WEA Trust

Preferred Provider Plan

A WEA Insurance Corporation Group Health Policy

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IC-LGL 3434-251-0707

Important Notice

(Keep this notice with your insurance papers)

Problems with your insurance?

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

WEA Insurance Corporation
P.O. Box 7338
Madison, WI 53707-7338
Voice/TDD: (608) 276-4000 or (800) 279-4000

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.

WEA Trust Preferred Provider Plan

A WEA Insurance Corporation Group Health Policy

This is a preferred provider health insurance policy. This document is a description of group health insurance benefits. If you are a covered employee, then this insurance policy entitles you to reimbursement of the covered health care costs incurred by you and your covered dependents, subject to the reimbursement limits defined in Section 4.

We do not cover all health care services. We reimburse only for those services that are explicitly defined in this policy. Except for those preventive services expressly listed, we cover services only when we find them to be medically necessary and medically appropriate for the diagnosis or treatment of an Illness or Injury. These concepts are defined and clarified in Section 4.

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

We cover some services only if you receive our written authorization before purchasing the service. When we preauthorize services based on a specified expenditure, the specified expenditure is the reimbursement limit. For more information, see "Preauthorization Requirements" in Section 7.

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

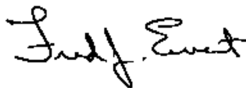
The benefits described in this policy may be changed by one or more of the optional benefit provisions that are located in the Appendix at the back of this document. Your Benefit Summary indicates which optional benefit provisions, if any, apply to your coverage.

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

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

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



Fred J. Evert, President

Michael L. Stoll, Vice President

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Section 1

Policyholder's Provisions: Rights and Obligations of the Employer and the WEA Insurance Corporation

This policy is a contract of insurance between the policyholder, referred to as the "employer," and the WEA Insurance Corporation, referred to as "we," "us," and "our."

General Information About This Policy

This is a preferred provider health insurance policy. It is guaranteed renewable except for the reasons stated below in this Section. In accordance with its terms, we will reimburse for covered health care services incurred by covered employees and their covered dependents, subject to the applicable deductible, copayment, and coinsurance amounts defined in Section 4 of the policy.

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

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

We have the right on July 1 of each year to add to, or delete from, the list of services that require preauthorization provided we have notified the employer in writing at least 60 days in advance. Preauthorization requirements are described in Section 7 of the policy.

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

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

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

Conditions of Issuance

This policy will take effect on the date, and in accordance with, the terms specified on the insurance agreement between the employer and us if the following requirements are met. If these requirements are not maintained, we may terminate this policy.

1. The employer and a bargaining agent affiliated with the Wisconsin Education Association Council must have negotiated WEA Insurance Corporation health plan coverage.
2. The employer's plan that provides the benefits of this policy must satisfy the nondiscrimination requirements of I.R.C. sec. 501(c)(9) and sec. 505(b).
3. The employer must meet all minimum participation and minimum contribution requirements we have established for this policy.

We will not permit this plan to be offered in a dual choice situation with another Trust or non-Trust plan without our prior written approval.

Minimum Participation Requirement

We reserve the right to nonrenew or terminate this policy, at our sole discretion, if the number of employees enrolled falls below 70% of the employees eligible for coverage. In evaluating whether enrollment has fallen below 70% of eligible employees, we will apply the following rules:

1. In calculating the total number of eligible employees, we will not include as eligible employees individuals who are covered only because they elected state continuation coverage or individuals who have completed a waiver or enrollment form identifying other qualifying coverage, unless the other coverage is another health benefit plan sponsored by this employer.
2. Before the nonrenewal or termination of this policy for failure to meet minimum participation requirements, we will notify the employer of the reason for the nonrenewal or termination, consistent with all statutory notice requirements.
3. Upon request, we will continue the group health coverage of this policy for at least 60 days after the nonrenewal or termination date, at the premium rate applicable for that time period, in order to give the employer an opportunity to increase the number of enrolled eligible employees so as to meet the policy's minimum participation requirement. If the employer does so, we will not nonrenew or terminate the policy.
4. We will not nonrenew or terminate the policy if the reason the number of enrolled employees is less than the required percentage is due to an employee's sickness or injury, approved leave of absence, or temporary layoff.

Minimum Employer Contribution

The employer must contribute at least 50% of the premium cost for a family plan for each full-time, covered employee, or 50% of the premium cost for a single plan if that is the plan selected. For part-time covered employees, the employer must contribute at least 50% of the regular contribution for full-time employees.

When Premiums Are Due

The premium is due each month on or before the 20th day of the month that precedes the month of coverage. This payment deadline applies whether the premium is due from the employer or from a covered individual who pays his or her own premiums directly to us.

Amount of the Premium

The monthly premium due is the sum of the premiums for all covered individuals. Premium is owed for each individual for each month in

which he or she is covered by this policy, except that when an employee's coverage begins after the 15th day of a month, the premium liability for that employee will begin on the first day of the following month.

The employer must notify us immediately whenever a covered employee ceases to be eligible for coverage. Depending on the event that caused the ineligibility, coverage for the employee will end either on the date the employee ceased to be eligible or on the last day of the month in which the employee ceased to be eligible. Premium liability will end when coverage ends. If coverage ends on or before the 15th of the month, no premium will be due for that month. If coverage ends after the 15th of the month, premium will be due for the entire month regardless of the date of the event that caused the ineligibility.

We will not be obligated to provide benefits to any individual who is not eligible for coverage even if premiums have been paid for that individual.

The premium will always be based on the rates for the benefits that are in effect on the date that the premium is due. We may establish a new rate for any or all of the policy's benefits on any of the following dates:

- Any policy renewal date, if we notify the employer at least 31 days before that date.
- Any date the premium is due, if previous rates have been in effect for at least 12 months and we notify the employer at least 31 days before that date.
- Any date on which we and the employer agree to materially change any provision of this policy.
- Any date on which a federal or state statute, or the governmental administration of a statute, materially changes any provision or term of this policy.

We will never increase premium rates by 25% or more without 60 days' notice to the employer.

Waiver of Premium

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

- The date the covered employee ceases to be Disabled as determined by us.
- The date the covered employee becomes eligible for Medicare benefits.
- The date the covered employee dies.
- The date the covered employee fails to furnish proof satisfactory to us of continued Disability.
- The date this policy terminates for any reason.
- The date the covered employee ceases to be eligible for coverage under the terms of this policy.

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

Premium payments must be resumed beginning with the month in which the covered employee resumes his or her regular job duties as a member of the eligible class of 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 and ending on the date on which the covered employee dies or ceases to be Disabled. Successive periods of Disability will be deemed to be the same Period of Disability unless:

- Due to an unrelated cause and separated by a return to the regular performance of job duties for the employer; ***or***
- Due to the same or related cause but separated by a return to the regular performance of job duties for the employer for 6 consecutive months.

The 60-day qualifying period referred to above must be satisfied only once for a Period of Disability. If a Disabled employee endeavors to resume work for the employer during a Period of Disability, the 30-month 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 the waiver of premium, the employee must be under the regular care of a Physician. This means that:

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

Waiver of premium applies only to a covered employee who becomes Disabled ***after*** the effective date of this policy.

Waiver of premium applies only to the type of coverage (single or family) in effect for the covered employee on the date of Disability.

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 the "Coverage Continuation Option for Retired Employees" described in Section 3 of the policy.

Grace Period

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

Termination of the Policy by the Employer

The employer may terminate this policy on the first day of any month by giving us written notice at least 31 days before that date. Similarly, the employer may terminate coverage under this policy, on the first day of any month, for an occupational group(s) of employees that is specified in the insurance agreement as eligible for coverage by giving us written notice at least 31 days before that date. If the employer does not pay the premium when it is due or within the grace period, this policy will terminate at the end of the grace period. The employer is liable for payment of all premiums due and unpaid, including the premium for coverage during the grace period, as well as the costs and reasonable legal fees we incur in collecting any premiums owed.

We may agree to waive the automatic termination of this policy resulting from nonpayment of premium. If we do, we have the right to charge interest on the delinquent premium, and the employer will be obligated to pay that interest. The interest rate charged will be the prime interest rate published in ***The Wall Street Journal*** on the first business day of that month plus 1%.

Termination or Nonrenewal of the Policy by Us

We will not terminate this policy midterm except for one or more of the following reasons:

- The employer's failure to pay premium when due.
- Fraud or misrepresentation by the employer.
- Substantial breaches of contractual duties, conditions, or warranties by the employer.
- The number of individuals covered under this policy is less than the minimum participation requirement established for this policy.
- The employer ceases operations.

- The employer has aligned this plan in a dual choice situation with another plan without our prior written approval.

If we terminate the policy for any of these reasons, we will give written notice to the employer at least 31 days before the termination date. The exception is termination due to breach of the minimum participation requirement. In that case, termination will follow the procedure described above in "Minimum Participation Requirement."

This policy is also guaranteed renewable unless one of the reasons cited above exists, or there is some other legally permissible reason to nonrenew. We have the right to change premium rates at renewal. We also have the right at renewal to alter the policy's benefit design consistent with that available to other policyholders as long as the alterations are not based upon the employer's particular claims experience. If we terminate the policy on any policy renewal date, we will give written notice to the employer at least 60 days before that date.

Employer's Duty to Furnish Information

The employer must furnish us with any information that we require to administer this policy. For example, the employer must notify us immediately whenever an employee's eligibility status changes. Examples include, but are not limited to:

- An employee becomes eligible for coverage.
- A change in job or hours renders an employee eligible for coverage.
- A covered employee is no longer eligible for coverage because of termination, retirement, reduction in hours, change in jobs, etc.
- A covered employee dies.

This information enables us to pay claims accurately and extend continuation coverage as required by law.

The employer must also notify us immediately whenever a covered employee suffers a work-related Illness or Injury or files a claim for worker's compensation benefits.

We have the right to inspect, at any reasonable time, any of the employer's records that are relevant to administering this policy, including verification that the policy's minimum participation and minimum contribution requirements are being met.

How Clerical Errors Will Be Handled

If, due to a clerical error, the employer fails to notify us of an employee who is eligible for coverage, that error will not deprive the employee and any dependents of coverage or affect their entitlement to benefits provided the error is corrected.

If, due to a clerical error, the employer fails to report the termination of coverage for an employee, that error will not extend coverage for the employee and any dependents beyond the appropriate termination date as defined by this policy. We will refund premium paid beyond the appropriate termination date for such an individual, up to a maximum of 6 months' premium, if claims were not paid during that time.

If, however, as a result of the employer's failure to report the termination of coverage for an employee, we pay claims beyond the appropriate termination date, the employer will pay premium for that employee's plan for the period of time up to and including the month during which we last paid claims or the employer reported the eligibility change to us, whichever is earlier. This will not change or extend any individual's legal rights with respect to group continuation coverage. The period of continuation coverage will be calculated from the date the individual was no longer eligible for coverage under this policy.

An employer's error will not create any liability whatsoever for us.

Statements by Our Employees or Agents

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

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

Entire Contract and Changes

The entire contract of insurance consists of:

1. This policy and any Optional Benefit Provisions.
2. The Benefit Summary.
3. The Rate Summary.
4. The insurance agreement between the employer and us.
5. The employees' enrollment forms.

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

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

Conformity With State Statutes

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

Section 2

Definitions That Apply to All Provisions

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

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

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

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

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

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

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

Physician or ***Surgeon*** means a qualified practitioner other than the covered individual or his or her covered dependent who is licensed to diagnose and treat physical or mental impairments. This includes only the following

practitioners and only to the extent that provided services are within the scope of the practitioner's professional license:

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

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

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

- Any time the word ***"services"*** appears in this policy, it refers to any professional service, medical or health care treatment, hospitalization and other use of facilities, laboratory services, durable medical equipment, medical supplies, and pharmaceuticals.
- Any time the words ***"you"*** or ***"your"*** appear in this policy, they refer to any individual who is covered by the policy. The exception to this is in Section 3, "Eligibility and Coverage of Employees and Their Dependents" where "you" and "your" refer only to the employee of the employer who purchased this group health insurance policy.
- Any time the word ***"covered"*** appears in the benefit provisions of this policy, it refers to services that are reimbursable if we find them to be medically necessary and medically appropriate in your specific circumstances. Reimbursement is subject to our reasonable and customary fee limits; any deductible, coinsurance, or copayments that apply; this policy's cost-effectiveness limits; and our preauthorization requirements. See Sections 4 and 7 for a discussion of these concepts.

Section 3
Eligibility and Coverage of Employees and Their Dependents

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

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

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

How to Obtain Coverage

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

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

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

Eligibility and When Coverage Begins

Current Active Employees

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

- You are engaged in the active performance of your regular job duties on that date (or would be so engaged if that date were a regularly scheduled workday).
- You belong to the eligible class of employees specified by your employer.

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

New Employees

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

- The date you begin the active performance of your regular job duties.
- The date you complete any waiting period specified by your employer.

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

Employees Who Retire at Age 55 or Older

If you retire at age 55 or older while you are covered by this policy, you may continue coverage for yourself and your dependents on the same terms as an active employee. This option is in addition to the rights of continuation coverage required by state and federal law. Your rights and obligations under this option are described later in this section under "Coverage Continuation Option for Retired Employees."

Employees on Paid Leave of Absence

If you are on an employer-approved paid leave of absence on the date this policy takes effect and would be actively at work on that date but for that fact, you are eligible for coverage if ***all*** of the following apply:

- You belong to the eligible class of employees specified by your employer.
- Your leave is a type that is available to all employees in the eligible class (for example, paid sick or sabbatical leave).
- Both you and your employer anticipate that you will return to work at the end of your leave.
- Your employer pays the required premium.

If you fulfill all of these criteria, you are eligible for coverage on the date the policy becomes effective. Your coverage will begin on the policy's effective date if we receive your enrollment form within 30 days of that date. Coverage will extend for a maximum of 2 years from the date your leave began (even though you started your leave before this policy took effect).

Retired Employees

If you are an employee who is retired as of the date this policy takes effect, you are eligible for coverage under this policy on the effective date if ***all*** of the following apply:

- The active employees in the occupational group of the eligible class from which you retired are covered by this policy.
- On the day before this policy takes effect, you were covered under the group health policy that this policy replaces.
- We receive your enrollment form within 30 days of the date this policy takes effect.

Your Dependents

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

1. Your legal spouse.
2. Your biological child, legally adopted child, stepchild, or legal ward* who is unmarried, ***and***:

- Under the age of 19.
- Between the ages of 19 and 25 and enrolled as a full-time student in an accredited school, college, or university. These dependents are covered between school terms (for example, summer months) if they complete the preceding term.

  Full-time student means a dependent who is enrolled in ***school*** on a full-time basis as defined by the school the student attends. ***School*** means an accredited college or university, a licensed or certified vocational institution, or a licensed or certified technical training institution.
- Between the ages of 19 and 25 and not a full-time student, but having less monthly income than the amount we establish and periodically modify as the standard for determining whether the child is primarily responsible for his or her own financial support.

  When we determine a dependent's monthly income, we take into consideration expected gross income, both earned and unearned, that the dependent receives from all sources including, but not limited to, gross wages, tips, disability benefits, worker's compensation benefits, unemployment compensation benefits, SSI benefits, veteran's benefits, AFDC benefits, real estate holdings, stocks, trust funds, gifts, and injury damage awards or settlements. Expected monthly income must be less than our monthly standard in order for the dependent to remain eligible for coverage. For example, a dependent who becomes employed with expected income that exceeds the monthly standard we have established is ineligible on the first day of employment. That dependent's coverage will end on the last day of the month during which he or she became ineligible.

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

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

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

If your covered dependent child becomes ineligible for coverage because he or she no longer meets the criteria to qualify as an eligible dependent, that child may once more become eligible if the criteria are again met. In this case, coverage for the re-eligible dependent child will begin on the first of the month following the event that gave rise to the eligibility if you notify us within 30 days after the event.

Example: Your 20-year-old covered dependent, Pat, stops attending college and becomes employed on November 12 with a salary that is above our monthly standard for determining whether a child is primarily responsible for his or her own financial support. Pat is ineligible for coverage on the first day of her employment, November 12. Her coverage will end on the last day of the month during which her employment began, or November 30. After two years of employment, Pat, who is now 22, returns to college as a full-time student on August 23. Assuming she meets all other eligibility criteria (remains unmarried, etc.), she again becomes eligible for coverage on August 23. Pat's coverage will begin on September 1 if you notify us before September 22.

Adding Dependents Through Marriage—If you marry, you may obtain coverage for any new eligible dependents and you may change from single to family coverage if we receive the required enrollment form within 30 days of the date of your marriage.

Adopted Children—An adopted child is eligible for coverage on the date that a court makes a final order granting adoption or on the date that the child is legally placed with you for adoption, whichever is earlier. Coverage for the adopted child will begin on the date of eligibility if we receive your notification in writing within 60 days after that date.

Newborns—A newborn's coverage begins at the moment of birth if you have family coverage. If you have single coverage, you must notify us of the birth and your desire to obtain family coverage within 60 days of the birth date. If we are not notified and the required premiums are not paid within 60 days of the birth date, we may refuse coverage for the newborn unless within 1 year of the birth date we receive all required premiums, plus interest as permitted by law, from the date of birth. If we do not receive the required premiums within 1 year of the birth date, you will be able to obtain coverage for the child only through our procedures for late applications described later in this section under "Rules for Late Enrollments."

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

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

Surviving Dependents—In the event of your death while you are covered by this policy, your surviving covered dependents have certain rights to continue their coverage. Those rights are described later in this section under "Coverage Continuation Rights of Surviving Dependents."

Your Duty to Provide Information

If you are covered by this policy, you must provide the information we need to administer its provisions and pay benefits. Examples include but are not limited to:

- ***You must let us know when one of your covered dependents is no longer eligible for coverage.*** This will enable us to process claims accurately and extend continuation coverage as required by law. Read about your rights and obligations regarding continuation coverage later in this section. If you do not notify us and, as a result, we pay claims beyond the dependent's appropriate termination date, we have the right to retroactively terminate coverage for the individual. In this case, you must repay us for all claims that we paid after the dependent became ineligible.
- ***You must notify us when you or a dependent becomes covered by another group health plan or by Medicare.*** The State of Wisconsin has adopted rules that must be followed by all insurers who coordinate benefits. These rules, included in Section 9, specify which insurer pays first, which pays second, etc. If we pay claims in error because you have not informed us of other insurance coverage, we have the right to recover the overpayment. See "Our Right of Review and Recoupment" in Section 8.
- You must respond to our requests for information. For example:

  When your dependent child nears the age at which he or she may no longer be eligible for coverage, we will send you a questionnaire requesting updated information about that dependent. Sometimes we may request documentation of his or her expected gross income. We will ask for this information as often as is necessary for us to determine your

dependent's continuing eligibility for coverage. Because we use this information to pay claims, we suspend claims processing until we receive the information from you.

Periodically we will send you a questionnaire asking if you or any of your dependents are covered by any other health policy. You must either complete and return the questionnaire or call one of our customer service representatives and provide the information. Because we rely on this information to coordinate benefits, we suspend claims processing until we receive the requested information. If you provide inaccurate or incomplete information and we pay claims in error as a result, we have the right to recover the overpayment. See "Our Right of Review and Recoupment" in Section 8.

- ***You must provide, at your own expense, the medical documentation we need to determine if services are covered and/or if you qualify for waiver of premium.*** We will tell you what we need to make this determination.
- ***You must inform us when you or your covered dependent receives medical services as a result of a work-related Illness or Injury, and you must notify us of any worker's compensation claim you make.*** You must also notify us of any worker's compensation benefits you receive as a result of an award, compromise, or settlement. Because we will use this information to determine whether any benefits are owed to you under this policy, you must promptly provide us with any related information or documentation that we require. This policy excludes services that are eligible for worker's compensation benefits whether or not you apply for or receive them. If we later discover that we have paid claims for services that were necessitated by work-related Illnesses or Injuries, we have the right to recover the overpayment. See "Our Right of Review and Recoupment" in Section 8.

When Coverage Ends

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

- The date this policy terminates for any reason.
- The end of the period for which the last premium was paid for you.
- The date on which you enter the military forces of any state or country, including the United States. This includes being called to active duty as a member of a reserve unit of the armed forces.
- The date on which you cease to be a member of the eligible class of employees; for example, you have a change in your job duties or in the number of hours worked that renders you ineligible for coverage.
- The date on which your occupational group ceases to be part of the eligible class of employees specified by the employer as being part of an insured group.
- The last day of the month in which you become ineligible because of the termination of your employment, whether voluntary or involuntary.
- The date on which you exhaust your maximum aggregate benefit. ***Note:*** Coverage for your eligible dependents will not end solely because you exhaust your maximum aggregate benefit and, thus, are no longer eligible for benefits yourself.
- The date of your death.

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

- The date this policy terminates for any reason.
- The end of the period for which the last premium was paid for your dependents.
- The date on which your dependent enters the military forces of any state or country, including the United States. This includes being called to active duty as a member of a reserve unit of the armed forces.

- The date your dependent child marries.
- The last day of the month in which you die. (Note that continuation options are available to your covered dependents in this event.)
- The last day of the month in which your dependent child no longer meets the criteria to be covered as a dependent under your coverage (for example, required age, earnings, or student status).
- The date on which your dependent exhausts his or her maximum aggregate benefit.
- The date of the dependent's death.

There are three exceptions:

1. ***Mental retardation or physical disability of your covered child.***

   If you have a covered dependent child or legal ward who is ***both*** incapable of self-sustaining employment because of mental retardation or physical disability ***and*** who is chiefly dependent on you for support and maintenance, coverage for that individual will not end solely because he or she reaches the limiting age. You may continue coverage for that child or legal ward as long as he or she continues to be both incapable of self-sustaining employment and chiefly dependent on you for support. In this case, you must provide us with proof of the incapacity and dependency within 31 days of the date he or she reaches the limiting age, and at any time we request it during the 2-year period that follows. After the 2-year period, we may request proof of incapacity and dependency on an annual basis.

2. ***The onset of Disability while covered by this policy.***

   If you become Disabled while covered under this policy as an active employee, your eligibility will not end solely because you are no longer actively working. You may continue your coverage for as long as you are Disabled if we receive the required premiums for your coverage and we continue to insure the active employees in the occupational group within the eligible class of employees to which you belonged before becoming Disabled. This option is in addition to your rights to continuation coverage required by state and federal law.

   If and when you are entitled to continuation coverage under state or federal law, that period of continuation coverage will run concurrently with the continued coverage provided for in this provision. The coverage you are eligible to continue will be the same health plan as that in effect for the active employees in the occupational group within the eligible class to which you belonged before becoming Disabled. See Examples 1 and 2 under "Coverage Continuation Option for Retired Employees" later in this section.

   If, while you enjoy the continued coverage provided for in this provision, you become eligible for Medicare Parts A and B, you should enroll for those benefits because we will coordinate the benefits of this policy with the benefits payable by Medicare, whether or not you enroll. See Section 9 for information about how we calculate benefits when this policy is secondary.

3. ***Continuation coverage as required by state and federal law*** (see "Your Legal Rights to Continuation Coverage" beginning later in this section).

Rules for Late Enrollments

Late Enrollment

It is important that you apply for coverage by submitting an enrollment form, listing all individuals for whom you wish coverage, within 30 days of becoming eligible. If you waive or decline coverage when you are initially eligible, your ability to enroll later will be seriously affected. Unless your late enrollment satisfies the conditions described below under "Special Late Enrollment Circumstances," you and your dependents will be required to exhaust a 12-month waiting period. The 12-month waiting period will begin on the date we

receive your late application, which must be in writing. During those 12 months, no benefits will be paid. Your coverage will be effective on the first day of the first month that begins at least 12 months after the date we receive your application, but only if ***both*** of the following apply:

- You and any dependents you seek to enroll remain eligible for coverage under this policy on that date.
- You were continuously employed by your employer during the 12-month waiting period.

Special Late Enrollment Circumstances

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

Late Enrollment Arising From Loss of Other Coverage

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

- You had submitted an enrollment form within 30 days of your initial date of eligibility and waived the benefits of this policy for yourself and your eligible dependents for the express reason that you had other health coverage.
- You and your dependents were either eligible for coverage or were covered by this policy when you initially waived the benefits of this policy.
- You lost coverage for yourself and your dependents under the other group health plan or qualifying health insurance coverage that you had when you waived the benefits of this policy.
- We receive your application for enrollment for yourself and your eligible dependents within 30 days after your other health coverage ends.

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

Other Special Late Enrollment Circumstances

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

1. You acquire an eligible dependent through marriage, birth of a child, or adoption or placement for adoption of a child.
2. The amount of premium you are required to contribute for coverage under this policy decreases by at least 10% of the total premium in any 12-month period.

   Note: In the above two circumstances, we must receive an enrollment form from you, listing all individuals for whom you wish coverage, within 30 days of the date you experience the special late enrollment circumstance. If we do, coverage for you and/or your eligible dependents will begin on the date you experience the special late enrollment circumstance. If we receive your enrollment form after the 30-day period, you will have to exhaust a 12-month waiting period before your coverage becomes effective.
3. You retire from active employment at age 55 or older.

   In this third circumstance, you may enroll yourself and your eligible dependents if ***all*** of the following apply:

   - You waived the benefits of this policy for yourself and your eligible dependents for the express reason that you had other group health plan coverage.
   - You and your eligible dependents are covered by another group health plan on the date you retire.
   - We receive an enrollment form from you, listing all individuals for whom you wish coverage, within 30 days of your retirement. If we receive your enrollment form within the 30-day limit, coverage for you and/or your eligible dependents will

begin on the date following your retirement. If we do not receive your application for enrollment within the 30-day limit, neither you nor your dependents will be enrolled and you will not be eligible to enroll later.

Note: These provisions regarding Special Late Enrollment Circumstances do not apply to you or your dependents if any of the following apply to you:

- You are on an unpaid leave (except if you have continued your coverage under this policy pursuant to "Your Legal Rights to Continuation Coverage" or are on leave under the Family and Medical Leave Act).
- You are covered under "Coverage Continuation Option for Retired Employees," described below.
- You are covered under "Coverage Continuation Rights of Surviving Dependents," described later in this section.

Coverage Continuation Option for Retired Employees

If you retire at age 55 or older while you are covered by this policy as an active employee, you have the option of continuing coverage under the same conditions as before your retirement. You may continue coverage under this option as long as ***both*** of the following apply:

- We receive the required premiums on time.
- We continue to insure the active employees in the occupational group within the eligible class of employees from which you retired.

The coverage you are eligible to continue will be the same health plan as that in effect for the active employees in the occupational group within the eligible class of employees from which you retired.

Example No. 1: You are a librarian covered under this policy at the time you retire at age 62. You decide to continue your coverage under this provision. Some time after you retire, the librarians that are actively working for your former employer move to a different Trust health plan. Because your coverage and benefits are the same as those in the occupational group to which you belonged before retiring, you will also be moved to the new health plan. You may, of course, decide that you no longer want to continue coverage because of the change and terminate your Trust health plan.

Example No. 2: You are a teacher covered under this policy at the time you retire at age 55, and you decide to continue your coverage under this provision. Later, the teachers that are actively working for your former employer move to a health plan with a different insurer. Because we no longer insure the active employees in the occupational group to which you belonged at the time you retired, you will lose your Trust coverage under this provision. Note that if you are still within the continuation period provided by state and federal law, you may be able to finish your period of continuation coverage under the employer's successor insurer.

This option is in addition to your rights to continuation coverage required by state and federal law. If and when you or your covered dependents are entitled to continuation coverage required by law, that period of continuation coverage will run concurrently with the continued coverage provided for in this section.

If you do not choose to continue coverage under this option at the time you retire, you cannot do so later even during an open enrollment period. In that case, continued coverage for you and your covered dependents will be limited to that required by state and federal law. Your rights and obligations under those laws are described later in this section under "Your Legal Rights to Continuation Coverage."

If you continue coverage under this option, you will be responsible for paying the required premiums for coverage. Your premium will be based on the group rates in effect for the employer on each date that premium is due. Your premium will depend on the rate classification to which you belong. You may find the rate classifications and corresponding premium amounts on the employer's Rate Summary.

If you exercise this option, the following rules will apply to your dependents:

- If you marry, you may obtain coverage for any new eligible dependents and may change from single to family coverage, but only if we receive the required enrollment form within 30 days of the date of your marriage. If you fail to enroll them within the initial 30-day period, you may not enroll them later under the provisions entitled "Rules for Late Enrollments," earlier in this section.
- You may obtain coverage for eligible dependents during any group open enrollment that applies to the eligible class of employees to which you belonged while you were working.
- If you divorce, your former spouse will have the continuation coverage rights required by state and federal law. When that period of continuation coverage ends, your former spouse may choose coverage under our health conversion policy.
- Your dependent children are eligible for coverage as long as they qualify as dependents. When they no longer qualify, they will have the continuation coverage rights required by state and federal law. When that period of continuation coverage ends, they may choose coverage under our health conversion policy.

Coverage Continuation Rights of Surviving Dependents

If you are covered by this policy at the time of your death, your surviving covered dependents have the right to continue the coverage they had before your death, as described below. This right is available as long as we receive the required premiums and continue to insure the active employees in the occupational group within the eligible class of employees to which you belonged before your death. If your surviving dependents choose to continue coverage, they will be responsible for paying the required premiums for coverage. The premium rate will be the same as the rate in effect, on each date that premium is due, for the eligible class of employees to which you belonged at the time of your death.

Survivors of Covered Employees Who Are Under Age 55

If you are under age 55 when you die, your dependents have the continuation coverage rights required by state and federal law. When that period of continuation coverage ends, they may choose coverage under our health conversion policy.

Survivors of Covered Employees Who Are Age 55 or Older

If you are covered by this policy as an active employee and are age 55 or older when you die, your dependents have the right to continue coverage, and that right will not be limited to their legal rights to continuation coverage. The period of continuation coverage required by law will run concurrently with the continued coverage provided for in this section.

Your spouse may continue coverage for as long as desired if ***both*** of the following apply:

- We receive the required premiums on time.
- We continue to insure the active employees in the occupational group within the eligible class of employees to which you belonged at the time of your death.

Your dependent children are eligible for coverage if your surviving spouse continues family coverage and they continue to qualify as dependents under this policy. The coverage your dependents are eligible to continue will be

the same health plan as that in effect for the active employees in the occupational group within the eligible class of employees to which you belonged at the time of your death. See Examples 1 and 2 under "Coverage Continuation Option for Retired Employees," earlier in this section.

If, during the period of continuation coverage required by law, your surviving spouse obtains coverage for a new spouse or children who qualify as dependents, coverage for these new dependents will be effective only for your spouse's remaining period of continuation coverage required by state and federal law. These new dependents have no rights to continue coverage after your surviving spouse ceases to be eligible for coverage or they cease to qualify as dependents under this policy.

Rights of Surviving Dependent Children

If your surviving covered dependent child chooses single coverage under this policy at the time of your death, continuation coverage rights for that child will be limited to those required by state and federal law. When that period of continuation coverage ends, that child may choose coverage under our health conversion policy.

Your Legal Rights to Continuation Coverage

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), provides a temporary extension of coverage for ***qualified beneficiaries*** who lose coverage under an employer's group health plan because of specified life events, called ***qualifying events***. The terms ***qualified beneficiary*** and ***qualifying event*** are explained below. If you or your dependents lose coverage under this policy due to a ***qualifying event***, you are entitled to continue coverage if ***all*** of the following apply:

- We receive timely notification of the qualifying event.
- You elect continuation coverage within the specified time limit.
- We continue to insure the active employees in the occupational group within the eligible class of employees to which you belonged on the day before your qualifying event.
- We receive the required premiums on time.

Under these circumstances, you may continue your coverage under this policy for a specified period or enroll in our health conversion policy. This subsection summarizes your rights and obligations regarding continuing coverage under this policy. The next subsection describes continuing coverage under our conversion policy.

In addition to COBRA rights, you have similar continuation rights under Wisconsin law. You may also have additional continuation rights granted by this policy in certain situations such as retirement, total disability, or the death of the covered employee. (See "Coverage Continuation Option for Retired Employees," "Coverage Continuation Rights of Surviving Dependents," and "The onset of Disability while covered by this policy," earlier in this section.) If you elect continuation coverage, your COBRA, state continuation, and policy-provided continuation coverage will all run concurrently, not consecutively.

What is Continuation Coverage?

Continuation coverage is a temporary extension of coverage that can become available if you and/or your covered dependents would otherwise lose coverage under your employer's group plan. Continuation coverage is the same coverage given to other covered individuals who are in your occupational group within the eligible class of employees but who have not experienced a qualifying event. Each qualified beneficiary who elects continuation coverage has the same rights and benefits under this policy as those covered individuals until his or her continuation coverage has ended.

Qualified Beneficiaries

A qualified beneficiary is an individual covered by this policy on the day before a qualifying event occurs, who will lose coverage because of

that qualifying event. Qualifying events are listed below. Depending on which qualifying event occurs, you, your spouse, and/or your children, stepchildren, and legal wards may be qualified beneficiaries. An alternate recipient under a National Medical Support Order that we received while you were employed may also be a qualified beneficiary.

If you have a newborn child or a child placed with you for adoption while you are on continuation coverage, that child is also considered a qualified beneficiary. That child's coverage begins when the child is enrolled in this plan (see the rules for enrollment under "Your Dependents" earlier in this section) and lasts for as long as continuation coverage lasts for you and/or your other dependents. To enroll such a child, call our eligibility services department.

While you are on continuation coverage, you may also obtain coverage for a spouse or dependent child who becomes eligible for coverage under the terms of this policy, but such dependents are not qualified beneficiaries. You must apply for their enrollment within 30 days of the date they first become eligible. Coverage for these dependents ends when your continuation coverage ends, and they have no continuation rights of their own.

Qualifying Events

You will become a qualified beneficiary if you lose your coverage because of either of these qualifying events:

1. The termination of your employment for reasons other than gross misconduct.
2. A reduction in the number of your work hours.

Your spouse and/or dependent children will become qualified beneficiaries if they lose coverage because of any of the following qualifying events:

1. The termination of your employment for reasons other than gross misconduct.
2. A reduction in the number of your work hours.
3. Your death.
4. Your divorce or the annulment of your marriage.

   Note: If an employee cancels a spouse's coverage in anticipation of divorce or annulment, and a divorce or annulment later occurs, the divorce or annulment will be considered a qualifying event even though the ex-spouse lost coverage earlier (in advance of the divorce or annulment). If the ex-spouse notifies us within 60 days after the date of the divorce or annulment and can establish that the employee cancelled the coverage earlier in anticipation of the divorce or annulment, continuation coverage may be available for the period after the divorce or annulment.
5. Your covered child, stepchild, or legal ward ceasing to qualify as a covered dependent.

Your Obligation to Notify Us When a Qualifying Event Occurs

We will offer continuation coverage to qualified beneficiaries only after we have been timely notified that a qualifying event has occurred. Depending on the qualifying event, either you or your employer is responsible for notifying us of its occurrence.

Your employer must notify us within 30 days of the date you experience any of the following qualifying events:

- The termination of your employment for reasons other than gross misconduct.
- A reduction in your work hours that results in the loss of coverage.
- Your death.

Important: You, your dependent, or your authorized representative must notify us within 60 days of the occurrence of either of the following qualifying events:

1. Your divorce or the annulment of your marriage.

2. Your covered child, stepchild, or legal ward ceasing to qualify as an eligible dependent.

If you or your dependent does not provide the required notice within the 60-day period, following the Notice Procedures below, you and/or your dependents will lose your rights to COBRA continuation coverage.

After we receive your notice of a qualifying event, we will acknowledge it in writing within 14 days. We will send either a notice of your right to continue coverage or a letter explaining why you are not eligible to continue coverage.

Notice Procedures

You or your employer may provide any notice required by these continuation coverage provisions by calling or writing:

Eligibility Services Department
WEA Trust Insurance Corporation
P.O. Box 7338
Madison, WI 53707-7338
(608) 276-4000 Voice/TDD
(800) 279-4000 Voice/TDD

If mailed, your notice must be postmarked no later than the last day of the required notice period. If you give your notice by phone, you must call us no later than the last day of the required notice period. We will need this information when you call or write:

1. Your name and subscriber number.
2. Your employer's name and group number, if known.
3. The specific qualifying event that is causing, or will cause, a loss of coverage.
4. The date of the qualifying event.
5. The names of all qualified beneficiaries who have lost or will lose coverage due to the qualifying event.
6. Your telephone number, address, and the addresses of any qualified beneficiaries if different from yours.

Duration of Continuation Coverage

The maximum period of continuation coverage depends on the qualifying event. You, your spouse, or dependent child may continue coverage for up to 18 months if coverage is lost because of one of the following qualifying events:

1. The termination of your employment for reasons other than gross misconduct.
2. A reduction in the number of your work hours.

Your spouse and/or dependent child may continue coverage for up to 36 months if they lose coverage because of one of the following qualifying events:

1. Your death.
2. Your divorce or the annulment of your marriage.
3. Your covered child, stepchild, or legal ward ceasing to qualify as a covered dependent.

Extension of the Period of Continuation Coverage

An 18-month period of continuation coverage can be extended under three circumstances. In all three circumstances, the extension applies only if the initial qualifying event was the termination of your employment or the reduction in your work hours.

Extension Due to a Second Qualifying Event

Spouses or dependent children who experience a second qualifying event while on continuation coverage may be eligible for up to a maximum of 36 months from the date of the original qualifying event. An event can be a second qualifying event only if it would have caused your spouse and/or dependent child to lose coverage had the first qualifying event not occurred. The extension is available if the second qualifying event is one of these:

1. Your death.
2. Your divorce or the annulment of your marriage.

3. Your covered child, stepchild, or legal ward ceasing to qualify as an eligible dependent.

Important: To obtain the extension, you or your dependent must notify us within 60 days after the second qualifying event occurs, using the "Notice Procedures" described in the box above. Failure to timely notify us will result in your dependent losing the right to extend coverage.

Extension Due to Disability

You and your dependents may receive up to an additional 11 months of continuation coverage, for a total of up to 29 months from your initial qualifying event, if ***both*** of the following apply:

1. The Social Security Administration (SSA) determines you or your covered dependent to be totally disabled at any time during the first 60 days of continuation coverage. The SSA does not have to make its determination during the first 60 days. However, you or your dependent must be totally disabled, by SSA standards, at some point during those first 60 days, and the disability must last at least until the end of the 18-month period of continuation.
2. You notify us of the SSA determination of disability before the end of the original 18-month period of continuation coverage ***and*** within 60 days after the latest of these dates:
   - The date of the SSA determination of disability.
   - The date of the qualifying event (that is, the date of your termination or reduction in your work hours).
   - The date on which you lose coverage because of the qualifying event.

When you notify us, you must provide the name of the disabled qualified beneficiary, the date the qualified beneficiary became disabled, and the date the SSA made its determination. You must also provide a copy of the SSA's determination. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if any one of them qualifies. Failure to provide timely notice using the "Notice Procedures" earlier in this subsection will result in loss of the right to extend the period of coverage.

If the SSA later determines that the qualified beneficiary is no longer disabled, you must notify us of that fact within 30 days of the SSA's determination. If that determination occurs during the 11-month extension period, continuation coverage will terminate, retroactively if applicable, for all qualified beneficiaries as of the first of the month following 30 days after the SSA's determination. You will be required to repay all benefits paid after the termination date, regardless of whether or when you provide notice that the disabled qualified beneficiary is no longer disabled.

Extension Due to Your Medicare Entitlement

If you become entitled to Medicare benefits less than 18 months before you and your dependents lose coverage due to the termination of your employment or reduction in your work hours, federal law provides a special extension of continuation coverage for your dependents. In this instance, continuation coverage for your spouse and dependent children may last for up to 36 months from the date of your Medicare entitlement. This 36-month period is available only to your dependents, and only if you become entitled to Medicare within 18 months ***before*** the termination or reduction in hours. To obtain this extension, you or your dependent must notify us ***before*** the end of the initial 18-month continuation period.

How to Obtain Continuation Coverage

Within 14 days after we receive the required timely notice that a qualifying event has occurred, we will send a written offer of continuation coverage to each qualified beneficiary. We will mail this information to the most current address we have on file for you. Thus, to protect your rights, keep us informed of changes in your address. You should also keep a copy, for your records, of all notices you send to us.

Qualified beneficiaries will have a 60-day period, known as an election period, to elect to continue coverage under this policy or under our conversion policy. The election period will end 60 days after the ***later*** of these two dates:

- The date coverage ends as the result of the qualifying event.
- The date we send you information about your rights to continue coverage.

If you do not return your election notice indicating your choice to continue your coverage within that 60-day period, you will lose your right to elect continuation coverage.

Each qualified beneficiary has a separate right to elect continuation coverage. For example, your spouse may elect continuation coverage even if you do not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. You or your spouse, if your spouse is a qualified beneficiary, can elect continuation on behalf of all qualified beneficiaries.

Premiums for Continuation Coverage

Qualified beneficiaries are responsible for paying the premiums for continuation coverage. The premium rate will be the same as the rate in effect, on each date that premium is due, for the eligible class of employees to which you belonged while working. Premiums will change on the annual renewal date of the employer's group under which you were/are covered, or when the benefits of the employer's group plan are changed.

The initial premium payment for continuation coverage is due 45 days after the election is made. This payment must include premiums for all months from the time you lost coverage under the employer's group plan through the current month of coverage. Claims will not be processed and paid until we have received your first premium payment. Qualified beneficiaries who do not make their first payments in full within this time limit will lose their coverage continuation rights.

All subsequent premium payments are due on the 20th of the month that precedes the month of coverage. A grace period of 31 days applies. The grace period starts on the first day of the coverage month for which the premium is due. We will provide continuation coverage for each month as long as we receive the premium for that month before the end of the grace period. If you do not pay the premium within the grace period, continuation coverage, and your rights to continuation coverage, will terminate.

If you or your dependents timely elect continuation coverage and pay premiums, the period of continuation coverage will begin the day after the qualifying event. If two or more qualified beneficiaries elect COBRA coverage under a plan, we will apply the full family premium, rather than two or more single premiums.

When Continuation Coverage Ends

A qualified beneficiary's continuation coverage under this policy will end on the earliest of the following dates:

- The end of the period for which the last premium was paid in full and on time.
- The date on which the applicable 18-month, 29-month, or 36-month period of continuation coverage ends.
- During an 11-month disability extension period, the first of the month following 30 days after the SSA determines the disabled qualified beneficiary is no longer disabled.
- The date on which the qualified beneficiary becomes covered under another group health plan that does not impose any exclusion or limitation for a pre-existing condition of the qualified beneficiary.
- For a qualified beneficiary who becomes entitled to Medicare benefits while on continuation coverage, the date that is 18 months after the date continuation coverage begins.

- The date on which we no longer insure the active employees in the occupational group within the eligible class of employees to which the covered employee belonged on the day before the qualifying event.
- The date on which the employer ceases to provide any group health coverage for the eligible class of employees.
- The date this policy terminates for any reason.
- The date on which you exhaust your maximum aggregate benefit.

Qualified beneficiaries must notify us within 30 days if, after electing continuation coverage, they become covered under Medicare or another group health plan (but only after any exclusion or limitation of that plan for a pre-existing condition of the qualified beneficiary has been exhausted or satisfied). Continuation coverage will terminate, retroactively if applicable, as of the beginning of the other group coverage. Qualified beneficiaries will be required to repay all benefits paid after the termination date, regardless of whether or when they provided notice of other health coverage.

Your Rights to Conversion Coverage

In addition to the continuation rights provided by state and federal law, you also have the right under state law to enroll in our conversion policy. The coverage provided by our conversion policy is similar but not identical to the coverage provided by this policy. Call us if you are interested in information about the conversion policy.

How to Obtain Conversion Coverage

If you or your dependents lose coverage under this policy due to one of the qualifying events listed previously under “Qualifying Events,” you may choose during the 60-day election period to enroll in our conversion policy rather than continue coverage under this policy. If you notify us of your choice within the 60-day election period, coverage under the conversion policy will take effect on the date following the termination of coverage under this policy if all required premiums are paid on time.

You may also enroll in our conversion policy when you have exhausted the maximum period of continuation coverage. You must notify us of your choice to enroll in the conversion policy and pay the required premium within 60 days after continuation coverage ends. If you do so, coverage under the conversion policy will begin on the day after continuation coverage under this policy ends.

The premium for conversion policy coverage for each individual will be based on the rate for coverage under this policy, but will contain actuarial modifications for several factors. Those factors include the individual’s age and geographic location and our additional cost of providing personalized administration of the policy. These modifications may increase the conversion policy premium above the rate for coverage under this policy.

Section 4

General Provisions That Apply to All Benefits

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

1. Illness and Injury
2. Medical necessity
3. Medical appropriateness

Some services require our advance authorization. Those services are specified on your Benefit Summary. Some services are explicitly excluded in Section 5 or in Section 6 under the specific benefit provision to which they pertain.

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

1. Your choice of health care provider (Network or non-network provider)
2. Reasonable and customary fee limit
3. Reimbursement limit on services that require preauthorization
4. Cost-effectiveness limit
5. Deductibles
6. Coinsurance
7. Copayments
8. Maximum out-of-pocket limit
9. Maximum aggregate benefit

How We Determine if a Service Is Covered

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

Whenever we have questions about whether claims meet these criteria, we rely on objective, contemporaneous, clearly documented medical records and the advice of our medical consultants. To provide the information we need to determine whether services meet our criteria for coverage, medical records should meet the documentation standards of the relevant medical and/or professional organization. If we are unable to establish the

medical necessity and appropriateness from the medical documentation we receive, we will not authorize or reimburse for the services.

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

We have the right to require that you be examined by a health care provider of our choice whenever it is necessary to evaluate a claim. When we do so, we pay the cost.

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

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

We cover only services to diagnose or treat Illnesses or Injuries, except for a limited number of preventive and routine services listed in Section 6.

When we use the term ***Illness,*** we mean a physical or mental disease or ailment that affects general soundness and healthfulness significantly and seriously and that undermines or diminishes health, vigor, or capability.

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

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

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

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

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

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

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

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

Note: Many beneficial health care services are recommended by Physicians but are not medically necessary as we use the term. Several examples are provided in Section 5, “General Exclusions.”

Medically necessary services exclude services performed in the absence of a diagnosed Illness or Injury and, thus, are not covered by this policy. A few exceptions are explicitly listed in “Reproductive Health Benefits,” in “Routine Physical and Preventive Care Benefits,” and in “Maternity and Newborn Benefits” in Section 6. This policy does not cover other preventive services or treatments. However, when the patient desires such services in response to a Physician’s recommendation, we will, in accordance with our preauthorization procedure, receive and evaluate such a request to participate in the funding of such services. The extent of our participation in any case will be determined in our sole discretion and will create no obligation with respect to future cases.

Medically necessary services also exclude treatments aimed at the development or acquisition of a functional ability that has not previously been achieved and, thus, are not covered by this policy. The exception to this is the limited benefit for habilitative therapy services explicitly described in Section 6 under "Physical, Occupational, and Speech Therapy."

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

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

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

- Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.
- Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline and MEDLARS database Health Services Technology Assessment Research (HSTAR).
- Medical journals recognized by the Secretary of Health and Human Services under the Social Security Act.
- These standard reference compendia: the American Hospital Formulary Service—Drug Information, the American Medical Association of Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia—Drug Information.
- Findings, studies, or research conducted by, or under the auspices of, federal governmental agencies and nationally recognized federal research institutes.
- Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services.

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

- Results of studies sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer.
- Anecdotal evidence of patients or Physicians.
- Studies published in other than peer-reviewed resources such as those listed above.
- Internet articles that do not have their foundation in one of the sources listed above.

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

- Contemporary medical consensus considers the risk of negative health effects acceptable in the patient's specific medical circumstances.
- Qualified providers perform the services within the scope of their license and/or certification. Qualifications include such education, training, state licensure, and professional certification as is legally required or recommended by credible professional societies.

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

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

- Contemporary medical consensus predicts the service will diagnose or correct the patient's Illness or Injury either in whole or significant measure. For example, services that have not been demonstrated in randomized clinical trials to have long-term efficacy or services we deem to be marginally effective will not be considered medically appropriate.
- Contemporary medical consensus considers the service, method of delivery, duration, frequency, and intensity of the service to be responsive to and commensurate with the patient's diagnosis, symptoms, and specific medical circumstances. For example, services that we deem inconsistent with current medical standards of practice for the patient's specific condition will not be considered medically appropriate.

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

We consider a treatment of unproven safety and effectiveness to be experimental if it is the subject of an ongoing clinical trial that meets the definition of a Phase I, II, or III clinical trial set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight.

Our medical review unit will determine if the service in question is experimental treatment.

Note: Medically appropriate services exclude all treatments of unproven safety and effectiveness, even when no other responsive medical alternatives exist. However, when the patient desires such services in the absence of proven medical alternatives, we will, in accordance with our preauthorization procedure, receive and evaluate a request to participate in the funding of such services. The extent of our participation in any case will be determined in our sole discretion and will create no obligation with respect to future cases.

Factors That Affect the Reimbursement Amount

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

Your choice of health care provider determines how much we will reimburse for covered services and, consequently, how much you must pay for your health care. Specifically, coinsurance, deductible, copayment, and maximum out-of-pocket amounts vary depending on whether you choose to receive your health care services from a Network or non-network provider. When we use the term ***provider***, we mean the following:

- Physicians and other qualified providers.
- Hospitals, clinics, skilled nursing facilities, and other health care facilities.
- Other providers of medical services, equipment, and supplies.

The term ***Network provider*** refers to any provider in the Preferred Provider Network that services your Preferred Provider Plan. The term ***non-network provider*** refers to all other providers.

Provider Directory

When you enroll, you will receive the Preferred Provider Plan Directory. The directory contains a listing of the Physicians, clinics, Hospitals, durable medical equipment providers, and transplantation centers in the Network that services your Preferred Provider Plan.

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

You Will Save Money When You Use Network Providers

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

Reimbursement for Emergency Care

We recognize that there may be times when you need medical emergency services and it is not reasonably possible for you to reach a Network provider. If you receive such medical emergency services from a non-network provider, or are admitted to a non-network Hospital under these circumstances, we will reimburse for covered services at the coinsurance, copayment, and deductible amounts that apply to Network providers. Our reimbursement will be subject to our reasonable and customary fee limits and all policy provisions, including Hospital admission notification and preauthorization requirements, if applicable. Read about Emergency Services in Section 6 and Hospital Notification Requirements in Section 7.

Reimbursement for Urgent Care

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

Identification Card

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

Reasonable and Customary Fee Limit

We reimburse charges that we consider to be reasonable and customary. If a charge for a service or group of services exceeds the amount we consider to be reasonable and customary, we will reimburse less than the billed charge. You are responsible for any amount that exceeds our reasonable and customary fee limit, and that excess amount does not apply to your maximum out-of-pocket limit. We base our Wisconsin reasonable and customary fees on averages of actual fees charged in the state, adjusted by factors to account for geographic, marketplace, and other legitimate price differences among providers. Our reasonable and customary fee limits for services provided in other states reflect the amounts charged by providers in the geographic area where the service is provided.

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

- The procedure or billing code for the service or services that will be performed. Your Physician can provide this to you.

- The estimated charges for each procedure or billing code.
- Your Physician's name and zip code.
- The approximate date you will receive the service.

Coding and Billing Standards

We rely on medical documentation to determine if procedure or billing codes for services reported and billed by a health care provider are appropriate. If the documentation indicates another code is more appropriate, we have the right to base our reimbursement on the service(s) supported by the documentation. We also have the right to deny claims for services that are billed inconsistently with industry-accepted coding standards.

Reimbursement Limit on Services That Require Preauthorization

It is important that you obtain our advance approval before receiving any of the services that require preauthorization. Services that require preauthorization are listed on your Benefit Summary. You can also view a list of these services on our Web site, weatrust.com.

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

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

If the preauthorized service is not one for which we have contracted with a specialty Network, reimbursement is limited to the reasonable and customary fee for the service, less deductible, coinsurance, and copayment amounts that apply to your choice of provider, and is subject to coding compliance rules, multiple surgery rules, and all of the policy's reimbursement rules.

Cost-Effectiveness Limit

When more than one viable alternative service or treatment protocol is available for diagnosis or treatment, we evaluate the predicted health benefits, risks, and costs of services that are comparable in safety and effectiveness for your medical circumstances. When we deem benefit/risk relationships to be comparable, you may choose the treatment you wish, but we reimburse no more than the reasonable and customary fee for the most cost-effective service. The most cost-effective alternative is one that meets ***both*** of these conditions:

- The service is the least costly of alternative services that are comparably equivalent in safety and effectiveness for your medical condition.
- The service is received in the least costly setting required for safe delivery of those services. Examples: An inpatient Hospital stay is cost-effective only if you cannot be safely treated as an outpatient. Use of an ambulatory (outpatient) surgical center is cost-effective only if the surgery cannot be safely performed in a Physician's office or clinic setting.

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

Deductibles

Reimbursement for covered services may be subject to a deductible. The deductible is the amount that you must pay in a Benefit Period for covered services before we will reimburse you for any covered costs you incur during the remainder of that Benefit Period. The deductible must be satisfied in each Benefit Period. Deductible amounts you must pay out-of-pocket are generally less for Network providers than for non-network providers.

Individual and Family Deductible—We apply an individual deductible to the reasonable and customary costs of covered services incurred by each individual during a Benefit Period. Once an individual satisfies his or her deductible, no further deductible applies to that individual for the remainder of that Benefit Period.

However, there is also a maximum family deductible. Deductible amounts paid for individuals are combined to satisfy the family deductible. Once each individual's deductible or the family deductible is met, whichever happens first, no further deductible applies to any family member for the remainder of that Benefit Period. Both the individual and the family deductible amounts are specified on your Benefit Summary. The individual and the family deductible amounts, for both Network and non-network services, are specified on your Benefit Summary.

Coinsurance

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

Copayments

A copayment is a fixed amount you must pay out-of-pocket each time you receive certain services. For example, Physician office visits, urgent care visits, emergency room visits, and the prescription drug benefit of this policy may be subject to copayments. Copayments do not apply to all services, and the amount may vary for different services. Copayment amounts you must pay out-of-pocket are generally less for Network providers than for non-network providers. Your Benefit Summary specifies copayments you must pay, for both Network and non-network services, and the services to which they apply.

Maximum Out-of-Pocket Limit

The maximum out-of-pocket limit is the most that you must pay for deductible, copayment, and/or coinsurance amounts during any Benefit Period. A maximum out-of-pocket limit is sometimes referred to as a stop loss. Maximum out-of-pocket limits are higher for non-network providers than for Network providers.

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

- Deductibles
- Coinsurance
- Copayments

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

- Amounts you pay for non-covered services.
- Amounts you pay for charges that exceed our reasonable and customary fee limits.
- Amounts you pay that exceed our reimbursement limit on preauthorized services.

- Penalty amount for failure to comply with our Hospital admission notification requirements.
- Amounts you pay for charges that do not comply with the policy's reimbursement rules.

Individual Maximum Out-of-Pocket Limit—
The individual maximum out-of-pocket limit applies to each covered individual. Once this individual limit is met, we reimburse 100% of the reasonable and customary costs of covered services for that individual during the remainder of that Benefit Period, except for amounts that do not apply to the maximum out-of-pocket limit.

Family Maximum Out-of-Pocket Limit—
Out-of-pocket amounts paid for all family members are applied toward the family maximum out-of-pocket limit. Once the family limit is met, we reimburse 100% of the reasonable and customary costs of covered services incurred by any covered family member during the remainder of that Benefit Period, except for amounts that do not apply to the maximum out-of-pocket limit.

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

Maximum Aggregate Benefit

The maximum aggregate benefit specified on your Benefit Summary is the total amount this policy will reimburse for covered services for each covered individual during his or her lifetime.

Maximum Aggregate Benefit Restoration—
Each covered individual's maximum aggregate benefit will be fully restored to the amount specified on your Benefit Summary on January 1 of each year ending in "0" or "5." This restoration will ***not*** apply to an individual whose coverage under this policy has already ended as a result of having exhausted the maximum aggregate benefit before the next restoration date.

Policy Changes

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

Noncompliance With Policy Requirements

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

Section 5
General Exclusions

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

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

- Legal services.
- Missed appointments.
- Copying and providing medical or any other type of information in support of a claim.
- Travel and lodging.
- Services rendered by a massage therapist.
- Weight control, weight loss, or the treatment of obesity, including but not limited to prescriptions, programs, and surgeries.
- Replacement of prescription drugs or medications, orthotics, prosthetics, or equipment that are lost, stolen, damaged, misplaced, missing, or otherwise compromised.
- Vocational rehabilitation, including work-hardening programs.
- Augmentative and/or alternative communicative devices and systems.
- Bariatric surgery, gastric restrictive or bypass procedures, or similar surgeries.
- Routine foot care except in cases where such foot care may pose a hazard for a patient with a recognized medical diagnosis, such as diabetes, peripheral neuropathies (as determined by us), arteriosclerosis, or chronic thrombophlebitis. Routine foot care includes, but is not limited to, the treatment of corns, calluses, plantar keratosis, and nail trimming.
- Gene therapies, treatments, or enhancements.

  Note: While we do not reimburse for gene therapies, treatments, or enhancements, we reimburse for genetic counseling and testing as specifically provided under "Maternity and Newborn Benefits" in Section 6 and as authorized by us in advance.
- Office visits, Physician charges, or any other service for, or in connection with, a procedure or service that this policy does not cover. This includes, but is not limited to, follow-up Physician and/or Surgeon visits, diagnostic tests necessary only or primarily because of the noncovered procedure, services to repair a failed procedure or service, services to repair scarring from services or surgery that this policy does not cover, and home health care required as a result of a noncovered procedure or service. This exclusion applies except where reimbursement is otherwise required by law.

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We do not reimburse for services that fall outside the policy's General Provisions to cover only medically necessary care for Illnesses and Injuries. Examples include these:

- Equipment or services to prevent Injury or to facilitate participation in physical activity or sports.
- Services to prevent Illness, except for those expressly listed in Section 6.
- Services or items for physical fitness, wellness, health education, nutritional or diet supplements, or personal hygiene.
- Services to educate or help adapt to a diagnosis or a chronic physical or mental condition. Examples are stress management classes and education and awareness training for those suffering from chronic pain.
- Services to improve an existing physical or mental state in the absence of an Illness or Injury.
- Services to improve appearance. Examples are hair restoration, services to improve skin appearance, ***cosmetic surgery***, and services to remove keloids or repair scarring or disfigurement resulting from body piercing, tattooing, implants, or other services or procedures that are not medically necessary or medically appropriate and/or were not performed by a licensed medical professional.

  Cosmetic surgery is elective surgery performed primarily to improve appearance. The procedure would provide little or no accompanying meaningful improvement in the functioning of a malformed body part or restoration of a bodily function.
- Services or supplies for the convenience of the patient, the Physician, the patient's family, or any other person.
- Custodial or long term care. By this, we mean services that can generally be provided by persons without professional medical training or skills and that are primarily for one or more of the following purposes:
  - Maintaining an individual's existing physical or mental condition of health.
  - Preserving an individual's condition from further decline.
  - Assisting an individual in performing the activities of daily living, such as bathing, eating, dressing, toileting, and transferring.
  - Protecting an individual from threats to health and safety due to cognitive impairment.
  - Meeting an individual's personal needs.

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

We do not reimburse for services that fall outside the policy's General Provisions to cover only medically appropriate care for Illnesses and Injuries. Examples include these:

- Services that continue after the patient reaches the expected state of improvement, resolution, or stabilization of a health condition.
- Holistic or homeopathic remedies and preparations.
- Services or interventions that, while they may be beneficial, have not been scientifically documented as safe and effective for a specific Illness or Injury. Examples include, but are not limited to, acupuncture, acupressure, guided imagery, meditation, Rolfing, reflexology, yoga, hypnosis, aromatherapy, relaxation techniques, herbal medicine, naturopathy, iridology, Ayurvedic medicine, and massage.
- Medical services that have not been proven in randomized clinical trials and recognized by contemporary medical consensus as being both safe and effective.

We do not reimburse expenses, even if medically necessary and medically appropriate, for the following:

- Prescription drugs and medications for individuals who are eligible to enroll in the Medicare Part D drug program, whether or not they enroll, except for:

  1. Employees who are actively at work and their covered dependents.
  2. Individuals who are covered by our standard family plan.
  3. Individuals who are covered under state and federal continuation (COBRA) coverage, unless they choose to waive prescription drug coverage under this plan in exchange for a lower premium rate.
  4. Any individual for whom this plan is primary under Medicare Secondary Payer rules.

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

- Services or items furnished free of charge or for which you are not legally obligated to pay in the absence of insurance.
- Services that a child's school is legally obligated to provide, whether or not the school actually provides them and whether or not you choose to use those services.
- Services or items furnished or paid for by a governmental entity, facility, or program other than Medicaid, unless we are required to do so by specific law.
- Services or items required by a third party. Examples are services required for insurance, employment, or special licensing purposes.
- Costs incurred while you are not covered by this policy.
- Care for a medical condition that arises from, or originates during, service in the armed forces.
- Care for a medical condition resulting from participation in a crime.
- Services provided to you by a covered member of your family.
- Services eligible for worker's compensation benefits, or benefits from any other payment program established by similar law, whether or not you apply for or receive them. This includes amounts received when a claim under worker's compensation or similar law is settled by stipulation or compromise.

Section 6

Specific Benefit Provisions

This section provides additional details about how the General Provisions of this policy (Section 4) apply to the specific health care services. It also describes special provisions that apply to these benefits.

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

Allergy Treatment

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

Covered Services

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

- Initial diagnostic evaluation. This includes the initial history, physical examination, relevant laboratory services, and the following diagnostic tests to determine the cause of an allergy:
  1. Scratch tests or specific intradermal tests, if warranted by the patient's history and physical examination.
  2. Specific laboratory tests to determine respiratory function and blood levels of the immune system.
  3. In vitro (via a blood sample) allergy tests if skin testing is not conclusive, if the patient has a condition that precludes the use of scratch testing or intradermal tests, or if these tests are used in lieu of scratch or intradermal testing.
- Injections of antigens (immunotherapy) to build up immunities, if warranted by the diagnosis.

Services Not Covered

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

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

- Provocative and neutralization testing and treatment, which involves placing allergy-producing substances under either the skin or the tongue and then “neutralizing” the symptoms with a weaker solution of the same substance.
- Repeated intradermal testing. Repeated testing is not covered unless information is provided that substantiates the need for continued intradermal testing according to AAAAI guidelines.
- Skin-test end-point titration for evaluating the effectiveness of immunotherapy.
- Food allergy desensitization therapy. Although testing for food allergies is covered under the policy if it is warranted by the history and physical exam, food allergy therapy is not. The AAAAI maintains that the only proven therapy in treating food allergies is the strict elimination of the offending food.

Ambulance Services

We reimburse for licensed ambulance transport if your condition requires rapid transport and the attendance of skilled medical professionals.

Covered Services

- Licensed ground ambulance transportation to the nearest facility equipped to handle your Illness or Injury.
- Licensed air ambulance transportation to the nearest facility equipped to handle your Illness or Injury, but only if such swift transport is essential for your safe and effective treatment.
- Licensed ambulance transport between medical facilities, but only if you cannot be treated safely and effectively in the facility where you are confined and your condition requires the attendance of medical professionals during transport. In this case, reimbursement is limited to the cost of transportation to the nearest facility equipped to treat your medical condition.

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

Chiropractic Treatment

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

Covered Services

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

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

Services Not Covered

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

- Services that continue after you have recovered from the acute stage of your Illness or Injury and further meaningful progress will be minimal or difficult to measure.
- Services to treat a chronic condition or any condition if there is no reasonable expectation of prompt and significant improvement.
- Services that continue after you reach your expected state of improvement, resolution, or stabilization of a health condition.
- Services intended to prevent a relapse, reversal, or exacerbation of a health condition.
- Services provided on a routine or scheduled basis in the absence of functional impairment, even if intended to maintain optimal functioning.
- Supplies, or counseling in connection with any supplies, such as vitamins, herbs, nutritional supplements, cervical pillows, heel lifts, and lumbar rolls.
- Orthotic devices unless custom made and prescribed by a Physician.

Dental Services

Covered Services

We cover only these dental services:

- The initial treatment required to repair and restore the functioning of sound, natural teeth that have been ***injured***. The term ***injured***, as used here, does not include dental conditions resulting from eating, biting, disease, or decay. A ***sound, natural tooth*** is one that is organic, not manufactured. Therefore, bridges, implants, crowns, and dentures are not natural teeth. Any service for, or in connection with, their restoration and repair is not covered under this policy.
- Oral surgery performed by a Doctor of Dental Surgery (D.D.S.) or a Doctor of Medical Dentistry (D.M.D.) in connection with a service that is covered by this policy; for example, removal of impacted wisdom teeth.
- Hospital and ambulatory surgery center charges, including anesthesia charges, if you must receive dental care in one of these settings because you meet one of these two conditions:
  1. You are less than 5 years old.
  2. You have a chronic disability or medical condition that requires Hospitalization or general anesthesia for dental care.

Services Not Covered

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

- Subsequent treatment to an injured tooth after the initial treatment.
- Orthodontia, occlusal adjustment, or dental restorations unless required to repair and restore the functioning of a natural tooth that is injured.
- Replacement of crowns, bridges, partial or full dentures, or implants.
- Extraction or replacement of natural teeth required because of disease or decay.
- Implants or oral surgery for, or in connection with, implants unless needed to repair and restore the functioning of a sound, natural tooth that has been injured.
- Orthognathic surgery unless required for the correction of a handicapping skeletal malocclusion that causes significant functional impairment.
- Behavior modification therapy or symptomatic care such as nutritional counseling and home therapy programs.
- Any service that is directed at improving the appearance of a tooth and that does not

meaningfully restore the function of an injured tooth or any tooth; for example, bleaching.

Diabetes Supplies and Equipment

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

Covered Services

Covered supplies and equipment for diabetes treatment include:

- Insulin and other prescription drugs and medications prescribed for the treatment of diabetes. If your health plan coverage includes a prescription drug plan, these drugs and medications are subject to the provisions and reimbursement rules that apply to your drug plan. If your health plan coverage does not include a prescription drug plan, these drugs and medications are subject to the provisions and reimbursement rules that apply to other medical services.
- Test strips, swabs and wipes, autolets or lancets, syringes, and hypodermic needles for administering insulin. If your health plan coverage includes a prescription drug plan, you should purchase these supplies with your prescription drug card at a pharmacy that participates in our prescription drug program. If your health plan coverage does not include a prescription drug plan, submit a claim to us after you purchase the drugs and/or supplies.
- Durable medical equipment such as insulin infusion pumps and non-invasive continuous glucose monitors, but only if we have authorized the expenditures in advance. We preauthorize the purchase of no more than one insulin infusion pump during a Benefit Period, and we may require you to use it for 30 days at our expense before we authorize its purchase.
- Diabetes self-management education programs.

Services Not Covered

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

Durable Medical Equipment and Supplies

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

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

Information About Our Preauthorization Criteria

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

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

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

Cost-effectiveness—In comparing equipment alternatives, we consider whether distinct medical advantages justify greater cost or more

frequent replacement. Thus, we do not authorize coverage of added costs for equipment that has no advantage over a suitable alternative other than convenience or personal preference. We also do not authorize repair or replacement of equipment damaged because of negligent use or abuse. We reserve the right to determine whether to rent or purchase.

Covered Equipment

These are examples of items we may preauthorize:

- Durable medical equipment for home use. Examples are morphine pumps, oxygen regulators, infusion pumps, and specialized feeding equipment.
- Prosthetic devices to replace a missing body part. Examples are artificial limbs, artificial eyes, and full cranial hair prostheses (wigs) in the case of sudden onset baldness that is the consequence of a covered disease, accident, or medical treatment and that is sufficiently extensive to significantly alter the patient's appearance.
- Durable mechanical equipment (which does not meet our definition of durable medical equipment) that we may preauthorize, such as wheelchairs and hospital beds.
- Functional repair of durable medical equipment.

Covered Supplies

These are covered supplies that do not require preauthorization:

- Orthopedic appliances. Examples are custom made orthotics prescribed by a Physician, casts, splints, trusses, braces, and crutches for short-term or long-term use.
- Supplies necessary for the proper mechanical operation of equipment that we have preauthorized.
- Ostomy care items, catheter maintenance supplies, and surgical stockings (for example, Jobst stockings).

Equipment and Supplies Not Covered

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

- Items that are useful in the absence of Illness, Injury, or disability. Examples are air conditioners, air cleaners and purifiers, humidifiers, whirlpools, dehumidifiers, lift chairs, stair lifts, van lifts, physical fitness items such as exercise cycles, and other similar items for an individual's comfort, personal hygiene, physical fitness, or convenience.
- Routine maintenance of equipment. This applies whether or not we have purchased the equipment.
- Repair or replacement of equipment damaged because of negligent use or abuse.
- Equipment or supplies to facilitate participation in physical activity or sports.
- Over-the-counter supplies other than those listed above or in the subsection on "Diabetes Supplies and Equipment" earlier in this section.

Emergency Services

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

Services received in an emergency room are subject to the copayment amount specified on

your Benefit Summary. This copayment is waived if you are admitted as an inpatient for at least 24 hours as a result of the medical emergency.

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

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

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

These are examples of medical emergencies:

- Suspected heart attack.
- Loss of consciousness.
- Suspected or actual poisoning.
- Acute appendicitis.
- Convulsions.
- Heat exhaustion.
- Uncontrollable bleeding.
- Fractures.
- Other acute conditions that are of sufficient severity to warrant immediate medical care.

These are examples of conditions that are not medical emergencies:

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

Hearing Services

Covered Services

Covered hearing-related services are limited to:

- Diagnostic tests to establish or confirm a hearing loss and determine the cause.
- Treatment of hearing pathology caused by an Illness or Injury.
- Surgery to repair malformed or malfunctioning hearing-related structures.
- Cochlear implants, but ***only*** if we have authorized both the evaluation services and the implant procedures in advance in accordance with our preauthorization review criteria.

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

Services Not Covered

These are examples of services that are not covered:

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

Home Health Care

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

Information About Our Preauthorization Criteria

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

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

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

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

- Your care would otherwise require confinement in a health care facility.
- The services you require are not available from members of your family or others living in your home without causing undue hardship.

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

Covered Services

Preauthorized covered services may include:

- Evaluation of the need for home health care and development of a home care plan by a registered nurse, or medical social worker when approved or requested by the attending Physician.
- Part-time or intermittent skilled nursing care provided by, or under the supervision of, a registered nurse who is other than the covered employee, covered dependents, or one who ordinarily resides in the patient's home.
- Part-time or intermittent home health aide services provided under the supervision of a registered nurse or medical social worker, including assistance in the performance of normal activities of daily living when such assistance is incidental to medical services.
- Skilled rehabilitation services.
- Prescribed medical supplies, drugs and medications, and laboratory services.
- Home infusion services.
- Prescribed intravenous (parenteral) or feeding tube (enteral) nutritional support systems. We cover food substitutes used for enteral nutrition when they are the only source of nutrition and the need is medically documented.

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

Services Not Covered

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

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

Hospice Care

We reimburse for hospice care for terminally ill patients but only if we have authorized the expenditure in advance. See Section 7 for information about our preauthorization requirements and reimbursement limits that apply.

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

Covered Services

These are examples of hospice services we may preauthorize:

- Room and board at a hospice facility, including services to alleviate physical symptoms.
- Physician and nursing care.
- Home health care services.
- Prescription and nonprescription medications provided by the hospice agency, organization, or facility.

Hospital Benefits

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

Hospital Admission Notification Requirement

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

Special note about childbirth: Remember that you must notify us within 72 hours of your Hospitalization for childbirth, unless you and your baby(ies) have been discharged within

72 hours of your admission. These notification requirements apply for other maternity-related emergency admissions as well, such as an admission for pre-term labor or other maternity complications when childbirth does not occur. If you do not notify us within the time required, your reimbursement will be reduced by the amount specified on your Benefit Summary, and this penalty does not apply to your maximum out-of-pocket limit.

Covered Services

Covered Hospital services include:

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

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

Services Not Covered

These are examples of services that are not covered:

- Nursing services performed during Hospitalization by nurses who are not employees of the Hospital.
- Convenience items or services other than those that are incidental to room occupancy.
- X-ray, laboratory, and other diagnostic services in connection with dental care, other than for oral surgery covered by this policy.

Kidney Disease Treatment

We reimburse for the treatment of chronic renal disease (CRD) or end-stage renal disease (ESRD) as required by state law. However, this policy does not limit reimbursement to the legally required amount. Covered services include kidney dialysis and transplantation services that we have authorized in advance. See Section 7 for information about our preauthorization requirements and reimbursement limits that apply.

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

Information About Our Coverage Criteria for Kidney Disease Treatment

We apply the coverage criteria described in Section 4, "General Provisions That Apply to

All Benefits” to your specific medical circumstances, but in general:

- We cover dialysis when recommended by a nephrologist and received at a renal dialysis center or facility certified by Medicare.
- We cover kidney transplantation when recommended by a transplant Surgeon and received at a facility that Medicare has certified for kidney transplantation, but only if we have authorized both the transplant evaluation services and the transplant procedures in advance. Read about our transplantation preauthorization review criteria later in this section under “Surgical Benefits.”
- We cover services at renal dialysis centers or renal transplant centers certified by Medicare.

Covered Services

These are examples of services we cover:

- Inpatient Hospital treatment including dialysis, surgery, and postoperative care.
- Dialysis performed at home by a trained ESRD patient or helper, or both.
- Inpatient, outpatient, or self-dialysis at a renal dialysis facility.
- Kidney transplantation, but only if we have authorized the expenditures in advance. This includes coverage for both the recipient and the living donor. Covered services for living donors include evaluation, Hospitalization, surgical costs, and postoperative care. Note that living donor services are covered only if the transplant recipient is covered by this policy.
- Procurement, transportation, and preservation of cadaveric donor kidneys.

Maternity and Newborn Benefits

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

Special Maternity Program—We encourage you to contact us early in your pregnancy, during the first trimester if possible, so you can receive information about our confidential, telephone-based maternity education program. This program is not intended to replace the care of your Physician, but rather to complement that care by giving you the resources you need to make informed decisions about your pregnancy and childbirth. You will receive support from obstetrical nurses with experience caring for pregnant women and newborns who will help you take an active role in planning a healthy pregnancy and give you access to current educational materials.

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

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

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

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

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you must comply with our Hospital admission notification requirement.

Hospital Admission Notification Requirement

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

Covered Maternity Services

These are examples of covered maternity services:

- Prenatal care. This includes physical examination, Pap test, laboratory tests, and HIV antibody test.
- Physician services related to labor, delivery, and postpartum care.
- Nurse-midwife services related to prenatal care, labor and delivery, and postpartum care performed by either (1) a registered nurse certified to practice as a nurse-midwife by the American College of Nurse-Midwives and the State of Wisconsin; or (2) a licensed registered nurse certified as a nurse-midwife in the state in which he or she practices. Except for emergency circumstances, you must receive the nurse-midwife services in a health care facility approved for the practice of nurse-midwifery by the state in which it is located.
- Hospital room and board.

Covered Special Services When a Pregnancy Exists

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

- The pregnant woman is 35 or older.
- The pregnant woman or her mate has a family history of a highly disabling hereditary disorder or has previously had a child with such a disorder.
- The pregnant woman has previously experienced a miscarriage or stillbirth.
- The pregnant woman is a known carrier of a genetic abnormality or disease.
- The pregnant woman was exposed, before or during pregnancy, to diseases or chemicals strongly linked to birth defects, or the pregnant woman's mate was exposed to such disease or chemicals before the pregnancy began.

Covered Special Services When No Pregnancy Exists

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

- The woman or her mate has a family history of a highly disabling hereditary disorder.
- The woman or her mate is a known carrier of a genetic abnormality or disease.
- The woman or her mate has previously had a child with a genetic disorder, abnormality, or disease.
- The woman has had multiple miscarriages or stillbirths.

Covered Newborn Services

Covered newborn services include:

- Services required by a newborn immediately after birth including care and treatment for pre-term or premature birth, low birth

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

- Treatment of congenital defects and birth abnormalities including functional repair necessary to achieve normal body function. However, we do not cover cosmetic surgery performed only to improve a newborn's appearance.
- Routine or "well baby" Physician visits after birth. See "Covered Services" under "Routine Physical and Preventive Care Benefits" later in this section for more details.

Maternity and Newborn Services Not Covered

These are examples of services that are not covered:

- Midwife labor and delivery services outside of a Hospital unless received in a facility that has met our requirements and has been approved as a qualified provider under this policy.
- Amniocentesis or ultrasound performed to alleviate anxiety or to determine the gender of the fetus.
- Childbirth education or preparation courses; for example, Lamaze classes.

Mental Health and Substance Abuse Benefits

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

- The clinical information documenting your condition at the time services are required.
- Your treatment history.
- The proposed treatment plan.

Benefits include inpatient, transitional, and outpatient treatment, whichever alternative is the most cost-effective and medically appropriate for receiving necessary services safely and effectively. You can read about our cost-effectiveness limit in Section 4. We have identified ***qualified providers*** of each type of treatment in the subsection to which they apply.

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

Special Factors That Affect Reimbursement

Preauthorization—Some mental health and substance abuse services require our advance approval; see your Benefit Summary for a list of services that require preauthorization.

Reimbursement Limit for Treatment at Certain Facilities—We reimburse only up to the amount mandated by Wisconsin law for inpatient and transitional treatment at a facility that does not meet our definition of a Hospital but has been certified by the State of Wisconsin for treating mental health and substance abuse disorders (e.g., private, state, and county mental health facilities). After we have paid the mandated amount for ***all*** inpatient and transitional care during a Benefit Period, we reimburse for additional inpatient and transitional treatment ***only*** if received at a general medical and surgical Hospital as defined in Section 2. There is one exception: This limit does not apply to a facility that is a Network provider.

Inpatient Treatment

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

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

Covered Inpatient Treatment Services

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

- Brief periods of Hospital confinement during which the individual is an active danger to herself or himself or others and therefore requires suicide or homicide precautions and continuous monitoring and intervention by skilled professionals.
- A period during which the patient requires medications that must be continuously monitored by skilled professionals.
- A period during which the patient's Illness has led to such severe physical or mental decline that the patient can no longer responsibly tend to his or her own general safety and physical well-being.
- A period during which the patient experiences acute and dangerous substance withdrawal symptoms that require continuous monitoring and intervention by skilled professionals.

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

- The acute stage has passed.
- The patient no longer needs continuous monitoring, observation, and intervention by skilled professionals.
- The patient's condition has stabilized.

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

Qualified Providers of Inpatient Treatment

Qualified providers of covered inpatient treatment are:

- General medical and surgical Hospitals.
- Private psychiatric hospitals certified by the State of Wisconsin for treating mental health and substance abuse disorders (e.g., private, state, and county mental health facilities).

Inpatient treatment received in states outside Wisconsin in a private psychiatric hospital is covered only if the facility has been certified by the State of Wisconsin or the hospital is a member of our Network.

Transitional Treatment

Covered Transitional Treatment Services

We cover transitional treatment services provided by qualified providers for each day for which clinical records substantiate that the treatment is medically necessary, medically appropriate, and cost-effective.

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

Transitional treatment refers to mental health and alcohol or other substance abuse treatment that is not inpatient but is more intensive than outpatient treatment. Examples of types of transitional treatment include:

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

Qualified Providers of Transitional Treatment Services

Qualified providers are those whose services and treatment programs we are required by law to cover and who have been certified by the State of Wisconsin. You can call us to find out if the services you anticipate receiving fulfill this requirement.

Transitional treatment received in states outside of Wisconsin is covered only if the facility has been certified by the State of Wisconsin or the provider is a member of our Network.

Outpatient Treatment

Covered Outpatient Treatment Services

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

We cover psychological and neuropsychological testing ***only*** if we authorize the services in advance. See Section 7 for information about our preauthorization requirements and reimbursement limits that apply. We preauthorize such testing only if ***all*** of the following apply:

- A thorough clinical assessment by a qualified provider has been conducted. A thorough clinical assessment includes a review of mental status, social functioning, applicable medical information, history, and applicable collateral information.
- There is significant uncertainty about a diagnosis that affects the choice of treatment interventions.
- The patient's symptoms are complex or unusual so that diagnosis and clarification of symptoms can be accomplished only through such testing.
- There are distinct treatment options based on the differential diagnosis that is clarified through the testing.
- The testing is likely to produce the required diagnosis and clarification necessary for planning treatment.

We cover nutritional counseling, when part of an approved treatment plan prescribed by a psychiatrist, provided by a certified or registered dietitian, and necessary for the effective treatment of a life-threatening Illness (e.g., anorexia nervosa), but ***only*** if we authorize the counseling in advance.

Qualified Providers of Outpatient Treatment

A qualified outpatient mental health provider is one of these:

- A state-licensed psychiatrist. This is a state-licensed Physician with a specialty in psychiatry.
- A state-licensed psychologist.
- A provider who is a member of our Mental Health Network.

Unless the provider is a member of our Mental Health Network, services by these providers are covered only if the outpatient clinic in which the services are provided has been certified by the State of Wisconsin:

- Licensed Independent Clinical Social Worker (LICSW).
- Licensed Professional Counselor (LPC).
- Licensed Independent Social Worker (LISW).
- Registered nurse with a master's degree and certified as a specialist in psychiatric and mental health nursing.
- Certified Alcohol and Drug Counselor (CADC).

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

Services Not Covered

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

- Residential mental health and eating disorder programs.
- Custodial or long term care. See Section 5 for a description of custodial care. Examples include group homes and halfway houses for supportive and maintenance care for mental health or substance abuse Illnesses.
- Psychological testing and assessments that are not likely to yield additional information that is useful for healing and curing or planning medical treatment. Examples include but are not limited to testing to assist with custody placement, vocational assessments, and academic assessments.
- Services for academic problems in the absence of a diagnosed mental health Illness, or that the child's school is legally obligated to provide, whether or not the school actually provides them and whether or not you choose to use those services.
- Treatment of a behavioral or psychological problem that, although it may appropriately be the focus of desired professional attention or treatment, is not attributable to a clinically diagnosed mental health Illness. Examples include antisocial behavior, uncomplicated bereavement, codependency, occupational problems such as job dissatisfaction or uncertainty about career choices, parent-child problems such as impaired communication or inadequate discipline, marital problems, and other interpersonal problems.
- Services for, or in connection with, nicotine addiction (unless received through our Tobacco Cessation program, described later in this section), excessive eating, or compulsive gambling.
- Mental health services for, or in connection with, developmental delays; for example, Autistic Disorder, Rett's Disorder, and Asperger's Disorder.
- Inpatient treatment that continues after the medical necessity of Hospitalization has passed and the patient is awaiting placement.
- Inpatient treatment of a chronic mental health or substance abuse disorder unless clinical records document significant physical decline or the patient represents an active danger to herself, himself, or others.

Physical, Speech, and Occupational Therapy

This policy distinguishes between ***rehabilitative*** and ***habilitative*** therapy treatments.

- ***Rehabilitative*** treatments are aimed at restoring a functional ability that was once achieved but has been diminished or lost because of an Illness or Injury. They also include treatments that minimize functional degeneration associated with a chronic progressive Illness such as Multiple Sclerosis.
- ***Habilitative*** treatments are aimed at acquisition of a functional ability that has been significantly delayed or impaired by congenital defect, birth abnormality, or early childhood Illness or Injury.

We reimburse for physical, speech, and occupational therapy that meets all of the conditions specified below for each type of therapy, but only if we have authorized both the evaluation and therapy services in advance. See Section 7 for information about our preauthorization requirements and reimbursement limits that apply.

Covered Rehabilitative Therapy Services

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

Information About Our Preauthorization Criteria—We preauthorize rehabilitative therapy treatment only if it meets ***all*** of the following criteria. The therapy must be:

- Prescribed by a Physician in a treatment plan that identifies both the expected goals and the frequency and duration of treatment.
- Reasonably expected to promptly and significantly restore or minimize the degeneration of the functional ability.

  We decide whether prompt and significant progress can reasonably be expected. When we make this determination, we consider your diagnosis, prognosis, medical records, progress notes related to prior therapy, contemporary medical consensus, and the advice of our medical consultants.
- Provided in a manner consistent with the treatment plan by an individual licensed to perform the therapy in the state in which he or she practices.

Rehabilitative Therapy Services Not Covered

We neither preauthorize nor cover any service that does not meet all of the above criteria. For example, none of the following is covered:

- Therapy that continues after you have recovered from the acute stage of inability and, in our opinion, further meaningful progress will be minimal or difficult to measure.
- Therapy that continues after you achieve your expected improvement, resolution, or stabilization of a health condition, as determined by us.
- Services intended to prevent a relapse, reversal, or exacerbation of a health condition.
- Therapy provided on a routine or scheduled basis in the absence of functional impairment even if intended to maintain optimal body functioning.
- Group therapy.
- Equipment or services to prevent Injury or to facilitate participation in physical activity or sports.
- General observation of exercises that can be performed in a home or health club setting.
- Services in which you have been instructed and demonstrated competence; for example, general range-of-motion exercises.
- Lifestyle educational services and materials even if provided to enhance therapy. Examples include chronic pain management classes, stress management classes, physical fitness instruction, behavior modification classes, nutritional counseling, books and other instructional materials related to health conditions, and classes to educate family members.

Covered Habilitative Therapy Services

While this policy generally covers only services to restore a function lost because of an Illness or Injury, it provides a limited benefit for services aimed at the acquisition of a physical functional ability. The policy does not cover services to enhance or attain all physical functional abilities or to develop all physical capacities considered normal or appropriate for an individual's chronological age. The policy covers habilitative therapy services only if they meet our specific criteria and have been authorized by us in advance.

Information About Our Preauthorization Criteria—We preauthorize habilitative therapy services that are reasonably expected to produce prompt and significant progress toward acquiring a functional ability that:

- Has been ***significantly*** delayed or impaired by congenital defect, birth abnormality, or early childhood Illness or Injury; ***and***
- Is essential for performing these basic self-care activities: eating, toileting, dressing, functional mobility, and functional communication.

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

1. Prescribed by a Physician in a treatment plan that:
   - Identifies the delayed or impaired essential functional ability.
   - Establishes the expected achievable goals toward the required level of functioning.
   - Specifies the frequency and duration of treatment necessary to achieve those goals.
2. Reasonably expected, in the patient's specific circumstances, to produce prompt and significant progress toward the treatment goals.
3. Provided in a manner consistent with the treatment plan by an individual licensed to perform the therapy in the state in which he or she practices.

Therapy will neither be preauthorized nor covered when we determine that the patient has ***either***:

- Acquired a level of functioning sufficient for performing self-care activities; ***or***
- Acquired the maximum functional ability for his or her maturational age, ***whichever comes first***.

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

Habilitative Therapy Services Not Covered

We will neither preauthorize nor cover any service that does not meet all of the above criteria. For example, none of the following is covered:

- Therapy that continues after the patient has stabilized at a level of functioning; that is, medical records do not clearly document meaningful, measurable progress toward the patient's ability to perform basic self-care activities.
- Therapy that continues after the patient has acquired the maximum level of functioning for his or her maturational age.
- Services in which the patient has been instructed and demonstrated competence; for example, general range-of-motion exercises.
- Services that the child's school is legally obligated to provide, whether or not the school actually provides them and whether or not you choose to use those services.
- Services aimed at developing or enhancing the patient's ability to perform school tasks such as grasping a pencil, writing, using a scissors, accessing playground equipment, developing play skills, reading, or understanding reading materials.
- Auditory processing evaluation and treatment (except as preauthorized in connection with a cochlear implant). Examples include but are not limited to auditory integration training, aural rehabilitation, and auditory training.
- Services aimed at developing social awareness and social skills that do not meaningfully contribute to acquiring a functional ability essential for performing a basic self-care activity or communicating basic needs.
- Services that are available without cost from a governmental or other public or private organization.
- Services that can be provided by members of your family without causing undue hardship.

Physician's Office and Outpatient Care Benefits

We reimburse for services by qualified providers in a Physician's office or other outpatient setting only if they are medically necessary and medically

appropriate to diagnose or treat Illnesses or Injuries. There is an exception: We cover a limited number of specified routine and preventive services, even when you have no symptoms of an Illness or Injury. Those services are listed under:

- "Maternity and Newborn Benefits."
- "Reproductive Health Benefits."
- "Routine Physical and Preventive Care Benefits."

Some outpatient services are covered only if we have authorized the expenditure in advance. Those services are specified on your Benefit Summary. See Section 7 for information about our preauthorization requirements and reimbursement limits that apply.

Prescription Drugs

Your coverage includes the prescription drug plan specified on your Benefit Summary. Read about your prescription drug benefits in the Optional Benefit Provisions located in the Appendix.

Reproductive Health Benefits

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

Covered Contraception and Surgical Sterilization Services

We cover these services and supplies:

- All safe and effective drugs, medications, and devices in general use as contraceptives that require a prescription or intervention by a Physician or other licensed health care provider. Examples include birth control pills, Norplant or similar contraceptives, Depo Provera, injectible contraceptives, intrauterine devices (IUDs), cervical caps, and diaphragms.
- Necessary services of a Physician or other licensed health care provider in connection with covered contraception. Such services include assessment, diagnosis, administration, insertion, or prescription.
- Surgical sterilizations such as tubal ligations and vasectomies.

Covered Preventive Services

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

- Pelvic exam, Pap test, and mammogram performed once each Benefit Period.
- Prostate cancer screening procedures performed once each Benefit Period.

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

Covered Infertility Services

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

- Services performed ***exclusively*** to diagnose the cause(s) of infertility. Once a diagnosis has been rendered, no further diagnostic tests are covered unless they are reasonably expected to reveal another clinical cause for infertility.
- Surgical procedures necessary to repair or restore a malformed or malfunctioning body part or process found to be the cause of infertility in order to enable natural conception. ***Note:*** The reversal of tubal ligations and vasectomies is not covered.

Services Not Covered

These are examples of services that are not covered:

- Diagnostic tests performed in connection with the treatment of infertility. Examples are diagnostic studies to determine the time of ovulation, abdominal ultrasounds to determine follicle growth, and diagnostic services that would not be performed in the absence of infertility treatment.
- Physician, Hospital, or any other service directed at, or for or in connection with, treating the cause of infertility other than surgical repair; for example, laparoscopic or transvaginal retrieval of ovum.
- Services for or in connection with any artificial, mechanical, or other alternative to the natural process of conception. Examples include in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), intracytoplasmic sperm injection (ICSI), embryo transplantation, artificial insemination, sperm and embryo storage, and similar methods or procedures.
- Medication prescribed for treating infertility. Examples are drugs for hyperstimulation of the ovaries (for example, Clomiphene or Serophene) or drugs for treating low sperm count or motility.
- Services for, or in connection with, the reversal of surgical sterilization such as tubal ligations and vasectomies.
- Services for, or in connection with, or leading to, a sex transformation.
- Contraceptive drugs, supplies, or devices that can be obtained without intervention by a Physician or other licensed health care professional. Examples include condoms and contraceptive foam or gel.

Routine Physical and Preventive Care Benefits

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

1. Contemporary medical consensus considers them reliable and effective.
2. They are performed by qualified providers.
3. They are safe and indicated for your individual medical history and risk group. Your risk group is defined by your age, sex, and risk factors such as family history, lifestyle, and tobacco and alcohol use.
4. They will provide new and relevant information about your health and are not redundant when performed with other procedures that have been or are performed.

Covered Services

We cover these routine and preventive services:

- Routine physical examination performed once each Benefit Period.
- Appropriate diagnostic procedures performed once each Benefit Period. Examples include complete blood count, total blood cholesterol test, thyroid function test, HIV antibody test, urinalysis, colorectal cancer screening procedures, mammogram, clinical breast exam, Pap test, pelvic examination, and prostate cancer screening. We cover these procedures at more frequent intervals if performed to treat a diagnosed Illness or if warranted by family history or other risk factors.
- Prenatal and maternity care. For more information see "Maternity and Newborn Benefits" earlier in Section 6.
- Well baby and child care. This includes hearing and vision tests, hemoglobin and hematocrit tests, and blood tests to detect lead exposure.
- Immunizations for children deemed appropriate by a Physician. These include vaccines such as diphtheria-pertussis-tetanus

(DPT), measles-mumps-rubella (MMR), hepatitis B (HBV), oral poliovirus vaccine (OPV), hemophilus influenza B, and varicella. The immunizations listed are not subject to deductibles, coinsurance, or copayments for children from birth to the age of 6 years when they are received from a Network provider.

- Immunizations for adults that are deemed appropriate by a Physician. These include vaccines such as tetanus, diphtheria, influenza, pneumococcal vaccine, and travel-related vaccines.

Services Not Covered

These are examples of services that are not covered:

- Diagnostic procedures that contemporary medical consensus considers ineffective, unreliable, unproven, or of dubious value to an individual with your medical and other risk factors.
- Office visits and routine hearing examinations or tests for, or in connection with, prescribing or fitting a hearing aid.
- Routine eye examinations unless your Benefit Summary indicates, under Optional Benefit Provisions, that the Vision Care Benefit or Vision Examination Benefit applies to your policy.

Second Opinion Benefits

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

Skilled Nursing Facility Care

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

Period of Confinement

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

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

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

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

- If your home stay before re-entering a skilled nursing facility was lengthy, we may determine that you had sufficiently recovered from the first condition and, therefore, you are entitled to a new period of confinement.
- If you experience an unexpected recurrence of your original condition after recovery, or you have a new medical condition, we may determine that you are entitled to a new period of confinement.

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

Qualified Providers of Skilled Nursing Facility Care

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

- An institution operated primarily for care and treatment of mental health disorders, drug abuse, or alcoholism.
- A facility that primarily provides residential, retirement, custodial, or long term care.
- A private room or apartment.

Information About Our Preauthorization Criteria

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

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

Skilled nursing and ***skilled rehabilitation*** services are described below.

Covered Services

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

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

Services Not Covered

We neither preauthorize nor cover skilled nursing facility care if the services are primarily custodial or long term care. By this, we mean services that can generally be provided by persons without professional medical training or skills and that are primarily for one or more of the following purposes:

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

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

Skilled Nursing Services

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

Services may be received in your place of residence or in a facility. When received in a facility (for example, Hospital or skilled nursing

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

Covered Services

These are examples of covered skilled nursing services:

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

Services Not Covered

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

- Planning and managing a plan of care that does not require skilled services.
- Periodic turning and positioning of a nonambulatory patient.
- Prophylactic or palliative skin care; for example, bathing and applying creams or lotions.
- Administering routine medications, eye drops, and ointments.
- Wound care for noninfected postoperative or chronic medical conditions.
- General administration of oxygen and other inhalation therapy after the initial phase of treatment adjustments and training the caregiver are completed.
- Services that, after instruction and demonstrated competence, can be reasonably and safely performed by the patient or the patient's family. Examples include, but are not limited to, routine insulin injection, self-urinary catheterization, and long-term feeding by gastrostomy or jejunostomy tube.
- General observation of exercises, including range-of-motion exercises.
- General maintenance of ostomies or catheters.
- Custodial or long term care (see Section 5 for a description of custodial care).

Skilled Rehabilitation Services

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

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

Information About Our Preauthorization Criteria

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

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

Covered Services

These are examples of skilled rehabilitation services we may preauthorize:

- Physical therapy for specific neurological, muscular, or skeletal problems resulting from an Illness or Injury.
- Teaching mobility or transfer skills.
- Range-of-motion exercises if they are part of the prescribed active treatment for a specific medical condition resulting in loss or restriction of mobility.
- Design of a maintenance program to be performed by the patient to prevent or minimize deterioration of the patient's condition. Services to aid the patient in performing this maintenance program are not covered unless the need is medically documented.
- Prescribed speech, physical, or occupational therapy services to promptly restore a previously possessed function that was lost as a result of an Illness or Injury.

Services Not Covered

We will neither preauthorize nor cover any service that does not meet ***all*** of our preauthorization criteria. For example, none of the following is covered:

- Services that do not require the supervision of, or performance by, skilled rehabilitation providers.
- Services that continue after you have recovered from the acute stage of your Illness or Injury and, in our opinion, further progress is expected to be minimal or difficult to measure.
- General observation of exercises, including range-of-motion exercises.
- Services in which the patient has been instructed and demonstrated competence; for example, general range-of-motion exercises.

Surgical Benefits

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

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

Important Reminders

- Some surgical services require our advance authorization; for example, reconstructive or plastic surgery and transplantation procedures. Your Benefit Summary lists all services that require preauthorization.
- In addition, if your surgery requires a Hospital stay, you must call us in advance to fulfill our Hospital admission notification requirements.
- If your surgery will be performed in a surgical facility (e.g., inpatient or outpatient ambulatory surgery center), we encourage you to call us in advance to confirm whether the use of the surgery facility will be covered.

Reconstructive Surgery Following Mastectomy

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

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

Transplants

We cover transplantation procedures ***only*** if ***both*** of these criteria are met:

1. We have authorized both the transplant evaluation services and the transplant procedures in advance.
2. The transplant evaluation and the transplant surgery are received at a facility that meets these requirements:
   - For solid organs, the facility must be certified by Medicare for the particular type of transplant surgery being performed.
   - For stem cell transplants, the facility must be certified to work with the National Marrow Donor Program (NMDP).

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

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

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

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

Although travel, meal, and lodging expenses are not generally covered by the policy, we may preauthorize such assistance when a patient chooses to receive a transplant at one of our specialty Network transplant facilities. The intent of this preauthorized reimbursement is to help ensure that patients who choose our specialty Network transplant facilities are not financially disadvantaged by doing so.

Special Presurgical Second Opinion Benefit

Whenever your Physician recommends surgery, we encourage you to obtain a presurgical second opinion consultation. We reimburse the reasonable and customary charges of such a consultation, provided we authorize it in advance. We preauthorize second opinion consultations with Physicians who are neither involved in the recommended surgery nor affiliated with the Physician who will perform the surgery. See Section 7 for information about our preauthorization requirements.

Reimbursement Factors That Pertain to Surgeries

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

Global Surgical Fee—We reimburse for surgeries on a global surgical fee basis. This assumes that certain services, pre-operative, operative, and post-operative, are included in the Surgeon's total charges. Operative care

comprises all services that are an essential and usual part of the primary surgical procedure. Examples include preparing and positioning the patient, consulting with the anesthesiologist or anesthetist, placing tubes and catheters, and the surgery itself. Post-operative care comprises all services necessary to monitor the patient's recovery. It begins when surgery is completed and continues for as long as is commonly accepted as adequate post-operative care for that procedure.

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

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

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

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

Covered Services

These are examples of covered surgical services:

- Surgical services of the Physician, Surgeon, or surgical assistant. This includes oral surgery performed by a Doctor of Dental Surgery (D.D.S.) or a Doctor of Medical Dentistry (D.M.D.) in connection with a service that is covered by this policy (e.g., removal of impacted wisdom teeth).
- Anesthesia services only if not generally included in the global surgical fee.
- Care provided by an anesthesiologist or anesthetist to monitor the patient's vital physiological signs.
- Essential ancillary services such as whole blood or blood plasma.

Services Not Covered

These are examples of surgical services that are not covered:

- Services for, or in connection with, surgeries that we regard as unsafe, ineffective, or unproven.
- Services for, or in connection with, surgical procedures primarily performed to improve appearance (i.e., cosmetic surgery) when there is little or no accompanying meaningful improvement in the functioning

of a malformed body part or restoration of a bodily function.

- Services for, or in connection with, any surgical treatment for obesity.
- Bariatric surgery, gastric restrictive or bypass procedures, or similar surgeries.
- Services that are generally included in the global surgical fee.
- Services for, or in connection with, a surgical procedure that is not covered.
- Costs for, or in connection with, early admission prior to surgery if pre-surgery services could be performed in an outpatient setting.

Temporomandibular Disorder (TMD) Treatment

We reimburse only for:

- TMD treatments, surgical and nonsurgical, that we have authorized in advance.
- TMD testing that contemporary medical consensus considers safe and effective.

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

This policy limits reimbursement to the preauthorized services and expenditures for surgical and nonsurgical treatment, and the reasonable and customary charges for covered diagnostic services, less applicable deductible, coinsurance, and copayment amounts.

Covered Services

These are examples of services we cover:

1. Initial diagnostic evaluation. This includes initial history, physical examination, and relevant laboratory and diagnostic services. The following diagnostic services are covered if they are responsive to your specific symptoms, likely to yield additional information useful for planning treatment, and not redundant with other diagnostic procedures:
   - Panoramic or TMD tomography, if warranted by your history and physical examination.
   - Magnetic resonance imaging (MRI), if the Physician's evaluation indicates the presence of joint disease and an MRI is needed to assist in the diagnosis.
   - Psychosocial assessment to determine if evaluation by a psychologist or psychiatrist is appropriate. However, comprehensive psychological inventories are not covered.
   - Blood testing and urinalysis to identify blood, musculoskeletal, chemical, or other abnormalities suggestive of systemic disease.
   - Diagnostic injections, such as nerve blocks.
2. Surgical and nonsurgical treatment that contemporary medical consensus considers safe and effective and that we have preauthorized. See Section 7 for information about our preauthorization requirements and reimbursement limits that apply. These are examples of services that we may preauthorize:
   - Reversible intraoral prosthetic devices and appliances, such as removable splints.
   - Physical therapy treatments reasonably expected to produce prompt and significant improvement.
   - Steroid joint injections.
   - Open surgical procedures and surgical arthroscopy, only if necessary to

rehabilitate a functional deficit or impairment caused by specific joint disease that has been resistant to other medical treatment.

Services Not Covered

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

- Electromyography (EMG) or muscle testing.
- Electronic jaw-tracking systems.
- Thermography and kinesiography.
- Ultrasonography.
- Radiography or regular dental X rays.

These are examples of treatment we will neither preauthorize nor cover because general medical consensus considers them unproven or unconventional:

- Orthodontic (use of braces) and orthognathic (use of surgery) treatment for changing the bite.
- Occlusal adjustment or modification of a dental surface to change the bite.
- Restorative therapy or prosthodontic treatment (use of crowns and bridges to balance the bite).
- Ultrasonic treatment, electrogalvanic stimulation, iontophoresis, and biofeedback.
- Transcutaneous electrical nerve stimulation (TENS).
- Nutritional counseling and home therapy programs.
- Services to treat a chronic condition or any condition for which there is no reasonable expectation of a prompt and predictable improvement in your health status.
- Services that continue after you reach the expected state of improvement, resolution, or stabilization of your health condition.

Tobacco Cessation Services

We reimburse for specified tobacco cessation aids if you are a tobacco user who is 18 years of age or older. You can receive 3 months of cessation aids per year, 1 month at a time, which are to be used during 3 consecutive months. Receiving a 1-month supply at a time offers you the opportunity to try different cessation aids over the 3-month period if the previous aids were not effective for you.

To obtain these aids through your prescription drug plan, you will need a Physician's prescription. You can view the list of covered prescription drugs and over-the-counter aids on our Web site at weatrust.com.

All such tobacco cessation drugs and aids are subject to the copayments and coordination of benefits provisions that apply to your prescription drug plan unless you enroll in our Tobacco Cessation Program.

Special Tobacco Cessation Program

If you choose to enroll in our confidential Tobacco Cessation Program, we will provide the following services ***at no charge*** to you:

- The covered prescription drugs and over-the-counter tobacco cessation aids, as described above. (You will not be required to pay the prescription drug copayment.)
- Tobacco cessation counseling services. These counseling services are covered ***only*** through our Tobacco Cessation Program and not from other providers.

If you choose not to participate in the counseling services, your covered prescribed tobacco cessation drugs and aids are subject to your drug plan copayment.

For additional information about this program and how to enroll, visit our Web site at weatrust.com. You will find tobacco cessation information in the Health and Wellness section. Or, call and talk to one of our customer service representatives.

Urgent Care

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

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

Vision Services

Covered Services

We cover only these vision services:

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

Services Not Covered

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

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

Optional Vision Coverage

We cover other vision services only if the Vision Care Benefit or the Vision Examination Benefit is included in the list of applicable Optional Benefit Provisions on your Benefit Summary. These optional benefits are included in the Appendix.

Section 7
Hospital Admission Notification and Preauthorization Requirements

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

Hospital Admission Notification Requirements

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

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

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

Penalty if You Do Not Comply

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

What You Must Do

- If yours is a ***planned admission***, you must notify us before you enter the Hospital—at least 5 days in advance, whenever possible. We encourage you to call us to comply with this requirement as soon as you know you will be Hospitalized. Advance notice allows us to review your treatment plan and tell you what services will be reimbursed. It also allows us to follow your recovery to determine if your continued Hospitalization meets the policy's criteria for coverage.
- If you are Hospitalized overnight due to an ***emergency admission***, you or a family member, Physician, or Hospital employee must notify us within 72 hours of being admitted or as soon as it is medically feasible for you to do so, whichever is later.

We'll need this information when you call or write to notify us of an overnight Hospitalization:

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

Depending on the nature of the Hospitalization, we may need more information.

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

Special Maternity Program—We encourage you to contact us early in your pregnancy, during the first trimester if possible, so you can receive information about our confidential, telephone-based maternity education program. This program is not intended to replace the care of your Physician, but rather to complement that care by giving you the resources you need to make informed decisions about your pregnancy and childbirth. You will receive support from obstetrical nurses with experience caring for pregnant women and newborns who will help you take an active role in planning a healthy pregnancy and give you access to current educational materials.

What We Do

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

Preauthorization Requirements

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

Penalty if You Do Not Comply

If you do not request or receive our advance authorization of expenditures for services that require preauthorization, we have no obligation to reimburse you. If we receive a claim for such unauthorized services, we will evaluate your request to participate in funding those services. The extent of our participation in any case will be determined in our sole discretion and will create no obligation with respect to future cases.

Services That Require Preauthorization

Services that require preauthorization are listed on your Benefit Summary.

Note: We have the right on July 1 of each year to add to, or delete from, the list of services that require preauthorization provided we notify your employer in writing at least 60 days in advance. In that event, we will notify you of such changes and send you an updated Benefit Summary. You can also obtain a current list of services that require preauthorization by visiting our Web site at weatrust.com or by calling us.

What You Must Do

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

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

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

What We Do

We review the information you provide and inform you in writing of our decision regarding your preauthorization request. Specifically, we will tell you:

1. If we deem the service medically necessary and medically appropriate in your specific circumstances. Whenever we have questions about whether services meet these criteria, we rely on objective, contemporaneous medical records and the advice of our medical consultants.
2. Any suppliers, providers, and facilities you must use to receive maximum reimbursement.
3. Reimbursement limits that apply.

Details about each of these three components are included below.

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

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

Reimbursement Limits—If the preauthorized service is one for which we have contracted with a specialty Network, as described in the preceding paragraph, our reimbursement limit is the contracted amount. Therefore, if you choose to receive the preauthorized service from our specialty Network, we reimburse the cost of the service, less applicable coinsurance, deductible, and copayment amounts. If you choose to receive the preauthorized service from another provider, you will be responsible for the difference between that provider's charge and the amount charged by our specialty Network, in addition to applicable coinsurance, deductible, and copayment amounts and charges that do not comply with industry-accepted coding and billing standards. Charges in excess of our reimbursement limit or charges that do not comply with the policy's reimbursement rules do not apply to your maximum out-of-pocket limit. (See Section 4 for more information about your maximum out-of-pocket limit.)

If the preauthorized service is not one for which we have contracted with a specialty Network, reimbursement is limited to the reasonable and customary fee for the service, less applicable deductible, coinsurance, and copayment amounts, and is subject to coding compliance rules, multiple surgery rules, and all of the policy's reimbursement rules.

Section 8
Claim Procedures

To receive reimbursement, you must send us within 90 days a written claim and proof that you have incurred a covered loss. Wisconsin law extends this period to 12 months beyond the 90 days required by this policy, but only if we are not prejudiced by the delay and it was not reasonably possible for you to meet our 90-day limit. You can get claim forms from your employer or from us. The identification card we issue you after enrollment gives the address to which claims must be submitted.

Most health care providers submit claims as a service to their patients. We are happy to accept provider-submitted claims that meet industry-accepted standards, and this will fulfill your obligation if the claim contains all the information we need to evaluate it.

Claim for Health Care Services

Your claim must include this information:

- The name and address of the covered employee.
- The employer's group number (this is listed on your insurance identification card).
- The patient's name, address, date of birth, and member number. The member number is listed on your insurance identification card.
- The name of the primary insurer, if other than the WEA Insurance Corporation.
- Information regarding any other group insurance coverage.
- The health care provider's name, complete address, telephone number, federal tax identification number, and national provider identifier.
- The name and telephone number of the individual practitioner who performed the service(s).
- The place and date of service or, for Hospital claims, admission and discharge dates.
- The patient's diagnosis and the appropriate procedure or billing code for each service received by the patient, with an itemization of charges for each service.

We rely on medical documentation to determine if procedure or billing codes for services reported and billed by a health care provider are appropriate. If the documentation indicates another code is more appropriate, we have the right to base our reimbursement on the service(s) supported by the documentation. We also have the right to deny charges for services that are billed inconsistently with industry-accepted coding standards.

Claim for Prescription Drugs

If your health plan includes prescription drug coverage, you may receive reimbursement of covered prescription drug expenses in either of two ways:

1. You may present your insurance identification card to a participating

pharmacy and pay the applicable copayment or coinsurance amount plus any additional cost for brand name drugs. We will then reimburse the pharmacy directly.

2. You may pay the entire cost of a prescription drug at any pharmacy and then submit a prescription drug claim form with the required information. We will then reimburse you for the appropriate amount. You can obtain prescription drug claim forms from your employer or from us. Remember, we reimburse only the amount that is charged us by a participating pharmacy, less the applicable copayment or coinsurance amount. If you use a nonparticipating pharmacy, our reimbursement to you may be significantly less than you were charged. ***Note:*** Most Hospital pharmacies are not participating pharmacies. If your Physician gives you a prescription when you leave the Hospital, you may want to go to a participating pharmacy to have it filled.

Proof of Loss

You must provide both satisfactory proof that you have incurred a covered loss and the information that we need to calculate your benefits. In many cases, your claim form provides that proof. In other cases, we require additional medical documentation that any services you received fulfill our criteria for coverage. Whenever we have questions about whether a claim meets our criteria for coverage and whether reimbursement limits apply, we rely on objective, contemporaneous medical documentation and records and the advice of our medical consultants. When your claim involves services to treat an Injury, we require documentation about the details of your Injury. We assist you in any way we can, but you are responsible for obtaining and providing this information.

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

We have the right to require that you be examined by a health care professional of our choice whenever it is necessary to establish proof of loss and evaluate a claim. When we do so, we pay the cost of the examination.

How and When Claims Will Be Paid

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

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

Our Right of Review and Recoupment

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

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

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

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

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

Section 9

Coordination of Benefits in Claims Payment

If you are covered by more than one group insurance plan including Medicare, we coordinate our benefits with any and all other benefits you are entitled to, whether or not you apply for or receive them. We coordinate benefits so that, whenever possible, the benefits available to you from all sources provide up to 100% of your allowable medical expenses but never exceed that amount.

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

Primary and Secondary Plans

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

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

- Any group insurance or group-type coverage, whether insured or uninsured, that provides continuous 24-hour coverage. This includes any type of health maintenance organization, individual practice association, prepaid group practice, preferred provider organization, or other prepayment, group practice, or individual practice plan.
- Labor-management trusteed plans, union welfare plans, employer organization plans, and employee benefit plans.
- Medical benefits coverage in group, group-type, and individual automobile "no-fault" contracts and in group or group-type automobile "fault" contracts.

- Coverage under any governmental plan or program, including Medicare, and any coverage that is required or provided by law, including coverage provided under no-fault and uninsured motorist statutes. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act) or a law or plan whose benefits, by law, are excess to any private insurance plan or other nongovernment plan.
- All benefits that are available to you, or that you are eligible to receive, under Medicare, whether or not you apply for and receive such benefits. This means that, if you are eligible for Medicare Parts A and B and Medicare would be your primary insurer, but you have not enrolled, we will estimate what Medicare would have paid and coordinate the benefits of this policy with that amount.

Order of Benefit Determination Rules

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

1. If the other plan does not have a coordination of benefits provision, it is primary.
2. The plan that covers the individual as an employee, member, or subscriber (in other words, other than as a dependent) is primary. The plan that covers the individual as a dependent is secondary. There is one exception: If the individual is covered by Medicare, any applicable federal Medicare regulations will supersede this rule.
3. When a child is covered as a dependent under the plans of both parents, the plan of the parent whose birthday falls earlier in the calendar year is primary. If both parents have the same birthday, the plan that covered a parent for the longer period of time is primary. There is one exception: If the other plan does not use the birthday rule just described, but instead uses a rule based on the gender of the parent, the rule based on gender will determine the order of benefits.
4. When two or more plans cover a child of divorced or legally separated parents, benefits for the child will be determined in this order:
   - The plan of the custodial parent.
   - The plan of the spouse of the custodial parent.
   - The plan of the noncustodial parent.

   There are two exceptions: (1) If a court decree specifies which parent is responsible for health care expenses, the plan of the specified parent will be primary; and (2) If a court decree states that parents share joint custody but does not state which parent is responsible for the child's health care expenses, the order of benefits will be determined by rule 3 above.
5. A plan that covers an individual as an active employee or as that employee's dependent will be primary over a plan that covers an individual as a laid-off or retired employee or a dependent of such an individual. There are two exceptions: (1) If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule will be ignored; and (2) If a dependent is a Medicare beneficiary, any applicable federal Medicare regulations will supersede this rule.
6. If an individual has continuation coverage provided pursuant to federal or state law and is also covered under another plan, benefits will be determined in this order:

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

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

7. If none of the above rules determines the order of benefits, the plan that covered the individual for the longer period of time will be primary.

How We Calculate Benefits When This Policy Is Secondary

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

Second, we determine the amount that we would have paid if this policy were the primary plan.

Third, we determine the amount of our payment as the secondary plan. If the primary plan paid less than the total allowable expenses, we will pay the difference, up to the amount we would have paid if this policy were the primary plan.

Finally, if the sum of our payment and the benefits paid by the primary plan is less than the total allowable expenses for the claim, we will use your available benefit credit to reimburse you for up to 100% of the total allowable expenses. (See the following subsection for an explanation of the benefit credit.)

Note: If your primary plan would have paid a benefit had you submitted a claim to that plan, we will treat that amount as a primary plan payment when we determine our payment as your secondary plan. Also, if you are eligible for Medicare Parts A and B, and Medicare would be your primary insurer, we will coordinate the benefits of this policy with the benefits payable by Medicare, whether or not you have enrolled. (In coordinating benefits with Medicare, we follow all Medicare rules, including the adoption of Medicare's maximum charge as the allowable expense.)

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

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

How We Calculate Benefit Credit

When this plan is secondary, we calculate the difference, if any, between the amount we would have paid had we been your primary plan and the amount we actually paid. (When this plan is secondary to Medicare, we calculate the difference, if any, between the maximum charges allowed by Medicare rules and the amount we actually paid.) We call this difference a benefit credit. We keep a running total of your benefit credit and use it to offset allowable expenses that are not otherwise reimbursed during your Benefit Period. (The Benefit Period is the 12-month period specified on the Benefit Summary.) Benefit credit is generated for each individual separately and applies only to that individual's claims.

If you incur an unreimbursed allowable expense at a time during your Benefit Period when you have no benefit credit available, we record that unreimbursed amount. If you later accumulate a benefit credit, we will send you a check at the end of the calendar year for the amount of your unreimbursed allowable expenses or the amount of the available benefit credit, whichever is less.

Our Rights Under This Provision

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

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

Section 10

Your Right to a Resolution of Complaints

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

Right to Information and Explanation

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

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

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

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

Right to an Investigation of Any Complaint by Our Ombudsperson

Most questions about benefits and claims payments can be resolved on an informal basis. Therefore, if you are dissatisfied after you have raised your question or complaint with our customer service representative, we encourage you to call our ombudsperson at (800) 279-4000 or (608) 276-4000 (Voice/TDD). Our ombudsperson will promptly investigate your complaint and keep you informed about the progress of the investigation. In the event the ombudsperson is unable to resolve your complaint to your satisfaction, the ombudsperson will provide you with all the necessary information and any forms you need to pursue your rights.

Right to Submit a Grievance

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

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

- You believe you have not received the reimbursement the policy promises.
- You believe you have been denied treatment promised by the policy.
- You are dissatisfied with covered services you received from one of our providers.
- You believe your coverage has been unfairly terminated.

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

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

Ombudsperson
WEA Insurance Corporation
P.O. Box 7338
Madison, WI 53707-7338

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

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

We will acknowledge receipt of your grievance within 5 business days after we receive it. Your grievance will be considered by our grievance committee within 30 days of its receipt. Our grievance committee is composed of three or more members. At least one committee member will be a subscriber who is not a company employee, if one is available to serve on the committee. Another member will be a WEA Insurance Corporation employee who is authorized to take any corrective action the committee deems appropriate.

We will notify you of the time and place of the grievance committee meeting at least 7 days in advance. You or your authorized representative has the right to appear in person, if you wish, to present information and to ask questions, or to submit written questions. The committee will review your grievance, make a decision, and inform you in writing of its decision. If the committee believes that the WEA Insurance Corporation has not reasonably handled your dissatisfaction in light of the insurance policy and the known facts, it will issue instructions for corrective action.

If we are unable to make a decision about your grievance within the 30-day time limit, we may extend the limit an additional 30 days by informing you in writing of the reason for the extension and the date by which the decision will be made.

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

- The duration of the standard grievance resolution process will result in serious jeopardy to the patient's life or health or to the patient's ability to regain maximum function.
- In the treating Physician's opinion, the patient is subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance.

- A Physician with knowledge of the patient's medical condition determines that the grievance shall be treated as an expedited grievance.

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

Right to an Independent External Review

You have the right to an independent external review of an ***adverse determination***, described below, if the cost to you of the denied services or course of treatment exceeds the amount established by Wisconsin law and updated annually by the Office of the Commissioner of Insurance as the minimum amount for an adverse determination to qualify for independent external review.

An ***adverse determination*** is our determination, after reviewing the medical information you or your provider supply to us, that health care services do not meet the policy's criteria for ***medical necessity***, ***medical appropriateness***, or ***cost-effectiveness***. These terms are explained in detail in Section 4 of this policy. Adverse determinations also include our decision that services are not covered because we consider them to be ***experimental***.

How the Independent External Review Process Works—An independent external review is performed by an independent review organization that you select from a list of organizations certified by the Office of the Commissioner of Insurance. You can get a list of these independent review organizations by calling us or requesting it from the Office of the Commissioner of Insurance.

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

1. You and we agree to waive the grievance procedure and proceed directly to an independent review.
2. The independent review organization, after receiving a request from you or your authorized representative that is simultaneously sent to us, determines that exhausting the grievance procedure would jeopardize your health or your ability to regain maximum function.

You or your authorized representative may initiate an independent external review by sending your written request to us within four months from the date of the adverse determination or the date of the notice of the grievance committee's decision, whichever is later. Your request must be accompanied by your check for $25 payable to the independent review organization you have chosen.

Within 5 business days after we receive your written request and check, we submit to the independent review organization all of the information you provided in support of your position, the relevant policy provisions on which we based our decision, and any other relevant documents or information used in our grievance determination. The review organization has 30 days from the date it receives the required information to notify you and us in writing of its decision. The decision is binding on both of us. If you prevail in the decision, either in whole or in part, the $25 filing fee you paid will be refunded.

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

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

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

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

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

Legal Actions

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

- You have exhausted the grievance procedures provided by law and outlined above.
- You file a legal action within 3 years of the date you were required by this policy to provide proof of loss.
- You have not chosen to use the independent external review process. If you choose to use the independent external review process, the decision of the independent review organization is binding.

Section 11
Our Right of Subrogation

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

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

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

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

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

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Appendix

Optional Benefit Provisions

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

Dependent Student to Age 25—Calendar Year

This benefit provision applies to your coverage only if your Benefit Summary indicates "Dependent Student to Age 25—Calendar Year"

The list of eligible dependents set forth in the section captioned "Your Dependents" in Section 3 of the policy is replaced with the following:

1. Your legal spouse.
2. Your biological child, legally adopted child, stepchild, or legal ward* who is unmarried ***and***:
   - Under the age of 19.
   - Age 19 or older and enrolled as a ***full-time student*** in an accredited school, college, or university, through the calendar year in which he or she reaches age 25. These dependents are covered between school terms (for example, summer months) if they complete the preceding term.

   Full-time student means a dependent who is enrolled in ***school*** on a full-time basis as defined by the school the student attends. ***School*** means an accredited college or university, a licensed or certified vocational institution, or a licensed or certified technical training institution.

   ****Note:*** To be initially eligible for coverage, your legal ward must be under the age of 18 or must be a ward who was covered by the previous employer-sponsored group health policy that this policy replaced. In addition, you must have ***sole*** and ***permanent*** guardianship of both the individual and the individual's estate.
3. A biological child of your covered dependent child or legal ward (i.e., your grandchild), but only until your child or legal ward becomes 18 years old or marries, whichever occurs first.

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Dependent Student to 25th Birthday

This benefit provision applies to your coverage only if your Benefit Summary indicates "Dependent Student to 25th Birthday"

The list of eligible dependents set forth in the section captioned "Your Dependents" in Section 3 of the policy is replaced with the following:

1. Your legal spouse.
2. Your biological child, legally adopted child, stepchild, or legal ward* who is unmarried ***and***:
   - Under the age of 19.
   - Between the ages of 19 and 25 and enrolled as a ***full-time student*** in an accredited school, college, or university. These dependents are covered between school terms (for example, summer months) if they complete the preceding term.

   Full-time student means a dependent who is enrolled in ***school*** on a full-time basis as defined by the school the student attends. ***School*** means an accredited college or university, a licensed or certified vocational institution, or a licensed or certified technical institution.

   ****Note:*** To be initially eligible for coverage, your legal ward must be under the age of 18 or must be a ward who was covered by the previous employer-sponsored group health policy that this policy replaced. In addition, you must have ***sole*** and ***permanent*** guardianship of both the individual and the individual's estate.
3. A biological child of your covered dependent child or legal ward (i.e., your grandchild), but only until your child or legal ward becomes 18 years old or marries, whichever occurs first.

Dependent to Age 25—Calendar Year

This benefit provision applies to your coverage only if your Benefit Summary indicates "Dependent to Age 25—Calendar Year"

The list of eligible dependents set forth in the section captioned "Your Dependents" in Section 3 of the policy is replaced with the following:

1. Your legal spouse.
2. Your biological child, legally adopted child, stepchild, or legal ward* who is unmarried, ***and***:
   - Under the age of 19.
   - Age 19 or older and enrolled as a ***full-time student*** in an accredited school, college, or university, through the calendar year in which he or she reaches age 25. These dependents are covered between school terms (for example, summer months) if they complete the preceding term.

   Full-time student means a dependent who is enrolled in ***school*** on a full-time basis as defined by the school the student attends. ***School*** means an accredited college or university, a licensed or certified vocational institution, or a licensed or certified technical institution.

   - Age 19 or older and not a full-time student, but having less monthly income than the amount we establish and periodically modify as the standard for determining whether the child is primarily responsible for his or her own financial support, through the calendar year in which he or she reaches age 25.

     When we determine a dependent's monthly income, we take into consideration expected gross income, both earned and unearned, that the dependent receives from all sources including, but not limited to, gross wages, tips, disability benefits, worker's compensation benefits, unemployment compensation benefits, SSI benefits, veteran's benefits, AFDC benefits, real estate holdings, stocks, trust funds, gifts, and injury damage awards or settlements. Expected monthly income must be less than our monthly standard in order for the dependent to remain eligible for coverage. For example, a dependent who becomes employed with expected income that exceeds the monthly standard we have established is ineligible on the first day of employment. That dependent's coverage will end on the last of day of the month during which he or she became ineligible.

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

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

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Domestic Partner Coverage

This benefit provision applies to your coverage only if your Benefit Summary indicates "Domestic Partner"

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

Definition of Domestic Partner

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

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

Qualifying for Eligibility as a Domestic Partner

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

1. You are both 18 years of age or older.
2. You are both mentally competent to make the declarations required by the form.
3. You are not related by blood closer than would bar marriage in the state of Wisconsin.
4. For at least the past 6 months, all of the following have been true:
   - You have lived together in the same dwelling unit.
   - Neither of you was married or legally separated in marriage.
   - Neither of you was a party to an action or proceeding for divorce or annulment.
   - Neither of you was in another domestic relationship.
   - You were financially interdependent as evidenced by at least two of the following:
     1. Common or joint ownership of a residence.
     2. Joint ownership of a motor vehicle.
     3. Joint credit account; for example, a credit card.
     4. Joint checking or savings account.

5. Your domestic partner identified as primary beneficiary in your will, life insurance policy(ies), tax-sheltered annuity account(s), IRA(s), or other retirement accounts.
6. Joint financial investments.
7. Other evidence of mutual financial interdependency that we deem acceptable.

The signed Designation of Domestic Partner form is part of the contract of insurance, and we reserve the right to verify the information at any time.

Your domestic partner is eligible for coverage on the later of these two dates:

- The date you are eligible for coverage.
- The earliest date on which your domestic partnership fulfilled all of the conditions we have described above.

How to Obtain Coverage

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

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

The required documents are these:

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

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

Policy Provision Exceptions That Apply to Domestic Partners

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

1. Domestic partners are not entitled by state and federal law to continuation of coverage when their coverage ends due to certain qualifying events. However, this policy provides continuation privileges to covered domestic partners and their covered biological or legally adopted children under circumstances, and for temporary periods, that are similar to those required by law for qualified beneficiaries.

   Please note that we require you or your domestic partner to notify us in writing within 60 days of the date of the termination of the domestic partnership in order to preserve these dependents' rights to group continuation or conversion coverage. If we don't receive the written notice within the time period specified, continuation of coverage under this policy or under our conversion policy will not be offered.

2. The coverage continuation rights of survivors of covered employees who are age 55 or older at the time of their death, described in Section 3 of this policy, will be provided to covered domestic partners and their covered dependents if ***both*** of the following apply:

   - The domestic partnership has been in existence for at least 3 years at the time of the covered employee's death; ***and***
   - The covered employee is 55 or older at the time of death.

   The 3-year existence of the domestic partnership must be documentable as having continuously met all of the requirements on our Designation of Domestic Partner form during the 3 years preceding the covered employee's death.

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

Eligibility of Your Domestic Partner's Children

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

- We have received your application for their coverage within 30 days after they first become eligible; ***and***
- We have approved coverage for your domestic partner.

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

When the Domestic Partnership Ends

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

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

The end of a domestic partnership has the same consequences under this policy as divorce or annulment of marriage. Therefore, the domestic partner and his or her children are no longer eligible for coverage as of the date the domestic partnership ends, except as described above.

Extraction/Replacement of Natural Teeth

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

In addition to the dental services described in Section 6, this policy covers:

1. The extraction of natural teeth.
2. The initial replacement of natural teeth that are extracted while you are covered under this policy.
3. The replacement of previously existing partial removable dentures or fixed bridgework if replacement is required by reason of the extraction of one or more natural teeth while you are covered under this policy.

The exclusion in Section 6 of the policy under "Dental Services" relating to the extraction or replacement of natural teeth required because of disease or decay does not apply to you.

MedWise Drug Plan

This benefit provision applies to your group's coverage only if your Benefit Summary indicates "MedWise Drug Plan"

Note: This policy does not cover prescription drugs and medications, regardless of where they are purchased or received, for individuals who are eligible to enroll in the Medicare Part D drug program, whether or not they enroll, except:

- Employees who are actively at work and their covered dependents.
- Individuals who are covered by our standard family plan.
- Individuals who are covered under state and federal continuation (COBRA) coverage, unless they choose to waive prescription drug coverage under this plan in exchange for a lower premium rate.
- Any other individual for whom this plan is the primary insurer under Medicare Secondary Payer rules.

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

Prescription Drugs

Your prescription drug plan has several distinguishing features, including:

- We do not reimburse for a prescription drug unless it is on our list of covered drugs or we have approved it in advance based on a clinically documented medical need.
- The amount of your copayment depends on whether your prescription drug is a Level 1 or a Level 2 drug.
- Obtaining prescription drugs from a nonparticipating pharmacy will usually result in significant out-of-pocket costs. (We have an extensive participating pharmacy Network. See "Pharmacy Selection" below.)
- Some drugs require preauthorization. Other drugs are subject to our medical review and monitoring.
- Dispensing is limited to a medically appropriate dosage, or what we have established as a 30-day supply.

These features are described in detail below.

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

Reimbursement Factors

While this drug plan does not reimburse for all prescription drugs, the list of covered drugs includes:

- Most generic drugs.
- Specified brand name drugs that we have selected based on clinical efficacy, cost

considerations, and the advice of our Pharmacy and Therapeutics Committee.

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

1. Whether or not the prescription drug you purchase is on the list of covered drugs.
2. Whether you purchase a Level 1 or a Level 2 drug. The copayment for a Level 1 drug is less than the copayment for a Level 2 drug.
3. Whether you select a participating or nonparticipating pharmacy.

These reimbursement factors are described below.

List of Covered Drugs—This drug plan does not cover all prescription drugs, even if they may be beneficial and are prescribed by a Physician. The plan covers most generic drugs and selected brand name drugs that we have determined to be ***medically necessary*** and ***medically appropriate*** as we define those terms in Section 4. You can obtain a current list of covered drugs by visiting our Web site at weatrust.com or by calling our customer service department.

We will not reimburse for a prescription drug unless it is one of the drugs on our list of covered prescription drugs. Thus, if you choose to use a drug that is not covered, you must pay the full cost yourself.

We will consider an exception on the rare occasion when ***all*** of the following apply:

- You have tried all the covered drugs in the appropriate therapeutic category.
- Your Physician provides us with compelling clinical evidence that (1) none of the drugs listed is effective for you; or (2) for a documented medical reason, you are unable to take any of the drugs on the list.
- The substitute drug you are requesting is the most cost-effective of the safe and effective alternative drugs in your specific medical circumstances.

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

Copayments—Your prescription drug copayments are adjusted on January 1 of each year. We will notify you of the actual dollar amounts at least 60 days before that date. The copayments for Level 1 and Level 2 drugs will be based on 20% of the average cost of generic drug and preferred brand name drug prescriptions, respectively, paid by the Trust during a 12-month period ending in the preceding year. These calculations will be actuarially adjusted for inflation and rounded to the next higher 50 cents. A $5 minimum copayment will always apply.

You must pay a copayment for each 30-day prescription or refill. The exception is our home delivery program, through which you can receive a 90-day supply for two copayments. Read about the home delivery drug program below.

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

Purchasing Prescription Drugs

If you are covered by this drug plan, you may use your insurance identification card to purchase covered prescription drugs from participating pharmacies. If you purchase prescription drugs from a nonparticipating pharmacy, you will be required to pay the full cost of the drug and submit a claim form. You can obtain claim forms for this purpose by calling us or by printing the form from our Web site at weatrust.com. When your claim is

received, we will reimburse the amount we would have paid a participating pharmacy, less the applicable copayment. Your out-of-pocket costs will usually be significantly higher when you use a nonparticipating pharmacy. An added advantage of using participating pharmacies is that they have up-to-date information on whether the drug you have been prescribed is covered by your plan.

Dispensing Limitation

All prescriptions or refills are limited to a medically appropriate dosage, or what we have established as a 30-day supply unless received through our home delivery drug program (read about this program below). A 30-day supply may be either more or less than 30 unit dosages.

If your Physician prescribes a quantity of unit dosages that exceeds our established 30-day supply and you present the prescription at a participating pharmacy, the pharmacist will inform you before filling the prescription. We reimburse only for the quantity that we consider a 30-day supply. We will consider exceptions on the rare occasion when compelling clinical evidence indicates a larger dosage is medically necessary and medically appropriate for your specific medical circumstances.

Home Delivery Program—Prescriptions and refills purchased through our specified home delivery program are limited to a 90-day supply instead of a 30-day supply. A 90-day supply is subject to two separate copayments, or twice the copayment amount applicable to a 30-day supply. (This arrangement is also available to any pharmacy that agrees to accept the same reimbursement terms that apply to our home delivery program.)

Specialty Drugs—An exception to the 90-day home delivery supply is a specialty drug. Specialty or biotech drugs are genetically engineered compounds designed to target and treat specific diseases. Examples are Avonex, Enbrel, Pegasys, and Xolair. Such drugs, which require unique storage and handling, are limited to a 30-day supply, even through our home delivery program, and are subject to one copayment per 30-day supply. In accordance with the policy's cost-effectiveness limit, we may require that you receive these specialty drugs through our specialty drug program for maximum reimbursement. You can obtain information about your drug plan and our home delivery program by visiting our Web site at weatrust.com or by calling one of our customer service representatives.

Drugs Subject to Preauthorization or Medical Monitoring

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

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

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

The list of these drugs that are subject to preauthorization or medical monitoring is small but will change frequently as new drugs become available and changes are made to existing brand name drugs. You can find an up-to-date list of these drugs on our Web site. If your Physician prescribes one of these drugs and you

present your prescription at a participating pharmacy, the pharmacist will inform you and you can call us to initiate any required review. If you present your prescription at a nonparticipating pharmacy, you will be required to pay for the prescription in advance. In this case, you take the risk that we will not reimburse you for the drug because preauthorization would have been denied or, if we do reimburse you, that your out-of-pocket costs will be significant (see "Pharmacy Selection" above).

Covered Prescription Drugs

We cover these drugs and medications when we find them to be medically necessary and medically appropriate:

- Drugs or medications included on our list of covered drugs.
- Those for the treatment of HIV infection.
- Insulin and other prescription drugs and medications prescribed for the treatment of diabetes.
- Specified prescription and over-the-counter tobacco cessation aids obtained through our Tobacco Cessation program. Read about covered services in Section 6 under "Tobacco Cessation Services."

Drugs and Services Not Covered

We never cover these:

- Drugs or medications that are not on our list of covered prescription drugs, unless we have given advance approval.
- Drugs or medications that can lawfully be obtained without a prescription, even if your Physician prescribes them. The rare exception to this is an over-the-counter drug that we have determined to be a cost-effective, comparably equivalent alternative to a prescription drug and have added to the list of covered drugs. Such over-the-counter drugs require a prescription from your Physician.
- Drugs or medications that we deem to be ineffective or marginally effective.
- Any drug or medication labeled, "Caution—limited by federal law to investigational use." (This exclusion does not apply to drugs for the treatment of HIV infection that this policy is required by law to cover.)
- Any drug that has not been approved by the FDA for the purpose for which it is being used.
- Drugs or medications for the treatment of alopecia or hair loss; for example, minoxidil or Rogaine.
- Drugs or medications prescribed primarily to improve appearance. This includes all dosage forms of tretinoin (for example, Retin-A) for individuals who are 26 years or older except for the treatment of acute acne.
- Drugs or medications prescribed for, or in connection with, weight loss or weight control. Examples include, but are not limited to, Ionamin, Dexedrine, Meridian, and Xenical.
- Drugs or medications prescribed for, or in connection with, infertility or conception. Examples include, but are not limited to, Clomid, Clomiphene Citrate, Serophine, Pergonal, Pregnyl, Profasi, Repronex, and Menogon.
- Early refills, refills in excess of the number of refills specified by the Physician, or any refill dispensed after one year from the date of the Physician's original order. For example, we do not reimburse for early or additional refills if your medications are lost, stolen, damaged, expired, misplaced, missing, or otherwise compromised.
- Drugs or medications provided in connection or associated with any medical service not covered by this policy.

How to Receive Reimbursement for Prescription Drugs

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

1. You may present your insurance identification card to a participating pharmacy and pay the applicable copayment.
2. You may pay the entire cost of a prescription drug at any pharmacy and then submit a prescription drug claim form with the required information. We will then reimburse you for the appropriate amount. You can obtain a prescription drug claim form by printing it from our Web site or calling our customer service department. Remember, we reimburse only the amount that is charged us by a participating pharmacy, less the applicable copayment. If you use a nonparticipating pharmacy, our reimbursement to you may be significantly less than you were charged or, in the case of a noncovered drug, there will be no reimbursement.

Three-Tier Drug Plan

This benefit provision applies to your group's coverage only if your Benefit Summary indicates "Three-Tier Drug Plan"

Note: This policy does not cover prescription drugs and medications, regardless of where they are purchased or received, for individuals who are eligible to enroll in the Medicare Part D drug program, whether or not they enroll, except:

- Employees who are actively at work and their covered dependents.
- Individuals who are covered by our standard family plan.
- Individuals who are covered under state and federal continuation (COBRA) coverage, unless they choose to waive prescription drug coverage under this plan in exchange for a lower premium rate.
- Any other individual for whom this plan is the primary insurer under Medicare Secondary Payer rules.

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

Prescription Drugs

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

- Prescription drugs are categorized into three groups, or tiers, each with its own copayment.
- Tier 1 generic equivalent or therapeutically equivalent drugs are required, when they exist, for maximum reimbursement.
- Obtaining prescription drugs from a nonparticipating pharmacy will usually result in significant out-of-pocket costs. (We have an extensive participating pharmacy Network. See "Pharmacy Selection" below.)
- Some drugs require preauthorization. Other drugs are subject to our medical review and monitoring.
- Dispensing is limited to a medically appropriate dosage, or what we have established as a 30-day supply.

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

Your prescription drug benefits include a comprehensive range of prescription drugs. However, not all prescription drugs are covered even if they may be beneficial and are prescribed by a Physician. We reimburse for a prescribed drug only when we find it ***medically necessary***, ***medically appropriate***, and ***cost-effective***. Thus, we may not cover a drug that has not been proven to be more effective than a less

expensive, therapeutically equivalent alternative. If you choose a drug that is not covered, you must pay the full cost yourself. We will consider an exception on the rare occasion when ***all*** of the following apply:

- You have tried all the covered drugs in the appropriate therapeutic category.
- Your Physician provides us with compelling clinical evidence that either (1) none of the covered drugs is effective for you, or (2) for a documented medical reason, you are unable to take any of the covered drugs.
- The substitute drug you are requesting is the most cost-effective of the safe and effective alternative drugs in your specific medical circumstances.

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

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

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

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

Three Drug Tiers

Prescription drugs that meet our tests for coverage are placed in one of three categories, or tiers. The tier in which we place a specific drug affects the amount we reimburse. (See "Reimbursement Factors" below.) Tier 1 includes most, but not all, generic drugs. Tier 1 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. All other covered generic and brand name drugs are placed in Tier 2 or Tier 3, based on cost, therapeutic efficacy, and the recommendations of our Pharmacy and Therapeutics Committee.

Our Web site, weatrust.com, includes the most current list of covered drugs, indicating the tier in which they have been placed. We encourage you to share this information with your Physician(s) so that you can make informed decisions about your treatment and its cost to you.

Reimbursement Factors

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

1. The copayments that apply to your prescription drugs. The amounts are different depending on whether you purchase a drug from Tier 1, Tier 2, or Tier 3.
2. The pharmacy you select; that is, whether you select a participating or non-participating pharmacy.
3. Whether you receive a cost-effective drug from among the viable alternatives.

These reimbursement factors are discussed below.

Copayments—Your Benefit Summary specifies the copayment that applies to each tier of your prescription drug benefits. The specified

amount applies separately to each prescription or refill.

If you are prescribed a Tier 3 drug, we will consider reducing your copayment to that applicable to Tier 2 on the rare occasion when ***both*** of the following apply:

- Compelling clinical evidence indicates that either (1) none of the Tier-1 or Tier-2 drugs in the therapeutic category of your prescribed drug is effective for you; or, (2) for some documented medical reason you are unable to take any of the drugs in Tier 1 and Tier 2; ***and***
- A Tier 3 drug is the ***only*** safe and effective alternative.

An indication from your Physician that a Tier 3 drug must be dispensed as written, without supporting objective, contemporaneous medical documentation, is not, by itself, sufficient documentation for us to reduce your copayment. Any exception request must be submitted to us by your Physician and authorized by us in advance of your receiving the prescription.

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

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

Cost-Effectiveness Limit—This policy limits reimbursement to the most cost-effective treatment from among viable alternatives (see "Cost-Effectiveness Limit" in Section 4). Accordingly, Tier 1 drugs are required for maximum reimbursement. You may purchase a Tier 2 or Tier 3 drug even when a Tier 1 generic equivalent drug, or a Tier 1 brand name or over-the-counter therapeutically equivalent drug exists. However, we always limit reimbursement to the charge for the Tier 1 equivalent of the prescribed drug unless there is no Tier 1 equivalent, or in the rare instance when compelling clinical evidence indicates that you, for some medical reason, are unable to take the Tier 1 drug.

Note: An indication from your Physician that a Tier 2 or Tier 3 drug must be dispensed as written is not, by itself, sufficient documentation for us to reimburse for the difference between the cost of the Tier 1 and the Tier 2 or Tier 3 drug. If supporting objective, contemporaneous medical documentation indicates that you are unable to take the Tier 1 drug for a specified medical reason, you must pay the appropriate Tier 2 or Tier 3 copayment. However, you will not be required to pay the difference between the cost of the Tier 1 drug and the drug you received. Any exception request must be submitted to us by your Physician and authorized by us in advance of your receiving the prescription.

If you buy a Tier 2 or Tier 3 drug when this exception does not apply, we limit reimbursement to the amount charged us by a participating pharmacy for the Tier 1 equivalent. In this case, you must pay the difference between the cost of the drug you received and the amount charged us by a participating pharmacy for the Tier 1 equivalent, ***in addition*** to your copayment. This usually results in significant out-of-pocket expense.

Dispensing Limitation

All prescriptions or refills are limited in quantity to a medically appropriate dosage or what we have established as a 30-day supply.

A 30-day supply may be either more or less than 30 unit dosages. If your Physician prescribes a quantity that exceeds our established 30-day supply and you present the prescription at a participating pharmacy, the pharmacist will inform you before filling the prescription. We reimburse only for the quantity that we consider a 30-day supply.

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

Home Delivery Program—Prescriptions and refills purchased through our specified home delivery program are limited to a 90-day supply instead of a 30-day supply. A 90-day supply is subject to two separate copayment amounts instead of three. This arrangement will also be available to any pharmacy that agrees to accept the same reimbursement terms that apply to our home delivery program.

Specialty Drugs—An exception to the 90-day home delivery supply is a specialty drug. Specialty or biotech drugs are genetically engineered compounds designed to target and treat specific diseases. Examples are Avonex, Enbrel, Pegasys, and Xolair. Such drugs, which require unique monitoring, storage, or handling, are limited to a 30-day supply even through our home delivery program and are subject to one copayment per 30-day supply. In accordance with the policy's cost-effectiveness limit, we may require that you receive these specialty drugs through our specialty drug program for maximum reimbursement.

You can obtain information about your drug plan and our home delivery program by visiting our Web site at weatrust.com or by calling our customer service department.

Drugs Subject to Preauthorization or Medical Monitoring

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

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

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

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

Covered Prescription Drugs

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

- Those required to carry the legend, "Federal law prohibits dispensing without prescription."

- Those that may be dispensed only upon a Physician's written prescription as required by state law.
- Those for the treatment of HIV infection.
- Insulin and other prescription drugs and medications prescribed for the treatment of diabetes.
- Specified prescription and over-the-counter tobacco cessation aids obtained through our Tobacco Cessation program. Read about covered services in Section 6 under "Tobacco Cessation Services."

Drugs and Services Not Covered

We never cover these:

- Drugs or medications that can lawfully be obtained without a prescription, even if your Physician prescribes them. The rare exception to this is an over-the-counter drug that we have determined to be a cost-effective, comparably equivalent alternative to a prescription drug and have added to the Three-Tier drug list. Such over-the-counter drugs require a prescription from your Physician.
- Drugs or medications that we deem to be ineffective or marginally effective.
- A drug or medication that has not been proven to be more effective than a less expensive, therapeutically equivalent drug.
- Any drug or medication labeled, "Caution—limited by federal law to investigational use." (This exclusion does not apply to drugs for the treatment of HIV infection that this policy is required by law to cover.)
- Any drug that has not been approved by the FDA for the purpose for which it is being used.
- Drugs or medications for the treatment of alopecia or hair loss; for example, minoxidil or Rogaine.
- Drugs or medications prescribed primarily to improve appearance. This includes all dosage forms of tretinoin (for example, Retin-A) for individuals who are 26 years or older except for the treatment of acute acne.
- Drugs or medications prescribed for, or in connection with, weight loss or weight control. Examples include, but are not limited to, Ionamin, Dexedrine, Meridian, and Xenical.
- Drugs or medications prescribed for, or in connection with, infertility or conception. Examples include, but are not limited to, Clomid, Clomiphene Citrate, Serophine, Pergonal, Pregnyl, Profasi, Repronex, and Menogon.
- Early refills, refills in excess of the number of refills specified by the Physician, or any refill dispensed after one year from the date of the Physician's original order. For example, we do not reimburse for early or additional refills if your medications are lost, stolen, damaged, expired, misplaced, missing, or otherwise compromised.
- Drugs or medications provided in connection with any medical service not covered by this policy.

How to Receive Reimbursement for Prescription Drugs

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

1. You may present your insurance identification card to a participating pharmacy and pay the applicable copayment plus any additional cost for brand name drugs. We will then reimburse the pharmacy directly.

2. You may pay the entire cost of a prescription drug at any pharmacy and then submit a prescription drug claim form with the required information. We will then reimburse you for the appropriate amount. You can obtain prescription drug claim forms by printing them from our Web site at weatrust.com or by calling our customer service department. Remember, we reimburse only the amount that is charged us by a participating pharmacy, less the applicable copayment. If you use a non-participating pharmacy, our reimbursement to you may be significantly less than you were charged.

Vision Care Benefit

This benefit provision applies to your coverage only if your Benefit Summary indicates "Vision Care Benefit"

Vision Examination

In addition to the vision services described in Section 6, this policy covers one complete examination of your eyes and related structures during each Benefit Period. Deductible, coinsurance, and copayment amounts do not apply to this benefit. The examination, to evaluate a new or existing visual condition, must be performed by a licensed ophthalmologist or licensed optometrist.

The examination may include a patient history, an external and ophthalmoscopic examination, biomicroscopy, tonometry, and a determination of refractive status, unless otherwise contraindicated. Determination of refractive status means the quantitative procedure that yields the refractive data needed to determine your best visual acuity with lenses and to prescribe lenses.

Covered Vision Materials

This policy covers lenses (regular or contact lenses) prescribed by a licensed ophthalmologist or licensed optometrist and frames as follows:

- We will reimburse you up to $100 in every Benefit Period for the cost of two lenses or contact lenses (disposable or conventional).
- We will reimburse you up to $50 in every Benefit Period for the cost of a new frame.

The maximum allowable benefit for vision materials may include necessary professional charges for:

- Prescribing and/or ordering proper lenses.
- Assisting in the selection of a frame.
- Verifying the accuracy of the lens(es).
- Proper fitting and adjustment of glasses and contact lenses.

Vision Services and Materials Not Covered

We do not cover any vision services or materials other than those specifically identified or described in the policy or this optional benefit provision.

Extended Coverage

Any vision materials normally covered by this Optional Benefit Provision that are ordered from a vendor prior to the date your coverage under this policy ends will be covered if those materials are dispensed to you within 30 days of that termination date.

Vision Examination Benefit

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

In addition to the vision services described in Section 6, this policy covers one complete examination of your eyes and related structures during each Benefit Period. Deductible, coinsurance, and copayment amounts do not apply to this benefit. The examination, to evaluate a new or existing visual condition, must be performed by a licensed ophthalmologist or licensed optometrist.

The examination may include a patient history, an external and ophthalmoscopic examination, biomicroscopy, tonometry, and a determination of refractive status, unless otherwise contraindicated. Determination of refractive status means the quantitative procedure that yields the refractive data needed to determine your best visual acuity with lenses and to prescribe lenses.

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

Waiver of Premium—Not Applicable

This benefit provision applies to your coverage only if your Benefit Summary indicates "Waiver of Premium—Not Applicable"

The following provision does not apply to your coverage:

"Waiver of Premium" in Section 1.

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