **Expedited Independent External Review**, it will return **Your** request back to **Us**. **We** will notify **You** if this occurs, and then review it using **Our** standard **Grievance** procedures. See the Standard **Grievance** Procedures section above for more information about this process.

If the **IRO** decides that **Your** request meets the criteria for **Expedited Independent External Review**, it will review all of the provided information and documentation and inform both **You** and **Us**, in writing, of its decision.

Decision Timeframe: The **IRO** must provide written notice of its decision as quickly as **Your** medical condition or circumstances require, but no later 72 hours of receiving **Your Expedited Independent External Review** request. If the **IRO** chooses to reverse **Our** decision, **We** will immediately provide coverage for the requested benefit, such as authorizing care or paying the disputed **Claim**.

Right to File a Complaint With OCI

You also have the right to file a **Complaint** with the Wisconsin Office of the Commissioner of Insurance (OCI). It is a state agency that enforces Wisconsin's insurance laws. **You** can file a complaint with OCI on its website at oci.wi.gov, or by writing to:

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

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

Legal Actions

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

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

SECTION 10: GENERAL PROVISIONS

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 **Plan** 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.

Premiums

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

Benefit Changes or Plan Termination

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

However, when termination is due to nonpayment by the employer, notice will also be given to the **Subscriber**. Notice to the **Subscriber** shall be deemed notice to all affected **Members**.

Statements by Our Employees or Agents

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

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

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

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

Entire Policy Contract and Changes

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

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

If there are any differences between the official **Policy** documents and any summaries **Your** employer gave **You**, the **Policy** documents will control.

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

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

Conformity with State Statutes

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

APPENDIX 1:
OPTIONAL ELIGIBILITY PROVISIONS

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

Note: Whenever the terms "**You**" or "**Your**" appear in these provisions, they refer only to an employee of the employer who purchased this group health insurance plan.

1.1 Domestic Partner Coverage

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

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

Definitions

The following definition is *added* to Section 1: Definitions.

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

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

Eligibility and Enrollment

In the entirety of the **Dependent Eligibility** portion of Section 6: Eligibility, Enrollment and Effective Date of Coverage of this **Certificate,** the language that currently refers to **Employee** or **Spouse** is revised to **include** "**Employee**, **Spouse** or **Domestic Partner**."

In Section 6: Eligibility, Enrollment and Effective Date of Coverage of this **Certificate**, the following section is *added*:

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

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

- The date **You** are eligible for coverage.
- The earliest date on which **Your** Domestic Partnership fulfilled all of the conditions described above. Subject to the terms of the special enrollment period provision of the **Certificate**.

In Section 6: Eligibility, Enrollment and Effective Date of Coverage, "Termination of Coverage**"** subsection of this **Certificate**, the following provision is *added*:

- When a Domestic Partnership ends, coverage for the **Domestic Partner** and his/her children will terminate on the last day of the month in which the Domestic Partnership ends.
    - A Domestic Partnership ends when relationship change causes the Domestic Partnership to no longer meet the definition of a Domestic Partner.

Surviving Dependent Continuation

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

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

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

The Domestic Partnership must have continuously met all of the requirements listed on **Our** *Designation of Domestic Partner* form during the three years before the covered **Employee** died. If requested, **You** must provide documented proof that these requirements were met.

1.2 Expanded Eligibility Options

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

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

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

If, while **You** and/or **Your Dependents** continue coverage provided for in any of these provisions, **You** and/or **Your Dependents** become eligible for Medicare Parts A and B, that individual should enroll for those benefits. This is because **We** will coordinate the benefits of this **Certificate** with the benefits payable by Medicare whether or not the individual actually enrolls. See Section 8: Coordination of Benefits of this **Certificate** for information about how **We** calculate benefits when this **Plan** is secondary.

Retired Employee Continuation

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

If **You** retire at age 55 or older while **You** are covered by this **Plan** as an **Active Status Employee**, **Your** coverage will continue under this provision as long as all of the following apply:

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

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

- If, however, **You** are enrolled as a **Dependent** of another **Active Status Employee** of **Your** employer, **You** will be considered to have had continuous coverage and be eligible to elect coverage under this Retired **Employee** Continuation period until **You** are no longer covered as a **Dependent** under another plan. **We** must receive **Your** election to continue coverage within 60 days of date **You** lose **Your** other coverage.

- If **Your** Retired **Employee** Continuation is subject to a Limited Duration provision, the duration of **Your** eligibility for Retired **Employee** Continuation will be calculated from the date you retire, not the date you elect Retired **Employee** Continuation.

If **You** continue coverage under this provision, the following rules will apply to **Your Dependents**:

- **Your Dependents** are eligible to continue coverage as long as **You** remain covered and they continue to qualify as **Dependents** under the **Plan**.

- If **You** acquire an eligible **Dependent** through marriage, birth of a child, or adoption or placement for adoption of a child, **You** may enroll **Your** new eligible **Dependents** if **We** receive the required enrollment form within 30 days of the date of the event.
- **You** may enroll **Your** eligible **Dependents** during **Your** employer's annual open enrollment period or any group open enrollment that applies to the class of **Eligible Employees** to which **You** belonged while **You** were working.

Retired Employee Continuation—Limited Duration

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

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

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

Retired Employee Spousal Continuation

This eligibility provision applies to Your coverage if Your Benefit Summary indicates "Retired Employee Spousal Continuation."

This provision provides that when a Retired **Employee**'s coverage ends due to Medicare eligibility, the Retired **Employee**'s **Spouse** can remain covered under this **Plan** until he or she becomes eligible for Medicare. The following rules apply to this coverage:

- **Your Spouse** must already be covered under this **Plan** when **You** lose coverage due to Medicare eligibility.
- **Your Spouse's Premium** must continue to be paid on time.
- **Your Spouse's** coverage under this **Plan** will end when he or she becomes eligible for Medicare, or otherwise loses eligibility for coverage under this **Plan**.

Retired Employee Continuation – Consecutive COBRA

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

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

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

Disabled Employee Continuation

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

If **You** become **Disabled** while covered under this **Certificate** as an **Active Status Employee**, **Your** coverage will continue for as long as **You** are **Disabled** and all of the following apply:

- **We** receive **Your** election to continue coverage under this option within 60 days of the date **You** become **Disabled**.
- **We** receive the required **Premiums** on time.
- **We** continue to insure the Active **Employees** in the occupational group within the class of **Eligible Employees** to which **You** belonged before becoming **Disabled**.
- **Your** employer permits all **Disabled** employees from **Your** class of **Eligible Employees** to continue coverage under this provision.

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

If **You** continue coverage under this provision, the following rules will apply to **Your Dependents**:

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

Disabled Employee Continuation—Limited Duration

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

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

Surviving Dependent Continuation

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

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

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

- **We** receive **Your Spouse's** election to continue coverage under this option within 60 days of **Your** date of death.
- **We** receive the required **Premiums** on time.
- **We** continue to insure the **Active Status** Employees in the occupational group within the class of **Eligible Employees** to which **You** belonged at the time of **Your** death.

- **Your** employer permits all surviving **Dependents** from **Your** class of **Eligible Employees** to continue coverage under this provision.

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

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

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

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

Surviving Dependent Continuation—Limited Duration

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

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

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

1.3 Waiver of Premium Benefit

Waiver of Premium Benefit

This eligibility provision applies to Your coverage only if Your Benefit Summary indicates "Waiver of Premium Benefit."

After a covered employee is **Disabled** for more than 60 continuous calendar days, **We** will waive the monthly **Premium** required for coverage of the covered employee and his or her covered **Dependent**(s). **We** will waive the **Premium** beginning on the first day of the month following 60 consecutive days of **Disability** until the earliest of the following dates:

- The date the covered employee ceases to be **Disabled**, as determined by **Us**.
- The date the covered employee becomes eligible for Medicare benefits.
- The date the covered employee dies.
- The date the covered employee fails to furnish proof satisfactory to **Us** of continued **Disability**.
- The date this plan terminates for **Your** employer for any reason.
- The date the covered employee ceases to be eligible for coverage under the terms of this **Certificate**.

Premium will be waived for a maximum of 30 months for any one Period of **Disability**.

Premium payments must be resumed beginning with the month in which the covered employee resumes his or her regular job duties as a member of the class of eligible employees specified by the employer.

Period of Disability means one continuous Period of **Disability** beginning on the covered employee's date of **Disability** as determined by **Us** or the prior insurer, if applicable, and ending on the date on which the covered employee dies or ceases to be **Disabled**. Successive Periods of **Disability** will be deemed to be the same Period of **Disability** unless:

- Due to an unrelated cause and separate by a return to the regular performance of job duties for the employer; or
- Due to the same or related cause by separated by a return to the regular performance of job duties for the employer for at least six (6) consecutive months.

The 60-day qualifying period referred to above must be satisfied only once for a Period of **Disability**. If a **Disabled** employee endeavors to resume work for the employer during a Period of **Disability**, the maximum period of **Premium** waiver will be extended. It will be extended by the number of days on which the covered employee works and for which resumed **Premium** payments are made.

To qualify for waiver of **Premium**, the employee must be under the regular care of a Physician. This means that:

- The employee is being seen by a Physician at intervals of time appropriate for treating the disabling impairment(s);
- The Physician is rendering and/or prescribing a pertinent treatment plan or a practical protocol, if one exists, for alleviating or eliminating the impairment(s) causing the **Disability**; **and**
- The employee is complying with all aspects of the Physician-prescribed treatment plan.

Waiver of **Premium** applies only to a covered employee who becomes **Disabled after** the effective date of this plan. There is one exception – a **Disabled** employee whose **Premium** is waived under the prior group health plan's waiver of **Premium** provision at the time this plan goes into effect may be eligible for waiver of **Premium**.

Waiver of **Premium** applies only to the type of coverage (single or family) in effect for the covered employee on the date of **Disability**, or in effect on the date this plan replaces the prior group health plan.

Waiver of **Premium** does not apply to a covered employee who was not **Disabled** at the time of his or her retirement and who is covered under either the "Retired **Employee** Continuation," or the "Retired **Employee** Continuation – Limited Duration" optional eligibility provision.

As part of the Waiver of **Premium** Benefit, eligibility criteria for **Disabled** employees are added to Section 6: Eligibility, Enrollment and Effective Date of Coverage of the **Certificate**. A **Disabled** employee whose **Premium** is waived under the prior group health plan's waiver of **Premium** provision may be eligible to enroll in this plan.

In Section 6: Eligibility, Enrollment and Effective Date of Coverage of the **Certificate** of the **Certificate**, a "**Disabled Employee** Eligibility" provision is inserted after "**Employee** Eligibility" as follows:

Employee Eligibility

…

Disabled Employee Eligibility

An employee is eligible for Coverage on the date this plan takes effect for **Your** employer only if **all** of the following apply:

- **You** belong to the class of eligible employees specified by **Your** employer under this **Certificate**.
- **You** are **Disabled** on the date this plan takes effect.
- **You** are covered under the group health plan being replaced by this plan under a waiver of **Premium** provision due to **Your** own **Disability**.

Your coverage will begin on the date this plan takes effect if **We** receive **Your** enrollment form within 30 days of that date.

Dependent Eligibility

…

Limited Waiver of Premium Benefit

This eligibility provision applies to Your coverage only if Your Benefit Summary indicates "Limited Waiver of Premium Benefit."

This provision is the same as the "Waiver of **Premium** Benefit" provision, with one exception:

- **Premium** will be waived for a maximum of 12 months, rather than 30 months, for any one Period of **Disability**.

APPENDIX 2:
OPTIONAL BENEFIT PROVISONS

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

Remember that **We** cover some health care services only if **You** receive **Prior Authorization** in advance of obtaining the service. See **Our** website, weatrust.com, for a list of services that require **Prior Authorization**.

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

2.1: Global Office Visit Benefit

This benefit provision applies to Your coverage only if Your Benefit Summary indicates "Global Office Visit Benefit."

This benefit provision modifies Section 2: General Provisions That Apply to All Benefits. This provision is inserted in between the subsections entitled "**Cost-Sharing Amounts**: **Deductibles**, **Coinsurance** and **Copayments**" and "Maximum Out-of-Pocket Limit."

Reduced Cost-Sharing for In-Network Office Visits and Other In-Network Services

We will not apply the **Deductible** or a **Coinsurance** amount to any covered office visit with an **In-Network Provider**. **You** are responsible for the In-Network office visit **Copayment** amount identified on **Your Benefit Summary**.

We will not apply the **Deductible** or a **Coinsurance** or **Copayment** amount to covered In-Network laboratory, ultrasound or x-ray services provided up to seven (7) calendar days before or seven (7) calendar days after the date of an **In-Network Provider** office visit. **You** will only be responsible for paying the **Copayment** amount identified on **Your Benefit Summary**.

Note: This benefit does not apply to routine maternity care services.

2.2: Extraction/Replacement of Natural Teeth

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

In addition to the dental services described in Section 3: Medical Benefits of this **Certificate**, this **Plan** covers the extraction of natural teeth.

This **Plan** also covers the following services if **You** get them within 18 months of the date **Your** natural teeth were extracted:

- The initial replacement of the extracted natural teeth.
- The replacement of previously existing fixed bridgework if replacement is required due to the extraction of one or more natural teeth that are:
    - Adjacent to the fixed bridgework, or
    - Abutment teeth supporting the existing bridgework.
- The replacement of previously existing partial removable dentures:
    - If replacement is required due to the extraction of one or more natural teeth, and
    - The existing partial denture is no longer serviceable and cannot be made serviceable.

The exclusion in Section 3: Medical Benefits of the **Certificate** under "Dental Services" for the "Extraction or replacement of natural teeth required because of disease or decay" does not apply to **You**.

2.3: Vision Examination Benefit

Vision Examination Benefit

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

In addition to the vision services described in the Medical Benefits Section, this **Certificate** covers one complete routine examination of **Your** eyes and related structures during each Benefit Period. It also covers one refraction, regardless of diagnosis.

The routine examination, to evaluate a new or existing visual condition, must be performed by a licensed optometrist. The examination may include a patient history, an internal ophthalmoscopic examination, biomicroscopy, and tonometry.

Refraction, or determination of refractive status, means the quantitative procedure that yields the refractive data needed to determine **Your** best visual acuity with lenses and to prescribe lenses.

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

Enhanced Vision Examination Benefit

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

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

- The examination to evaluate a new or existing visual condition may also be performed by an ophthalmologist; and
- **Deductible**, coinsurance, and copayment amounts do not apply to this benefit.

2.4 Erectile Dysfunction Benefit

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

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

2.5: Drug Plan Amendment for Medicare Part D Eligible Individuals

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

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

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

In Section 5: General Exclusions and Limitations, in the "General Exclusions and Limitations: Non-Medical" subsection, under "Services, Treatments and Supplies," the exclusion regarding **Prescription Drugs** covered under Medicare Part D is deleted and replaced with the following:

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

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

. . .

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

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

- If **You** are eligible to enroll in the Medicare Part D drug program but do not enroll, **We** do not cover **Prescription Drugs** or medications, regardless of where **You** get them
    - This rule does not apply to the following individuals:
        - Active-Status **Employees** and their covered **Dependents**.
        - Members covered by **Our** standard **Family Plan**.
        - **Members** who continues coverage under any of the Expanded Eligibility Options.
        - Members covered under state and federal continuation (COBRA) coverage, unless they choose to waive **Prescription Drug** coverage under this **Plan**.
        - Members for whom this plan is the primary insurer under Medicare Secondary Payer rules.

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

