WEA Trust

Individual
Long Term Care Plan

A WEA Insurance Corporation
Insurance Policy

THE WISCONSIN INSURANCE COMMISSIONER HAS ESTABLISHED MINIMUM STANDARDS FOR LONG TERM CARE INSURANCE.

THIS POLICY MEETS THOSE STANDARDS. THIS POLICY COVERS CERTAIN TYPES OF NURSING HOME AND HOME HEALTH CARE SERVICES. THERE MAY BE LIMITATIONS ON THE SERVICES COVERED. READ YOUR POLICY CAREFULLY.

FOR MORE INFORMATION ON LONG TERM CARE, SEE THE "GUIDE TO LONG TERM CARE" GIVEN TO YOU WHEN YOU APPLIED FOR THIS POLICY. THIS POLICY'S BENEFITS ARE NOT RELATED TO MEDICARE.

IC LGL 3202-255-0105

Important Notice

(Keep these notices with your insurance papers)

Problems with your insurance?

If you are having problems with WEA Insurance Corporation, do not hesitate to call or write us to resolve your problem. The address and phone number are:

WEA Insurance Corporation
P.O. Box 64904
St. Paul, MN 55164-0904
(888) 564-3473

You may also write the ***OFFICE OF THE COMMISSIONER OF INSURANCE***, a state agency that enforces Wisconsin's insurance laws, and file a complaint. The address is:

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

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

Right to Return and Cancel Policy

Read this policy carefully. It is a legal contract. If you are not satisfied for any reason with the terms of this policy, then you may return the policy within 30 days of the date the policy was delivered, whether by mail or in person, and we will refund the full premium.

IMPORTANT NOTICE CONCERNING STATEMENTS IN THE APPLICATION FOR YOUR INSURANCE

Please read the copy of the Application attached to this notice or to your policy. Omissions or misstatements in the Application could cause an otherwise valid claim to be denied. Carefully check the Application and write to us within 10 days if any information shown on the Application is not correct and complete or if any medical history has not been included. The Application is part of the insurance contract. The insurance contract was issued on the basis that the answers to all questions and any other material information shown on the Application are correct and complete.

WEA Trust
Individual Long Term Care Plan

Tax-Qualified Long Term Care Insurance Policy
Underwritten by WEA Insurance Corporation

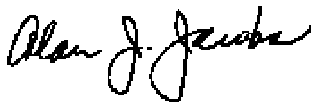
This policy is intended to be a tax-qualified long term care insurance policy under Section 7702B(b) of the Internal Revenue Code of 1986 (as amended by the Health Insurance Portability and Accountability Act of 1996–Public Law 104–191).

This policy is guaranteed renewable for life. You have the right, subject to the terms of this policy, to continue it as long as you pay the required premiums on time. Your premiums will not increase during the initial 3 years your coverage is in force. We will not change any of the terms of your policy without your permission, except that in the future we may change your premiums if we do so for all policyholders with coverage similar to yours, or make changes to stay compliant with the law. We will not change your premiums solely due to a change in your age or health. If we change your premiums, we will give you at least 60 days' notice. Any premium changes will be effective on the anniversary of your Original Coverage Effective Date. Your Original Coverage Effective Date is specified on your Benefit Summary.

This policy may not cover all of the costs you may incur for Long Term Care. Your benefits are subject to a Maximum Daily Benefit and a Maximum Lifetime Benefit, depending on the benefit levels you purchase.

The WEA Insurance Corporation hereby agrees to provide benefits in accordance with all of the provisions, exclusions, and limitations of this policy.

WEA Insurance Corporation
Madison, Wisconsin



Alan J. Jacobs, President

Michael L. Stoll, Vice President

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Section 1

Your Rights and Responsibilities

This section tells you about your right to return or terminate this policy and your right to renew your coverage if premiums are paid on time. It also tells you when premiums are due, what happens if you don't pay premiums when due, and when we waive premium as a result of your qualification for benefits.

General Information About This Policy

This policy is intended to be a tax-qualified long term care insurance policy under Section 7702B(b) of the Internal Revenue Code of 1986 (as amended by the Health Insurance Portability and Accountability Act of 1996—Public Law 104-191).

This is an indemnity insurance policy. This policy provides reimbursement for a portion of the actual covered expenses you may incur, while Chronically Ill, for Long Term Care services received in an institutional, community-based, or home care setting. This policy may not cover all of the costs you may incur. Your benefits are subject to a Maximum Daily Benefit and a Maximum Lifetime Benefit, depending on the benefit levels you purchased. We strongly encourage you to review all policy provisions and limitations carefully. To be eligible for benefits, you must be either:

- Unable to perform the requisite number of Activities of Daily Living without assistance, ***or***
- Have a Severe Cognitive Impairment.

Your inability to perform the Activities of Daily Living must be expected to last for at least 90 days.

This policy is not a Medicare Supplement Policy. If you are eligible for Medicare, review the Guide to Health Insurance for People With Medicare, which is available from us.

If you have any questions about the benefits or requirements of this policy, call us at (888) 564-3473.

Right to Return and Cancel Policy

Read this policy carefully. It is a legal contract. If you are not satisfied for any reason with the terms of this policy, then you may return the policy within 30 days of the date the policy was delivered, whether by mail or in person, and we will refund the full premium.

Guaranteed Renewable

This policy is guaranteed renewable for life. You have the right, subject to the terms of this policy, to continue it as long as you pay the required premiums on time. Your premiums will not increase during the initial 3 years your coverage is in force. We will not change any of

the terms of your policy without your permission, except that in the future we may change your premiums if we do so for all policyholders with coverage similar to yours, or make changes to stay compliant with the law. We will not change your premiums solely due to a change in your age or health. If we change your premiums, we will give you at least 60 days' notice. Any premium changes will be effective on the anniversary of your Original Coverage Effective Date. Your Original Coverage Effective Date is specified on your Benefit Summary.

When Premiums Are Due

Your first premium is due on your Original Coverage Effective Date. You must pay subsequent premiums on or before the date they are due. Your Benefit Summary shows the method you have chosen to pay your premiums. You may change your method of paying premiums once a year by notifying us in writing. The change will take effect 30 days after we receive your notice.

Grace Period

We will allow a grace period of 65 days. This means that if you do not pay a premium on or before the date it is due, you may pay it during the following 65 days. We will continue your coverage during the grace period unless you have advised us in writing that you wish to terminate your coverage before the end of the grace period. If the premium remains unpaid at the end of the grace period, your coverage will terminate at the end of the period for which the last premium was paid.

Notification of Nonpayment

If your premium remains unpaid 30 days after it was due, we will send a notice of termination to you and your chosen designee. This notice of termination will be sent by first class mail at least 35 days in advance of termination and will state the amount of unpaid premium, the date by which it must be paid, and the date the coverage will terminate. We will consider you and your designee to have been notified 5 days after the date we mailed the notice. If the premium remains unpaid on the termination date stated in the notice, your coverage will terminate as of the end of the period for which the last premium was paid.

You may designate a person to receive the notice or change the designated person at any time by notifying us in writing of the name and address of your designee.

Protection Against Unintentional Lapse

Normally, if premium is not timely paid, your coverage will terminate on the last day of the period for which premium has been paid. However, we will retroactively reinstate coverage if ***both*** of the following conditions are met within 5 months of the date coverage terminated:

1. You, or someone on your behalf, submits a written request for reinstatement that includes evidence demonstrating to our satisfaction that your failure to make timely payment of premium was caused by the fact that you were Functionally Incapacitated or had a Severe Cognitive Impairment at the time your premium payments were due.
2. You or someone on your behalf pays the full retroactive premium due.

If these conditions are met, we will retroactively reinstate your coverage. We will also consider any claim for benefits that you incurred during the period of lapse, subject to all other policy provisions.

Reinstatement

If your coverage is terminated for nonpayment of premium and you do not qualify for the "Protection Against Unintentional Lapse" provision above, you may apply for reinstatement by writing to us. You will be asked to complete an Application for reinstatement. We must receive your completed reinstatement Application within

one year after the end of the grace period. We have the right to require evidence of insurability that we, in our sole discretion, deem satisfactory. You will be required to pay the cost of any records that may be necessary to provide this evidence.

If we approve your Application for reinstatement, you must pay the required retroactive premium. We will then reinstate your coverage retroactively to the date your coverage was terminated. In all other respects, you will have the same rights under the policy as you had prior to the date your coverage was terminated due to nonpayment of premium.

We have the right to decline a request for reinstatement of coverage.

Any premium accepted in connection with a reinstatement will be applied to the period for which premium was not previously paid. Acceptance of premium by our employee or agent does not guarantee your reinstatement Application will be approved.

Changes in Premium Rates

Your premiums will not change solely because of a change in your health or age.

If we increase premium rates, we will notify you at least 60 days in advance. Such changes will be made only on an anniversary of your Original Coverage Effective Date and only if we change premiums for all policyholders with coverage similar to yours.

Your Options if Premium Rates Change

If premium rates are increased, you will have the option of maintaining your current benefits at the increased premium rate or electing a decrease in coverage to an amount we offer that maintains or reduces your current premium. The procedure for decreasing coverage is described in Section 3.

If you do not notify us otherwise within 30 days of receiving our notice of an increase in premiums, you will have elected to maintain your current benefit amount at the increased premium rate.

Unpaid Premiums

When we pay a claim, we will deduct any premium that is due and unpaid.

Waiver of Premium

After you have met the qualification for benefits criteria described in Section 4 and satisfied your Elimination Period, we will waive your premiums. To qualify for this waiver of premium, you must remain Chronically Ill throughout your entire Elimination Period. We will waive premiums beginning on the first of the month following the completion of your Elimination Period. Any premium amounts you have paid for coverage beyond the date this waiver begins will be refunded or credited. The premium will be waived until the ***earlier*** of the following dates:

- The date you cease to be Chronically Ill.
- The date you fail to furnish proof satisfactory to us of continued Chronic Illness.

Premium liability will resume on the first of the month following the date on which waiver of premium ceased.

Refund of Premiums Paid Beyond Your Death

If you die while this policy is in force, we will refund the unearned portion of any premium paid to your estate or to whomever we consider to be legally entitled to receive it. We will make this refund within 30 days after we receive notification and proof of your death.

Your Right to Terminate

You may terminate this policy at any time by sending us written notice. We must receive your request to terminate at least 30 days before the requested termination date. We will promptly return the unearned portion of any premium paid.

Clerical Errors

If we make an error, we have the right to correct it. We have this right whether we have made the error in calculating your premium or benefits, in increasing, reducing, or ending your coverage, or in any other aspect of our contract of insurance with you. If we find an error, or if you call one to our attention, we will adjust premiums, benefits, and terms of your insurance coverage accordingly, based on the facts and the provisions of this policy.

Statements by Our Employees or Agents

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

Entire Contract

The entire contract of insurance consists of:

1. This policy.
2. Your Benefit Summary.
3. Optional benefits, if any, that apply to your coverage. Your Benefit Summary indicates any applicable optional benefits.
4. Any amendments, riders, or endorsements we have issued.
5. Your Application, including evidence of insurability.

Changes in the Policy

No change in this policy is effective until you accept the change in writing, with the following exceptions:

- A change in premiums. This exception does not include an increase in benefits or coverage with an accompanying increase in premium.
- A change required by law or regulation.
- A change that does not reduce or eliminate benefits or coverage.

A change (except for an increase in benefit levels resulting from an inflation protection optional benefit that applies to your coverage) will apply only to a period of Chronic Illness that begins after the date of the change.

Conformity With State and Federal Statutes

Any provision of this policy that conflicts with the applicable statutes of Wisconsin or applicable federal laws regulating tax-qualified long term care insurance is hereby amended to conform to the minimum requirements of such laws. The effective date of any such required amendment will be the latest date permitted by those laws.

Section 2

Definitions That Apply to All Provisions

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

Activities of Daily Living (ADLs) are Bathing, Continence, Dressing, Eating, Toileting, and Transferring, as defined here:

Bathing means washing yourself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower, without Substantial Assistance from another person.

Continence means the ability to maintain control of bowel and bladder function or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for a catheter or colostomy bag, without Substantial Assistance from another person.

Dressing means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs without Substantial Assistance from another person. You will be considered able to dress yourself even if these tasks can only be performed by using modified clothing or adaptive devices such as tape fasteners or zipper pulls.

Eating means feeding yourself by getting food into your body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously without Substantial Assistance from another person. You will be considered able to eat even if you require assistance preparing or serving the food, such as cutting food or opening cartons.

Toileting means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene without Substantial Assistance from another person.

Transferring means the ability to move into or out of a bed, chair, or wheelchair without Substantial Assistance from another person. You will be considered able to transfer even if you use or require equipment such as canes, quad canes, walkers, crutches, grab bars, or other support devices, including mechanical or motorized devices, in order to transfer or ambulate.

Adult Day Care means assistance in the performance of the Activities of Daily Living, or Substantial Supervision, provided to a Chronically Ill individual in an Adult Day Care Center by appropriately trained and/or licensed persons through an individual program of health, social, custodial, and related support services that are appropriate to the needs of the individual.

Adult Day Care Center means a facility that meets ***all*** of the following criteria:

- The facility provides a program of Adult Day Care in an organized, nonresidential setting, and providing the program is its primary function.

- The Adult Day Care program is provided at least 5 days a week for a minimum of 6 hours and a maximum of 12 hours each day, to 3 or more unrelated adults who require assistance in the Activities of Daily Living or Substantial Supervision.
- The facility is established, licensed, and operated as an Adult Day Care Center in accordance with all applicable laws of the state in which it is located, or is approved by us in our sole discretion.

Alternate Care Facility means a residential facility that we have approved and that meets ***all*** of the following criteria:

- The facility provides care, treatment, or services to 5 or more unrelated Chronically Ill adults.
- The services provided are above the level of room and board, but less than the level required to be licensed as a nursing home.
- The facility provides general supervision and assistance with Activities of Daily Living on a 24-hour basis for those who cannot perform the Activities of Daily Living for themselves.
- Its supervisory personnel are trained in the techniques and aspects of caring for Chronically Ill individuals.
- It has a trained, awake, and ready-to-respond employee on duty in the facility at all times to provide care.
- It provides supportive services such as meals.
- It has appropriate measures and procedures to provide onsite assistance with prescription medications.
- The facility maintains patient care records, including the plan of care and the name and location of the personal physician for each resident.
- It has formal arrangements for the services of a physician or nurse to furnish medical care in case of emergencies.
- The facility is established, licensed, and operated in accordance with all applicable laws of the state in which it is located, or approved by us in our sole discretion.

An Alternate Care Facility may include, but is not limited to, the following facilities if all of the above requirements are met: community-based residential facilities, assisted living facilities, or residential care facilities for the elderly.

Application means the written application form(s) provided by us and completed by you when you apply for coverage.

Assessment means an evaluation done by a Licensed Health Care Practitioner to determine or verify that you are Chronically Ill. The Assessment uses generally accepted tests and instruments that use objective measures and produce verifiable results.

Chronically Ill or ***Chronic Illness*** means that within the 12-month period immediately preceding the application for benefits, you have been certified by a Licensed Health Care Practitioner and verified by us to have either a Functional Incapacity or a Severe Cognitive Impairment.

Custodial Care means care that can generally be provided by persons without professional medical training or skills and that is primarily for one or more of the following purposes:

- Maintaining an individual's existing physical or mental condition of health.
- Preserving an individual's condition from further decline.
- Assisting an individual in performing the Activities of Daily Living.
- Protecting an individual from threats to health and safety due to Severe Cognitive Impairment.
- Meeting an individual's personal needs.

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

Domestic Partner means an individual with whom you have agreed to live as sole domestic partners in a relationship that is characterized by all of the following:

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

Elimination Period means the number of days you are a Chronically Ill individual, as confirmed by us, before you are eligible to receive benefits. The Elimination Period is the period of consecutive days, specified on the Benefit Summary, for which no benefits will be paid under this policy even though you have satisfied all other requirements for receipt of benefits. You must remain Chronically Ill for each consecutive day to satisfy the Elimination Period. The Elimination Period begins, at the earliest, on the date a Licensed Health Care Practitioner, after assessing your condition, signs a certification verifying that you are a Chronically Ill individual due to either Functional Incapacity or Severe Cognitive Impairment. You must meet the Elimination Period only once in your lifetime.

Functional Incapacity means the inability to perform, without Substantial Assistance from another person, 3 or more Activities of Daily Living, defined above, as a result of physical or cognitive impairment(s).

Home Health Care means part-time or intermittent health care services or assistance with the Activities of Daily Living, provided through a Home Health Care Agency to a Chronically Ill individual in his or her home under a Plan of Care established and reviewed at appropriate intervals by a Licensed Health Care Practitioner, and approved by us in writing. Home Health Care may include any of the following:

- Home nursing care by or under the supervision of a registered nurse.
- Home health aide services under the supervision of a registered nurse or medical social worker.
- Homemaker services.
- Nutritional counseling provided by or under the supervision of a registered or certified dietician.
- Physical, respiratory, occupational, or speech therapy.

Home Health Care Agency means an agency or organization that meets ***all*** of the following criteria:

- It is state-licensed or Medicare-certified to provide coordinated Home Health Care, or is approved by us in our sole discretion.
- Its primary function is to provide Home Health Care.
- It is established and operated in accordance with all applicable laws of the state in which it is located.
- It maintains complete and accurate patient care records for each patient.
- It employs one or more physicians or registered nurses.

Hospice Care means palliative and supportive care provided to a Terminally Ill individual by a state-licensed or Medicare-approved program, agency, or organization. Hospice Care includes services provided by a licensed public agency or private organization intended primarily to provide pain relief, symptom management, and psychosocial support services. Services may be rendered at a Hospice Care Facility or in the individual's place of residence.

Hospice Care Facility means a state-licensed facility in which Hospice Care services are provided to Terminally Ill individuals. A Hospice Care Facility may be housed within a structure in which other services are provided (for example, a hospital or a Nursing Facility) or it may be a freestanding unit.

Immediate Family means your spouse or Domestic Partner, and anyone who is related to you or your spouse or Domestic Partner (including adopted, in-law and step-relatives) as a parent, grandparent, child, grandchild, brother, sister, aunt, uncle, first cousin, nephew, or niece.

Intermediate Nursing Care means basic care, including physical, emotional, social, and other rehabilitative services, provided under periodic medical supervision. This type of nursing care requires the skill of a registered nurse in the administration (including the observation and recording of reactions and symptoms) and supervision of the nursing care, and provides a planned, continuous program of nursing care that is preventive or rehabilitative in nature. The level of skill required and the nature of the nursing care provided are less than that required and provided for Skilled Nursing Care, but greater than that required and provided for Custodial Care.

Irreversible Dementia means deterioration or loss of intellectual faculties, reasoning, power, memory, and will due to organic brain disease characterized by confusion, disorientation, apathy, and stupor of varying degree which is not capable of being reversed and from which recovery is impossible.

Licensed Health Care Practitioner means a physician or a registered professional nurse, a licensed or certified social worker, or other individual who meets the federal definition of a Licensed Health Care Practitioner required for tax-qualified long term care insurance plans. We will verify that your Licensed Health Care Practitioner is qualified to make an Assessment of, and certify, a Functional Incapacity or Severe Cognitive Impairment and establish an appropriate Plan of Care to meet Long Term Care needs.

Long Term Care means care or services provided to a Chronically Ill individual for which a charge is made, pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner and approved by us, that are necessary to either assist or enable the individual to successfully perform the Activities of Daily Living, or protect the individual from threats to health and safety due to Severe Cognitive Impairment.

In this policy, Long Term Care includes Skilled Nursing Care, Intermediate Nursing Care, Custodial Care, Home Health Care, Adult Day Care, Hospice Care, Respite Care, and care that we have approved under an alternate care plan. Such care or services must be provided in a Nursing Facility, in an Alternate Care Facility, in your residence by a Home Health Care Agency, in an Adult Day Care Center, or in a Hospice Care Facility.

Maximum Daily Benefit is the total amount of benefits that will be paid for Long Term Care you receive under this policy in one day. The Benefit Summary specifies the amount of your Maximum Daily Benefit.

Maximum Lifetime Benefit is the total amount of benefits that will be paid for Long Term Care you receive under this policy during your lifetime. The Benefit Summary specifies the amount of your Maximum Lifetime Benefit.

Nursing Facility means a facility other than a hospital that meets all of the following criteria. It is:

- Primarily engaged in providing 24-hour continuous nursing care and related services, including room and board, on an inpatient basis.
- Established and operated in accordance with all applicable laws of the state in which it is located.

- Licensed or certified in the state in which it is operating to provide Skilled Nursing Care, Intermediate Nursing Care, or Custodial Care, or approved by us in our sole discretion.

A Nursing Facility may be a freestanding facility, including a skilled nursing facility, an intermediate nursing care facility, a convalescent nursing facility, a custodial care facility, and an extended care facility. It may also be a distinct part of a facility, including a ward, wing, or unit of a hospital or other institution.

Nursing Facility does not include a hospital or any of the following:

- An institution operated primarily for the treatment and care of mental health disorders, drug abuse, or alcoholism.
- A facility that provides only room and board.
- A facility that primarily provides residential or retirement services.
- A private home or apartment.

Nursing Facility Care means care or treatment received in a Nursing Facility. In this policy, Nursing Facility Care includes Skilled Nursing Care, Intermediate Nursing Care, and Custodial Care.

Optional Benefit Effective Date means the date an optional benefit provision takes effect for you. Optional Benefit Effective Dates, if any, that apply to your coverage are specified on your Benefit Summary.

Original Coverage Effective Date means the date your coverage under this policy begins.

Plan of Care means a written individualized plan of services, prescribed by a Licensed Health Care Practitioner and approved by us, that specifies your Long Term Care needs; the type, frequency, and providers of the services appropriate to meet those needs; and the costs, if any, of those services. We require that the Plan of Care be modified to reflect changes in your functional or cognitive abilities, your social situation, and your care needs.

Respite Care means either nursing or custodial care that is necessary to assist the Chronically Ill individual with the Activities of Daily Living, or to protect a Chronically Ill individual with a Severe Cognitive Impairment from threats to health and safety. Respite Care is provided on a temporary, substitute basis, to enable the regular caregiver, who must live with the Chronically Ill individual, to take a rest or vacation from providing care. Respite Care is limited to the number of days specified on your Benefit Summary for each calendar year. It may be provided by nonlicensed providers or by members of your Immediate Family.

Severe Cognitive Impairment means a loss or deterioration in intellectual capacity that has been demonstrated by clinical evidence and standardized tests that reliably measure impairment in short-term or long-term memory; orientation as to people, places, or time; and deductive or abstract reasoning; ***and*** that is comparable to Alzheimer's disease and similar forms of Irreversible Dementia.

Skilled Nursing Care means care furnished on a physician's orders that is available 24 hours a day, that requires the skills of professional personnel such as a nurse, and that is provided either directly or indirectly by or under the supervision of such personnel.

Substantial Assistance means one or both of the following:

- The physical assistance of another person without which the Chronically Ill individual would be unable to perform the Activities of Daily Living. This is referred to as "hands-on assistance."
- The presence of another person within arm's reach of the Chronically Ill individual that is necessary to prevent, by physical intervention, injury to the Chronically Ill individual while he or she is performing an Activity of Daily Living. This is referred to as "standby assistance."

Substantial Supervision means continual supervision (which may include cuing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the Severely Cognitively Impaired individual from threats to his or her health or safety (such as may result from wandering).

Terminally Ill means having 6 months or less to live, as determined by a physician.

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

- Any time the words "***you***," "***your***," or "***yourself***" appear in this policy, they refer to the policyholder, the individual named on the Benefit Summary, who is covered by the policy.
- Any time the words "***we***," "***us***," or "***our***" appear in this policy, they refer to the WEA Insurance Corporation.

Section 3

Eligibility, Coverage, and Changes in Coverage

This section describes the individuals who are eligible for coverage under this policy. It explains when coverage begins, when coverage ends, and how to increase or decrease coverage.

Who Is Eligible for Coverage

The following individuals are eligible to apply for coverage under this policy provided they are residents of Wisconsin at the time they purchase this policy:

1. Employees and retirees of Wisconsin employers that have a collective bargaining relationship with an affiliate of the Wisconsin Education Association Council (WEAC). Examples of such employers are public school districts, technical colleges, and CESA districts.
2. WEAC members who are employed by, or retired from, Wisconsin employers such as public school districts, technical colleges, and CESA districts.
3. Employees of WEAC and WEAC affiliates, the WEA Property and Casualty Insurance Company, and the WEA Insurance Corporation.
4. Spouses and Domestic Partners of the individuals in 1, 2, and 3 above.
5. Adult children of the individuals in 1, 2, and 3 above. Children include biological children, adopted children, stepchildren, and legal wards.
6. Parents and parents-in-law of the individuals in 1, 2, and 3 above.

Your Application for Insurance

All statements you make for obtaining insurance are considered true and complete to the best of your knowledge and belief. These statements are representations and not warranties.

Evidence of Insurability

To obtain coverage under this policy and to increase or add to your coverage, you will be required to provide evidence of insurability that we, in our sole discretion, deem satisfactory. You must provide this evidence of insurability in a form and manner specified by us.

Coverage Based on Evidence of Insurability

When we make decisions about coverage based on evidence of insurability, we rely on the accuracy and completeness of the information submitted. We monitor all claims for 2 years following our approval. If, during that period, we learn that the information we relied on was incorrect, or relevant information was omitted, we may rescind coverage and deny claims, as described below:

- If coverage has been in force for less than 6 months, we may retroactively rescind coverage and deny otherwise valid claims if the omission or inaccuracy is material to our coverage decision.

- If coverage has been in force for at least 6 months but less than 2 years, we may retroactively rescind coverage and deny otherwise valid claims if the omission or inaccuracy is both material to our coverage decision and related to the condition for which benefits are sought.
- If coverage has been in force for 2 years or more, we will not contest coverage unless you knowingly and intentionally misrepresented relevant facts relating to your health.

When Coverage Begins

Your initial coverage under this policy will begin on the first day of the month following our approval of your Application for insurance, provided you pay the required premium. This day is specified on your Benefit Summary as the Original Coverage Effective Date.

If you increase or decrease your coverage, as provided below, we will send you a new Benefit Summary showing the change in coverage and the date the change is effective.

Pre-Existing Conditions

We will not reduce or deny any claim under this policy because of a sickness or physical or medical condition that existed before the Original Coverage Effective Date.

When Coverage Ends

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

1. The end of the period for which the last premium was paid for your coverage if the amount due is not received within the grace period.
2. The date on which you exhaust your Maximum Lifetime Benefit.
3. The date coverage ends pursuant to your request.
4. The date of your death.

Misstatement of Age

If your age was misstated in your Application, we will adjust your premium to the correct amount for your insurance at your correct age as of your Original Coverage Effective Date. The amount of insurance will not be affected, provided that any necessary adjustment in premium is made.

Increases in Coverage

You may request an increase in your coverage, at any time, to an amount that we offer. You will be required to provide a written Application and evidence of insurability that we, in our sole discretion, deem satisfactory. Evidence of insurability must be provided in a form and manner specified by us. If we approve your Application, the premium for the increased coverage will be based on your age as of the date the increase in coverage becomes effective. Premium for previously purchased coverage will not be affected.

When Increases in Coverage Become Effective

If, within 60 days of your Original Coverage Effective Date, you make written Application to increase coverage and we approve your Application, the change will be effective as of the Original Coverage Effective Date. If you make written Application to increase coverage after that time and we approve your Application, the change will be effective on the first of the month following the date of our approval.

You May Decrease Your Coverage

After one year from your Original Coverage Effective Date, you may reduce your future premiums by changing to a lower coverage amount that we offer. We reserve the right to determine what represents a decrease in coverage. The decrease in coverage will take effect on the first day of the month following receipt of your written request if we approve your request as a decrease in your coverage.

The premium for the reduced coverage will be based on your original issue age for the reduced coverage.

If you request a change to an amount that represents a decrease in coverage, you will not be required to provide evidence of insurability.

If your premiums are increased, or if your coverage is about to lapse, we will again notify you of your right to reduce coverage.

Upgrade Privilege

We will notify you of any new benefits or provisions that become available in the future that are not included in your policy, provided you are not currently receiving benefits. You will have the opportunity to obtain the new benefits or provisions that become available within 12 months of their availability. If you wish to obtain the new benefits and/or provisions, you will be required to provide a written Application and evidence of insurability that we, in our sole discretion, deem satisfactory. You must provide this evidence of insurability in a form and manner specified by us. If we approve your Application, we will recognize your past insured status by granting a premium credit of an amount determined by us. New benefits and/or provisions for which we approve your Application will take effect on the first day of the month following the date of our approval.

Group Plan Paid-Up Feature Credit

You will accrue credit toward the paid-up feature of a WEA Trust Group Long Term Care Plan (Group Plan), pursuant to the provisions below, in the event you become eligible for, and are enrolled in, such a Group Plan after your coverage under this plan has been in effect for at least one month.

Note: The Group Plan has its own criteria for eligibility, and being covered by this policy does not satisfy those criteria or guarantee that you will meet the eligibility criteria of the Group Plan.

What Is the Value of This Feature?

The WEA Trust Group Plan provides an opportunity to qualify for paid-up long term care insurance. This means that if certain conditions are met, Group Plan coverage will continue, until death, without further premium payments.

To qualify for Group Plan paid-up coverage, you must be covered by a Group Plan that includes the paid-up feature as part of the coverage. You will owe no further premiums for coverage under the Group Plan beginning on the date that ***all*** of the following conditions are met:

1. You are at least 65 years old.
2. You are retired.
3. Premiums have been paid by you or on your behalf for at least 360 months. Months of credit you have received for premium payment under this policy (described below under “How Does This Feature Work?”) will count toward the 360 months. Months during which we waived premium based on Chronic Illness do not count toward the 360 months, nor do any months for which Group Plan coverage did not include the paid-up feature.

Who Is Eligible for This Feature?

This feature is available to you if ***both*** of the following apply:

- You were covered at or above the required minimum daily benefit on your Original Coverage Effective Date, or you became covered at or above the required minimum daily benefit in effect on the date we approved your Application for a coverage increase.

  The required minimum daily benefit level as of January 1, 2005, is $125 and will remain at this level until 60% of the Group Plan Maximum Daily Benefit is equal to, or greater than, $150. At that time, the required minimum daily benefit level will be $150. Thereafter, the required minimum

daily benefit level will be 60% of the Group Plan Maximum Daily Benefit, reduced to the nearest $25 increment. (The Group Plan Maximum Daily Benefit increases by 5% annually on September 1.)

- You subsequently become eligible for, and are enrolled in, a WEA Trust Group Long Term Care Plan that includes the paid-up feature.

How Does This Feature Work?

On the date you become enrolled in a WEA Trust Group Plan that includes the paid-up feature, you will receive one month's credit toward the paid-up feature of the Group Plan for each month for which you have paid premium under this policy at the required benefit level. The months of premium payment under this policy need not be consecutive to apply as a credit toward the Group Plan paid-up feature. However, in calculating the months that apply toward that credit, we do not include:

- Any month for which you decreased your coverage under this policy to an amount less than the required minimum daily benefit level in effect on the date of the decrease.
- Any month during which we waived your premium payment because you were Chronically Ill.

When Do You Stop Accruing Credit?

On the date you become enrolled in a WEA Trust Group Plan that includes the paid-up feature, you will stop accruing credit for premium payments on this policy. You will not accrue credit even if you continue your coverage under this policy in addition to your coverage under the Group Plan. However, you will begin to accrue credit toward the Group Plan paid-up feature for months for which premiums are paid, by you or on your behalf, for your Group Plan coverage.

If you become enrolled in a WEA Trust Group Plan that does not include the paid-up feature, and you continue your coverage under this policy at the required minimum daily benefit level, the months for which you pay premiums for this policy after you are enrolled in the Group Plan will be eligible for credit should your Group Plan coverage later include the paid-up feature.

Section 4

Qualifying for and Receiving Benefits

This section tells you what you must do to qualify for benefits. It also describes your responsibilities after you begin receiving benefits.

Important: Please call us as soon as you become Chronically Ill and believe you may be eligible for benefits. This will enable us to provide you with applicable forms that will facilitate getting all of the information we need to approve your application for benefits.

Remember that should you become Chronically Ill, your benefits will begin, at the earliest, on the date you complete the Elimination Period specified on your Benefit Summary. Because the Elimination Period does not begin until a Licensed Health Care Practitioner signs the required certification described in this section, it is important that you obtain the certification promptly.

If you would like us to assist you in obtaining the necessary Assessment and certification, developing the Plan of Care, and completing the application for benefits, call us as soon as you believe you may need Long Term Care services.

How to Qualify for Benefits

You qualify for benefits under this policy when ***all*** of the following conditions have been met:

1. We verify that you have a Functional Incapacity or Severe Cognitive Impairment that first occurred after your Original Coverage Effective Date.

   Note: Benefits that begin after an increase in your coverage will be subject to the increased amount only if the Functional Incapacity or Severe Cognitive Impairment first occurred after the effective date of the coverage increase.

2. We have received and approved all of the following from you:

   - A timely signed certification from a Licensed Health Care Practitioner, following his or her Assessment of your condition, that meets all of the certification requirements described below under "Certification Requirements." The certification cannot be backdated, and it must be received within 12 months of the date it was originally signed.
   - A Licensed Health Care Practitioner's Plan of Care, describing the type of Long Term Care being recommended.
   - Your application for Long Term Care benefits.

To ensure that you provide all of the information we need and thus facilitate our approval of your application for benefits, please call us to obtain applicable forms. If you would like us to assist you in completing these documents, we will be happy to do so.

3. We have verified that you have satisfied the Elimination Period specified on your Benefit Summary. You must satisfy the Elimination Period only once in your lifetime.
4. You have not exhausted the Maximum Lifetime Benefit.

Your eligibility for benefits will not be conditioned on a requirement of prior hospitalization or institutionalization.

Certification Requirements

To meet the certification requirements referred to above, you must meet one of two distinct benefit triggers—Functional Incapacity or Severe Cognitive Impairment. After assessing your condition, a Licensed Health Care Practitioner, whom we have verified is qualified to make such an Assessment, must complete and sign a certification form verifying that you are Chronically Ill due to either Functional Incapacity or Severe Cognitive Impairment. The criteria for each are described below.

A Licensed Health Care Practitioner's declaration that you are Chronically Ill, without supporting objective, contemporaneous medical and/or psychiatric evidence, is not sufficient to substantiate your Chronic Illness.

Functional Incapacity

You are Chronically Ill due to Functional Incapacity if ***both*** of the following criteria are satisfied:

1. You are unable to perform 3 or more Activities of Daily Living (ADLs), as defined in Section 2, without ***Substantial Assistance*** from another individual because of physical or cognitive impairment(s).
2. Your inability to perform 3 or more ADLs has continued or is reasonably expected to continue for at least 90 consecutive days.

   Substantial Assistance means one or both of the following:

   - The physical assistance of another person without which you would be unable to perform the ADL.
   - The presence of another person within arm's reach of you that is necessary to prevent, by physical intervention, injury to you while you are performing an ADL.

   You will not be eligible for benefits if your failure to successfully perform any of the ADLs is volitional or attitudinal in nature or origin and not due to physical or cognitive impairments.

Severe Cognitive Impairment

You are Chronically Ill due to Severe Cognitive Impairment if ***both*** of the following criteria are satisfied:

1. You have experienced a loss or deterioration in intellectual capacity that:
   - Has been demonstrated by clinical evidence and standardized tests that reliably measure impairment in your (a) short-term or long-term memory; (b) orientation as to people, places, or time; and (c) deductive or abstract reasoning; ***and***
   - Is comparable to Alzheimer's disease and similar forms of Irreversible Dementia.
2. ***In addition***, you require ***Substantial Supervision*** to protect yourself or others from threats to health or safety.

   Substantial Supervision means continual supervision (which may include cuing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect you and others from threats to health or safety.

When You Are Eligible to Receive Benefits

You are eligible for benefits, at the earliest, on the date you complete the required Elimination Period. Remember that the Elimination Period does not begin until the required certification is signed by a Licensed Health Care Practitioner. The certification cannot be backdated, so it should be obtained and sent to us promptly so that we can evaluate it and begin our approval process. In most cases, the required Assessment and certification will be completed at about the same time as you submit your application for benefits. If it is not, we must at least receive the signed certification within 12 months of the date it was signed. If it is not received within 12 months, you cannot qualify for benefits until you obtain a new certification.

When Benefits Begin

Benefits will begin when we verify that ***both*** of the following conditions have been met:

- You have satisfied the Elimination Period specified on your Benefit Summary
- You have provided us with satisfactory proof that you have incurred a covered loss. A covered loss is an expense you have incurred, as a result of your Chronic Illness, that is eligible for Long Term Care benefits described in Section 5. Benefits will be paid only for those covered Long Term Care services that you receive ***after*** you satisfy the Elimination Period.

The Benefits You Are Entitled To

The benefits you are entitled to during any period of Chronic Illness are those in effect on the date a Licensed Health Care Practitioner signs the certification, which we have evaluated and approved, verifying you are Chronically Ill. We will pay up to the Maximum Daily Benefit for any combination of covered Long Term Care services received pursuant to an approved Plan of Care. However, the Respite Care benefit may be paid, where appropriate, in addition to the Maximum Daily Benefit for other covered services.

Receiving Benefits for a Subsequent Period of Chronic Illness

If, after you have ceased receiving benefits under this policy, you experience a recurrence of Chronic Illness, you need not requalify for benefits if ***all*** of the following apply:

- You remain covered by this policy.
- You experience the recurrence within 180 consecutive days of the date we determined you were no longer Chronically Ill.
- We verify that you are Chronically Ill.

In this case, benefits are payable from the date of your recurrence for as long as you remain Chronically Ill, satisfy all provisions of this policy, and have not exhausted your Maximum Lifetime Benefit.

If, however, you subsequently experience another period of Chronic Illness more than 180 consecutive days after the date we determined you were no longer Chronically Ill and you remain covered by this policy, you will have to requalify for benefits as described in this section. This means you must submit a new Plan of Care, certification of Chronic Illness signed by a Licensed Health Care Practitioner, and application for benefits. In this case, benefits are payable from the date the new certification form is signed if you remain Chronically Ill for at least 31 consecutive days or you die within those 31 days.

Benefits Paid Reduce the Maximum Lifetime Benefit

All expenses paid under this policy, except expenses we incur under the care coordination benefit described in Section 5, reduce the amount of your remaining Maximum Lifetime Benefit.

When Benefits End

Once we have determined that you are eligible for benefits, you will be entitled to such benefits until the ***earliest*** of:

- The date on which you no longer have a Functional Incapacity or Severe Cognitive Impairment.
- The date on which you fail to provide the required proof of continuing Functional Incapacity or Severe Cognitive Impairment.
- The date you cease to be eligible for benefits under the other terms of this policy.
- The date on which your coverage under this policy ends. See "When Coverage Ends" in Section 3.
- The date on which your Maximum Lifetime Benefit is exhausted.

Extension of Benefits

If, while you are receiving Nursing Facility or Alternate Care Facility benefits, your policy terminates, we will continue to provide benefits for your facility confinement. Benefits will be provided as long as your need for facility confinement continues without interruption pursuant to your approved Plan of Care. Claims will be paid according to the terms and provisions in effect at the time your policy terminated. This extension of benefits will terminate on the earliest of the following dates:

- The date on which you no longer have a Functional Incapacity or Severe Cognitive Impairment.
- The date on which you fail to provide the required proof of continuing Functional Incapacity or Severe Cognitive Impairment.
- The date you cease to be eligible for benefits under the other terms of this policy.
- The date you no longer require facility confinement pursuant to your approved Plan of Care.
- The date on which your Maximum Lifetime Benefit is exhausted.

This extension of benefits provision applies only to Nursing Facility Care and Alternate Care Facility benefits.

Section 5

Long Term Care Benefits

This section describes the Long Term Care services that are benefits of this policy. To be eligible to receive these benefits, you must qualify for benefits as described in Section 4. All benefits are subject to the Exclusions and Limitations in Section 6. Read them carefully.

For each day you are entitled to benefits, we will pay up to the Maximum Daily Benefit for any combination of covered Long Term Care services pursuant to an approved Plan of Care. The Respite Care benefit may be paid, where appropriate, in addition to the Maximum Daily Benefit for other covered services. Your Maximum Daily Benefit is specified on your Benefit Summary.

Care Coordination Benefit

At your request, we will assist you and your family in identifying available services and making the best use of your benefits. Care coordination includes, but is not limited to, such services as assisting you and your family with the following:

- Obtaining comprehensive individualized Assessments, including reassessments as needed.
- Establishing an initial Plan of Care and reviewing a Plan of Care if you or your family has concerns about the type of care you are receiving.
- Working with you to determine the specific services and types of providers you require.
- Coordinating and monitoring your care needs on an ongoing basis to help you receive appropriate care.
- Helping you arrange for care, if you desire.
- Investigating alternative care options that meet your needs.

The care coordination benefit is provided by a ***care coordinator*** designated by us and is at no charge to you. You are not required to follow the recommendations of the ***care coordinator***. This benefit is advisory only.

A ***care coordinator*** is a nurse, certified case manager credentialed by the Commission for Case Manager Certification, or licensed or certified social worker who is qualified by training and experience to assess and coordinate the overall care needs of a person who is Chronically Ill.

Nursing Facility Care Benefit

For each day you receive Nursing Facility Care, we will pay your covered expenses up to the Maximum Daily Benefit specified on your Benefit Summary. Covered expenses include room and board and ancillary services such as physical, occupational, speech, and respiratory therapy. To be eligible for this benefit, you must be confined in a Nursing Facility, receiving services pursuant to an approved Plan of Care, and your confinement must begin after you are covered by this policy.

Alternate Care Facility Benefit

For each day you are confined in an Alternate Care Facility, we will pay your covered expenses up to the Maximum Daily Benefit specified on your Benefit Summary. Covered expenses include room and board and ancillary services such as physical, occupational, speech, and respiratory therapy. To be eligible for this benefit, you must be confined in an Alternate Care Facility, receiving services pursuant to an approved Plan of Care, and your confinement must begin after you are covered by this policy.

Bed Reservation at a Nursing or Alternate Care Facility

In the event you are temporarily hospitalized while you are confined in a Nursing Facility or Alternate Care Facility, this daily benefit may continue for up to 30 days per hospital admission if that is necessary to preserve your residence at the facility.

In the event you temporarily return to your home or place of residence while you are confined in a Nursing Facility or Alternate Care Facility, this daily benefit may continue for up to 7 days per home stay event, to a maximum of 30 days per calendar year, if that is necessary to preserve your residence at the facility.

Home Health Care Benefit

For each day you receive Home Health Care, we will pay covered expenses for services provided by the Home Health Care Agency up to the Maximum Daily Benefit specified on your Benefit Summary. To qualify for this benefit, you must be receiving Home Health Care provided by a Home Health Care Agency pursuant to an approved Plan of Care.

Adult Day Care Benefit

For each day you receive Adult Day Care, we will pay covered expenses for services provided by the Adult Day Care Center up to the Maximum Daily Benefit specified on your Benefit Summary. To qualify for this benefit, you must receive the services in an Adult Day Care Center, and the services must be specified in an approved Plan of Care.

Hospice Care Benefit

For each day you receive Hospice Care, we will pay covered expenses up to the Maximum Daily Benefit specified on your Benefit Summary. Covered expenses for Hospice Care do not include the cost of drugs, supplies, equipment, or physician visits. To qualify for this benefit, you must be receiving Hospice Care from a state-licensed or Medicare-approved Hospice Care provider pursuant to an approved Plan of Care. The services may be received in a Hospice Care Facility or in your home or place of residence.

Respite Care Benefit

When you have been receiving regular care from someone who lives with you on a 24-hour basis and who receives no compensation for providing that care, you are eligible for the Respite Care benefit. For each day you receive Respite Care, we will pay the Respite Care benefit specified on your Benefit Summary, provided ***all*** of the following apply:

- You have received regular care and assistance because of your Functional Incapacity or Severe Cognitive Impairment from your regular live-in caregiver for at least 90 consecutive days prior to your request for the Respite Care benefit.
- Your regular caregiver takes a rest or vacation from providing care to you.
- You temporarily receive Respite Care from someone other than your regular caregiver.

This benefit is limited to the number of days specified on your Benefit Summary. The days on which you receive Respite Care do not have to be consecutive. Unlike all other benefits of this policy, the benefit for Respite Care will be paid even if that Respite Care is provided by non-licensed providers or by members of your Immediate Family.

If you are eligible for the Home Health Care benefit or the Adult Day Care benefit for a day on which you are also eligible for the Respite Care benefit, the Respite Care benefit will be paid in addition to one of these other benefits. You are not eligible for the Respite Care benefit for any day on which you are also receiving the Nursing Facility Care benefit, the Alternate Care Facility benefit, or the Hospice Care benefit.

Alternate Care Benefit

If you believe that another form of long term care that is not covered under this policy is both more appropriate and cost-effective for your personal condition, we will evaluate a request for benefits for such care. Your request must include a written Plan of Care, Assessment, and certification from a Licensed Health Care Practitioner. In addition, you must tell us how and why the alternate form of long term care is more appropriate and cost-effective. The decision to pay benefits for all such alternate care will be determined in our sole discretion and will create no obligation with respect to future claims filed by you or others.

Similarly, if we believe that another form of long term care is more appropriate and cost-effective in your personal circumstances, we will recommend such a plan to you. Our plan is advisory and you are under no obligation to follow our recommendation.

All expenses paid as an alternate care benefit reduce the amount of your remaining Maximum Lifetime Benefit.

Section 6
Exclusions and Limitations

All benefits are subject to the exclusions and limitations listed in this section.

Exclusions

We do not reimburse expenses for the following:

- Care resulting, directly or indirectly, from attempted suicide or an intentionally self-inflicted injury while sane or insane.
- Care resulting from your alcoholism or addiction to drugs or narcotics. This does not include addiction that results from drugs or narcotics taken as prescribed by a physician.
- Care for a condition that results from war or an act of war, whether declared or undeclared.
- Care for a condition resulting from participation in a felony or illegal occupation.
- Services received outside the United States or its territories or possessions.
- Services provided to you by a member of your Immediate Family, except as specifically described in "Respite Care Benefit" in Section 5.
- Services provided to you by any person other than an employee of a licensed provider of Long Term Care services, or a provider specifically approved by us, except as specifically described in "Respite Care Benefit" in Section 5.
- Services or items furnished by or in a Veteran's Administration or federal government facility, unless otherwise required by law.
- Services or items furnished free of charge or for which you are not legally obligated to pay in the absence of insurance.
- Services that fall outside the established Plan of Care that we have approved.
- Any personal care items. Personal care items are those articles or supplies that are used for the personal care, grooming, hygiene, entertainment, enjoyment, refreshment, or convenience of an individual and that are not necessary, as determined by us, to assist or enable the individual to successfully perform the Activities of Daily Living.
- Costs of mechanical assistance, machinery, or devices, including installation.
- Transportation, including ambulance transfer.
- Prescription and over-the-counter drugs and medications and physician visits.
- Services received while your coverage is not in force except as provided under "Extension of Benefits" in Section 4.

Irreversible Dementia Not Excluded

This policy does not exclude benefits for covered expenses incurred for care necessitated by Irreversible Dementia.

Nonduplication of Benefits

Even if you are otherwise eligible for benefits, we do not duplicate benefits for expenses that are eligible for payment under any of the following:

- Any governmental plan or program other than Medicaid, including Parts A and B of Medicare, and any coverage that is required or provided by law, including coverage provided under no-fault and uninsured motorist statutes.
- Any employer-provided group health plan, whether insured or uninsured. This includes self-funded or self-insured plans.
- Any worker's compensation, employer's liability, occupational disease, or other payment program established by similar law. This includes amounts received when a claim under worker's compensation or similar law is settled by stipulation or compromise.

This limitation applies to any benefits that you are eligible to receive from these sources even if you do not apply for or receive such benefits.

If you incur charges for Long Term Care services that are reimbursable only in part from any of the sources described above, we will pay the difference between your actual covered expense and the benefits payable by all other sources, but our payment will not exceed the amount we would have paid in the absence of other insurance.

Section 7
Claim Procedures

To qualify for Long Term Care benefits, you must file a written application for benefits as described in Section 4.

To receive reimbursement for covered Long Term Care services, you must send us, within 90 days, a written claim and proof that you have incurred a covered loss. Wisconsin law extends this period to 12 months beyond the 90 days required by this policy, but only if we are not prejudiced by the delay and it was not reasonably possible for you to meet our 90-day limit. You can get claim forms by calling us. We will send them within 15 days of your request.

Application for Benefits

To be eligible for benefits under this policy, you must first file a written application with us that meets all of the requirements described in Section 4, "Qualifying for and Receiving Benefits." The application for benefits, including a Licensed Health Care Practitioner's Plan of Care and certification of your status, should be submitted to us as soon as your Functional Incapacity or Severe Cognitive Impairment is established. To ensure that you provide all of the information we need and thus facilitate our approval of your application, we recommend that you contact us to obtain the applicable forms. At your request, we will be happy to assist you in completing your application for benefits.

Claim and Proof of Loss

You must provide both satisfactory proof that you have incurred a covered loss and the information that we need to calculate your benefits. In many cases, your claim form provides that proof. In other cases, we require additional documentation that any services you received fulfill our criteria for coverage; for example, objective medical evidence verifying your Chronic Illness, information that the services you receive fulfill our criteria for coverage, etc. A Licensed Health Care Practitioner's declaration that you are Chronically Ill, without supporting objective, contemporaneous medical and/or psychiatric evidence, is not sufficient to substantiate your Chronic Illness. We will assist you in any way we can, but you are responsible for obtaining and providing this information.

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

Initial and Ongoing Proof of Eligibility for Benefits

Our Right to Examine

We have the right to require that you be independently evaluated by a Licensed Health Care Practitioner of our choice following

receipt of your certification form and your application for benefits. We also have the right to require that your continued eligibility for benefits be reassessed at reasonable intervals by a Licensed Health Care Practitioner of our choice. If we do so, we pay the cost of the evaluation or assessment.

You have an obligation to cooperate with us in being evaluated and in obtaining and providing any information that we need to establish and confirm your eligibility for benefits.

Continuing Proof of Loss

After you begin receiving benefits, we will periodically require proof that you remain Chronically Ill. This may include objective, contemporaneous medical and/or psychiatric evidence. If a reassessment demonstrates that you are no longer eligible for benefits, we will notify you in writing of the reason for the termination of benefits.

How Claims Are Evaluated

When we receive a claim, we collect the information we need to determine whether you qualify for benefits, as described in Section 4. As part of our evaluation, we will review the Assessment and certification from your Licensed Health Care Practitioner, verify that you are Chronically Ill, and evaluate your Plan of Care. We may arrange for an Assessment by a Licensed Health Care Practitioner of our choice. We may also request permission to contact your physician or other health care provider and to review your medical records. Based on our evaluation of this information, we will determine if you are eligible to receive benefits. We will not pay benefits until we have determined that you are eligible for benefits.

You must promptly provide us with all information that we need to administer your claim for benefits. This includes authorizing medical providers and appropriate agencies and organizations to provide us with all information and records we need to verify, calculate, and pay your claims.

Your claims will be compared to, and paid in accordance with, the Plan of Care that we have approved. If your Plan of Care needs modification to reflect changes in your care needs, we will be happy to assist you with that.

How and When Claims Will Be Paid

We pay benefits within 30 days after we receive a claim and the required proof of loss. We reimburse the providers from whom you received the services, unless they have already been paid. If we know you have paid them, we reimburse you.

In the event of your death, we may pay any benefits to which you were entitled to your estate or to whomever we consider to be legally entitled to receive them.

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

Section 8
Our Right of Subrogation

This section describes our right to seek repayment from other parties that are liable for costs we have paid in benefits. It also describes your obligation to cooperate with us in our attempts to recover such payments.

In some circumstances, we may pay benefits to you or on your behalf even though another party or insurance company is liable for the costs associated with your Functional Incapacity or Severe Cognitive Impairment. We have the right in such circumstances to seek repayment from any liable party or parties. This is known as the right of subrogation.

We have a subrogation right against any party or insurance policy that is liable for the costs associated with your Functional Incapacity or Severe Cognitive Impairment for the amount of benefits we have paid. This includes any payments to which you are entitled under the uninsured or underinsured motorist provisions of an automobile insurance policy or a no-fault insurance policy.

This policy obligates you to cooperate with us in our 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.

Section 9

Your Rights in the Event of a Denial of Benefits

This section describes your rights under this policy and by law in the event we deny your application for benefits or a claim for benefits.

If we deny either your qualification for benefits or a claim for benefits, you have the following rights:

- The right to submit, within the time required by this policy, all relevant evidence of your entitlement to benefits.
- The right to a full and fair review of your entitlement to benefits.
- The right to a written explanation of the reason(s) for our denial of your application for benefits or claim, including reference to the policy provisions upon which our denial is based.
- The right to examine any document in our possession that is relevant to your entitlement to benefits.
- The right to appeal the denial of your application for benefits or claim in accordance with our appeal procedure, if we receive your written appeal within 3 years of the date on our final notice of denial of the benefit application or claim. We will send you our decision in writing within 30 days after we receive your appeal request.

To obtain a written explanation of the procedures and requirements of our appeal procedure, including any necessary forms, call our toll-free number or write us:

WEA Insurance Corporation
P.O. Box 64904
St. Paul, MN 55164-0904
(888) 564-3473

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

You have the right to file a complaint with the ***Office of the Commissioner of Insurance***, a state agency that enforces Wisconsin's insurance laws. You can contact the ***Office of the Commissioner of Insurance*** by writing to:

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

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

Legal Actions

You may not bring an action at law or in equity to recover under this policy until 60 days after proof of loss has been given. No action can be brought more than 3 years from the date written proof of loss was required to be given.

Optional Benefit Provisions

These benefit provisions do not apply to your coverage unless they are listed on your Benefit Summary.

Automatic Inflation Protection—Compound Annual Increases—Capped

This benefit provision applies to your coverage only if your Benefit Summary indicates "Automatic Inflation Protection—Compound Annual Increases—Capped."

This optional benefit provides for your Maximum Daily Benefit and Maximum Lifetime Benefit to automatically increase each year, up to the limit provided below, as long as your policy and this optional benefit remain in force, pursuant to the provisions below.

How Does This Benefit Work?

Every year on the anniversary of this Optional Benefit Effective Date, we will increase your Maximum Daily Benefit and the unused balance remaining in your Maximum Lifetime Benefit by 5% compounded annually. The increased amounts will be rounded to the nearest whole dollar. These increased benefit amounts will apply to any covered expenses you incur for Long Term Care services received after the effective date of the increase.

The unused balance remaining in your Maximum Lifetime Benefit will be based on the amount of covered Long Term Care expenses ***incurred*** by you as of the day before the anniversary of this Optional Benefit Effective Date, whether or not a claim for those expenses has yet been filed with or paid by us.

When Will the Increases Become Effective?

The increase will be effective on each anniversary of this Optional Benefit Effective Date, even if you are receiving benefits.

Does Premium Also Increase?

Your premium rate will not change as a result of these annual benefit increases. However, your premium may change subject to the other terms of the policy.

When Do the Benefit Increases End?

The increases continue each year until your Maximum Daily Benefit has reached 200% of the initial Maximum Daily Benefit amount in force on this Optional Benefit Effective Date.

Additionally, annual inflation protection increases will end if your coverage is continuing in effect under any of the following:

- Extension of Benefits provision described in Section 4.
- Nonforfeiture Benefit (optional benefit).
- Contingent Benefit Upon Lapse (optional benefit).

Terminating This Optional Benefit

You may terminate this optional benefit at any time by notifying us in writing. The change will take effect on the first day of the month following the date we receive your written notice.

Automatic Inflation Protection—Compound Annual Increases—Uncapped

This benefit provision applies to your coverage only if your Benefit Summary indicates "Automatic Inflation Protection—Compound Annual Increases—Uncapped."

This optional benefit provides for your Maximum Daily Benefit and Maximum Lifetime Benefit to automatically increase each year as long as your policy and this optional benefit remain in force, pursuant to the provisions below.

How Does This Benefit Work?

Every year on the anniversary of this Optional Benefit Effective Date, we will increase your Maximum Daily Benefit and the unused balance remaining in your Maximum Lifetime Benefit by 5% compounded annually. The increased amounts will be rounded to the nearest whole dollar. These increased benefit amounts will apply to any covered expenses you incur for Long Term Care services received after the effective date of the increase.

The unused balance remaining in your Maximum Lifetime Benefit will be based on the amount of covered Long Term Care expenses ***incurred*** by you as of the day before the anniversary of this Optional Benefit Effective Date, whether or not a claim for those expenses has yet been filed with or paid by us.

When Will the Increases Become Effective?

The increase will be effective on each anniversary of this Optional Benefit Effective Date, even if you are receiving benefits.

Does Premium Also Increase?

Your premium rate will not change as a result of these annual benefit increases. However, your premium may change subject to the other terms of the policy.

When Do the Benefit Increases End?

Annual inflation protection increases will end if your coverage is continuing in effect under any of the following:

- Extension of Benefits provision described in Section 4.
- Nonforfeiture Benefit (optional benefit).
- Contingent Benefit Upon Lapse (optional benefit).

Terminating This Optional Benefit

You may terminate this optional benefit at any time by notifying us in writing. The change will take effect on the first day of the month following the date we receive your written notice.

Automatic Inflation Protection—Step-Rated Compound Annual Increases

This benefit provision applies to your coverage only if your Benefit Summary indicates "Automatic Inflation Protection—Step-Rated Compound Annual Increases."

This optional benefit provides for your Maximum Daily Benefit and Maximum Lifetime Benefit to automatically increase each year as long as your policy and this optional benefit remain in force, pursuant to the provisions below.

How Does This Benefit Work?

Every year on the anniversary of this Optional Benefit Effective Date, we will increase your Maximum Daily Benefit and the unused balance remaining in your Maximum Lifetime Benefit by 5% compounded annually. The increased amounts will be rounded to the nearest whole dollar. These increased benefit amounts will apply to any covered expenses you incur for Long Term Care services received after the effective date of the increase.

The unused balance remaining in your Maximum Lifetime Benefit will be based on the amount of covered Long Term Care expenses ***incurred*** by you as of the day before the anniversary of this Optional Benefit Effective Date, whether or not a claim for those expenses has yet been filed with or paid by us.

When Will the Increases Become Effective?

The increases will be effective on each anniversary of this Optional Benefit Effective Date, even if you are receiving benefits.

Does Premium Also Increase?

Your premium will be increased by 5% per year on the anniversary of this Optional Benefit Effective Date shown on your Benefit Summary, as long as this optional benefit and your policy are in force. Your premium may also change subject to the other terms of the policy.

When Do the Benefit Increases End?

Annual inflation protection increases will end if your coverage is continuing in effect under any of the following:

- Extension of Benefits provision described in Section 4.
- Nonforfeiture Benefit (optional benefit).
- Contingent Benefit Upon Lapse (optional benefit).

Terminating This Optional Benefit

You may terminate this optional benefit at any time by notifying us in writing. The change will take effect on the first day of the month following the date we receive your written notice. In this event, ***both*** of the following will apply:

- Your benefit amounts will remain at the level they were prior to the date the change took effect.
- Your premium will remain at the rate charged prior to the date the change took effect. This does not include premium increases for all policyholders with coverage similar to yours, a premium increase as a result of an increase in your coverage, or a premium increase subject to other terms of this policy.

Contingent Benefit Upon Lapse

This benefit provision applies to your coverage only if your Benefit Summary indicates "Contingent Benefit Upon Lapse."

This optional benefit provides an opportunity, in the event of a substantial increase in premium and pursuant to the provisions below, to convert your coverage to a paid-up status with a Shortened Benefit Period Allowance, defined below, if your coverage terminates due to nonpayment of premium.

Who Is Eligible for This Benefit?

This benefit will be available to you if you have not elected the Nonforfeiture Benefit. However, this benefit will apply to you if, and only if, there is a substantial increase in the premium rates for your coverage, as described below. Your Benefit Summary shows whether this optional benefit is available to you.

How Does This Benefit Work?

As provided in Section 1, we will give you at least 60 days' written notice before we make any change in premium rates. If there is an increase in premium rates so that the cumulative amount of all premium rate increases is considered to be a substantial increase in premium rates, as determined by the Wisconsin Office of the Commissioner of Insurance, we will do all of the following:

- Offer to reduce your current level of coverage without evidence of insurability so that the required premium rates for your coverage are not increased.
- Offer to convert coverage to a paid-up status with a Shortened Benefit Period Allowance as described below. You may elect this option at any time during the 120-day period following the date of the substantial premium rate increase.
- Notify you that a default or lapse at any time during the 120-day period following the date of the premium increase will be deemed to be the election of the preceding offer to convert.

Shortened Benefit Period Allowance

If you convert your coverage in accordance with the provisions above, we will continue to pay benefits, subject to all of the terms and conditions of the policy in effect at the time of lapse. Benefits for covered services will be paid up to the applicable Maximum Daily Benefit in effect at the time your coverage terminated due to nonpayment of premium, until the Shortened Benefit Period Allowance has been reached.

The Shortened Benefit Period Allowance we will pay will be the greater of these:

- 100% of the sum of all premiums paid for your coverage, excluding any waived premiums.
- 30 times your Maximum Daily Benefit in effect at the time of lapse.

The Shortened Benefit Period Allowance is reduced by the sum of all benefits previously paid to you. In no event will the total of benefits payable under this policy exceed the Maximum Lifetime Benefit.

Automatic Inflation Protection Will Not Apply to This Benefit

If your coverage includes an automatic inflation protection optional benefit, any benefit paid on or after your coverage terminates due to non-payment of premium will be the benefit amount in effect on the date coverage terminated, and no further increases in benefit amounts will occur.

When Will Benefits End?

Benefits will be paid as long as ***all*** of the following apply:

- You qualify for benefits as described in Section 4.
- You have not reached the Shortened Benefit Period Allowance.
- You have not exhausted the Maximum Lifetime Benefit.

Nonforfeiture Benefit

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

This optional benefit provides a continuation of your coverage pursuant to the provisions below, but on a reduced basis, in the event your coverage terminates due to nonpayment of premium.

How Does This Benefit Work?

The Nonforfeiture Benefit provides a continuation of your coverage up to a specified dollar amount, called the Nonforfeiture Benefit Allowance, if your coverage terminates due to nonpayment of premium before the Maximum Lifetime Benefit has been exhausted. The following are conditions under which we will pay benefits under this provision:

- If your coverage terminates due to non-payment of premium on or after the third anniversary of your Optional Benefit Effective Date, we will continue to pay benefits, subject to all of the terms and conditions of the policy.
- Benefits for covered services will be paid up to the applicable Maximum Daily Benefit in effect at the time your coverage terminated due to nonpayment of premium, until the Nonforfeiture Benefit Allowance has been reached.

Nonforfeiture Benefit Allowance

The Nonforfeiture Benefit Allowance we will pay will be the greater of these:

- 100% of the sum of all premiums paid for your coverage, excluding any waived premiums.
- 30 times your Maximum Daily Benefit in effect at the time of lapse.

The Nonforfeiture Benefit Allowance is reduced by the sum of all benefits previously paid to you.

In no event will the total of benefits payable under this policy exceed the Maximum Lifetime Benefit.

Automatic Inflation Protection Will Not Apply to This Benefit

If your coverage includes an automatic inflation protection optional benefit, any benefit paid on or after your coverage terminates due to non-payment of premium will be the benefit amount in effect on the date coverage terminated and no further increases in benefit amounts will occur.

When Will Benefits End?

Benefits will be paid as long as ***all*** of the following apply:

- You qualify for benefits as described in Section 4.
- You have not reached the Nonforfeiture Benefit Allowance.
- You have not exhausted the Maximum Lifetime Benefit.

Terminating This Optional Benefit

You may terminate this optional benefit at any time by notifying us in writing. The change will take effect on the first day of the month following the date we receive your written notice.