MONTANA GROUP HEALTH INSURANCE CERTIFICATE BOOKLET

WMI Mutual Insurance Company

P.O. Box 572450
(800) 748-5340 (801) 263-8000
FAX (801) 263-1247
Salt Lake City, UT 84157

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I. DEFINITIONS:

The following terms are defined for guidance only and do not create coverage.

"Accident" or **"Accidental Bodily Injury"** means an unexpected traumatic incident or unusual strain which is: (1) identified by time and place of occurrence; (2) identifiable by part of the body affected; and (3) caused by a specific event on a single day. Some examples include: (a) fracture or dislocation; (b) sprain or strain; (c) abrasion, laceration; (d) contusion; (e) embedded foreign body; (f) burns; and (g) concussion.

"Actively at Work" and **"Active Work"** means being in attendance in person at the usual and customary place or places of business and acting in the performance of the duties of the Employee's occupation on a full time basis. An Employee shall be deemed to be Actively at Work on each day of a regular paid vacation if he/she was Actively at Work on the last preceding regular work day. An Employee shall also be deemed to be Actively at Work on any day in which he/she is absent from work due to a health factor, for a period not to exceed twelve (12) weeks, if he/she was Actively at Work on the last preceding regular work day. In the case of a new enrollee, eligibility will not be denied if the Employee is absent from work due to a health factor as long as work begins before coverage becomes effective.

"Advanced Practice Registered Nurse" means a nurse who has additional professional education beyond the basic nursing degree required of a registered nurse and who is considered an Advance Practice Registered Nurse by applicable state law. Advance Practice Registered Nurse includes nurse practitioners, nurse-midwives, nurse-anesthetists and clinical nurse specialists.

"Ambulance" means a vehicle for transporting the sick or the injured and that is staffed with appropriately certified or licensed personnel. An Ambulance must be equipped with emergency medical care and supplies. An Ambulance must be equipped with equipment such as oxygen, a defibrillator, splints, bandages, adjunctive airway devices, and patient-carrying devices.

"Ambulatory Service Facility" means any public or private establishment with an organized medical staff of Physicians. This type of facility must be licensed. This type of facility must also be accredited by the Joint Commission on Accreditation of Hospitals ("JCAH"), and/or be certified by Medicare. This type of facility must be equipped and must be operated primarily for the purpose of performing ambulatory surgical procedures. This type of facility must have Physician services that are continuous whenever an Insured is in the facility. This type of facility does not provide services or other accommodations for Insureds to stay overnight.

"Benefits" means the payments that are provided for the Insured Employee or Insured Dependent(s) under this Plan.

"Brand Drugs" are Prescription Drugs that have been reviewed by the Food and Drug Administration ("FDA") as full new drug applications (NDA). Brand Drugs are also nationally recognized innovators, and may be, or once were, protected by patents.

"Calendar Year" means January 1 through December 31 of a year. The first Calendar Year begins on the effective date and ends on December 31 of the same year.

"Certificate" means the written statement that is prepared by the Company, and includes all riders and supplements, if any. The Certificate sets forth a summary of the insurance to which an Employee and his Dependents are entitled. The Certificate also sets forth to whom the Benefits are payable, and any exclusions, limitations, or requirements that may apply.

"Chemical Dependency Treatment Center" means a facility that provides a program for the treatment of alcoholism or drug addiction. The program must be provided pursuant to a written treatment plan that is approved and is monitored by a Physician or an addiction counselor who is certified by the state. This type of facility must be licensed or approved as a treatment center by the Department of Public Health and Human Services.

"Child(ren)" means, for the purposes of this Plan, a Child(ren) by birth, legal adoption as of the date of placement for adoption, legal (court appointed) guardianship, or other Child(ren), who is a Dependent of the Employee as that term is defined in this Policy.

"Company" means the WMI Mutual Insurance Company.

"Cosmetic" or "Cosmetic Surgery" means any surgical procedure that is performed to improve appearance or to correct a deformity but that does not restore a physical bodily function. Psychological factors, such as poor body image and difficult peer relations, are not considered to be a bodily function, and they do not establish medical necessity.

"Covered Expenses" means those expenses that are incurred by an Insured Employee or an Insured Dependent for an Injury or an Illness and for which the Plan provides Benefits.

"Covered Services" means the services, the supplies, or the accommodations for which the Plan provides Benefits.

"Custodial Care" means services, supplies or accommodations for care which meet any of the following.

(a) They do not provide treatment of an Injury or an Illness.

(b) They could be provided by persons who do not have professional skills or qualifications.

(c) They are provided primarily to assist the Insured in daily living.

(d) They are for convenience, contentment or other purposes that are not therapeutic.

(e) They maintain a physical condition when there is no prospect of affecting remission or restoration of the patient to a condition in which the care would not be required.

"Date Incurred" means the date that services were provided.

"Deductible" means the amount of Eligible Charges that are paid by each Insured person before insurance Benefits are paid. Deductible does not include any amounts that are paid by the Insured toward services or treatment where the Deductible is waived.

"Dependent(s)" includes any of the following.

(a) The lawful spouse of an Insured Employee.

(b) The Insured Employee's (or the Insured Employee's Spouse's) Child(ren) until the attainment of age twenty-six (26).

(c) A Child who has reached the limiting age for termination of coverage who is Disabled and dependent upon the Insured. The Child must have been enrolled in this Plan at the time of reaching the limiting age.

"Disability or Disabled" as that term is applied to Employees, means the continuing inability of the Employee to perform the duties related to his employment for which he is otherwise qualified in a substantial manner because of an Illness or Injury. The term **"Disability or Disabled,"** as that term is applied to Dependents, means a physiological or psychological condition which prevents the Dependent from performing normal life functions. Periods of Disability that are not separated by at least ninety (90) days and that are for the same, or substantially the same, condition shall be considered the same Disability.

"Durable Medical Equipment" is medical equipment that meets all of the requirements listed below.

(a) It is intended only for the patient's use and benefit in the care and treatment of an Illness or an Injury.

(b) It is durable and usable over an extended period of time.

(c) It is primarily and customarily used for a medical purpose.

(d) It is prescribed by a Physician or a Practitioner.

Durable Medical Equipment includes, but is not limited to, all types of wheelchairs, crutches, braces, hospital beds, CPAP machines, insulin pumps, pain management pumps, infusion-type pumps, and pacemakers. Durable Medical Equipment does not include air conditioners, swimming pools, hot tubs, exercise equipment, or similar equipment.

"Effective Date" as it pertains to the Employer's Plan, means the date the Employer's Plan becomes in force. As pertains to the Employee or Dependent, the term "Effective Date" shall mean the date that the Employee or Dependent becomes Insured.

"Eligible Charges" means those charges that are incurred by an Insured Employee or an Insured Dependent for which coverage is available under the terms and conditions of the Policy. Eligible Charges for PPO expenses are based on negotiated fee schedules. Eligible Charges for non-PPO expenses are based on the Usual and Customary rate as determined by the Company.

"Emergency" means: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition that places the health of the individual in serious jeopardy, would result in serious impairment to bodily functions, or serious dysfunction of any bodily

organ or part; or with respect to a pregnant woman having contractions, that there is inadequate time to safely transfer the woman to another Hospital for delivery or that a transfer may pose a threat to the health or safety of the woman or the fetus.

"Emergency medical services" means health care items or services furnished or required to evaluate and treat an Emergency medical condition.

"Employee" means any person who is in an Employee/Employer relationship and who is Actively at Work. An Employee must work a minimum of one hundred twenty (120) hours per month and must receive compensation for his services from the Employer. An Employee of the subsidiaries and affiliates, if any, of the Employer, shall be deemed to be an Employee of the Employer. Service with any such subsidiaries and affiliates shall be deemed to be service with the Employer, if it is in compliance with hours worked. For the purpose of this definition, an owner, a sole proprietor, a partner, an officer or a director shall be considered to be an "Employee" as long as he or she is Actively at Work as set forth herein.

"Employer" or **"Participating Employer"** means any corporation or proprietorship operating as a business entity. An Employer is one that contracts with the Company to provide insurance Benefits to its Employees. An Employer is one that has eligible Employees that are insured with the Company, and that has agreed in writing to become a Policyholder of the Company.

"Experimental or **Investigational Treatment or Procedures"** means medical treatment, services, supplies, medications, drugs, or other methods of therapy or medical practices which have not been accepted as a valid course of treatment for at least three years. They must be accepted as a valid course of treatment by the U.S. Food and Drug Administration, the American Medical Association, the Surgeon General, or any other medical society that is recognized by the Company. Any services, supplies, or accommodations that are provided in connection with such procedures are included in this definition.

"Extended Care Facility/Rehabilitation Care Facility" means an institution, or distinct part thereof, which is licensed pursuant to state or local law to provide extended care and treatment or rehabilitation care (whether acute care or extended care). This care is provided to individuals convalescing from an Injury or an Illness. Any institution which is, other than incidentally, a rest home, a home for the aged, or a place for the treatment of mental disease, drug addiction or alcoholism, is not considered to be an "Extended Care Facility/Rehabilitation Care Facility."

"Family Deductible" means two (2) times the individual Deductible amount. Each family member may only contribute his individual Deductible amount to the satisfaction of the Family Deductible amount.

"Family Out-of-Pocket" means two (2) times the individual Out-of-Pocket amount. An individual family member may not contribute more than one-half of the Family Out-of-Pocket maximum. Each family member must satisfy an individual Deductible amount (unless the Family Deductible has been satisfied) even if the Family Out-of-Pocket maximum amount has been satisfied. Only Deductible and co-insurance amounts that are paid by the Insured during the Calendar Year will be applied toward the satisfaction of the Out-of-Pocket maximum. Amounts that are paid for care or treatment that is not covered do not apply toward the Out-of-Pocket maximums.

"Generic Drugs" are Prescription Drugs that have been reviewed by the Food and Drug Administration ("FDA") as abbreviated new drug applications (ANDA). Generic Drugs are also multisource products that have lower costs than Brand Drugs, and are no longer protected by patents.

"Habilitative Care Services" coverage will be provided when the covered person needs help to keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services include, but are not limited to, physical and occupational therapy, speech-language pathology and other services for people with disabilities which may be provided in a variety of Inpatient and/or outpatient settings as prescribed by a Physician. Coverage for habilitative care and rehabilitative care are subject to the benefit requirements specified in the federal Affordable Care Act.

"Home Health Care" means services that are provided by a licensed home health agency to an Insured in his place of residence. These services are prescribed by the Insured's attending Physician as part of a written plan of care. Services provided by Home Health Care include: nursing, home health aide services, physical therapy, Occupational therapy, speech therapy, Hospice services. Services also include medical supplies and equipment suitable for use in the home, and Medically Necessary personal hygiene, grooming, and dietary assistance.

"Hospice" means a licensed agency that operates within the scope of such license. A Hospice provides palliative care and treatment of patients with a life expectancy of six (6) months or less. The focus of the care and treatment is the acknowledgement of death and dealing with it in both its physical and psychological aspects. Such services are covered if the Hospice meets all of the following criteria.

(a) It is engaged in providing nursing services and other medical services under the supervision of a Physician.

(b) It maintains a complete medical record on each patient.

(c) It is not engaged in providing Custodial Care, care or treatment of Mental Illness, or care or treatment for drug or alcohol abuse or dependency.

(d) It qualifies as a reimbursable service under Medicare.

"Hospital" means a facility which is licensed and accredited by the Joint Commission on Accreditation of Hospitals. Such facility must operate within the scope of its license. Such facility must make use of at least clinical, laboratory, and diagnostic x-ray services. Such facility must also make use of major surgical facilities. A Hospital does not include the following: a nursing home; a rest home; a hospice; a rehabilitation facility; a skilled nursing facility; a convalescent home; a long-term, chronic-care institution or facility providing the type of care previously listed.

"Hospital Confined" means admitted to and confined as a patient in a Hospital upon the recommendation of a Physician.

"Illness" means a bodily disorder that results from a disease, a sickness, or a malfunction of the body. Illness also mean a congenital malformation which causes functional impairment. The

Employee or Dependent(s) must not be entitled to receive any Benefits under any workers' compensation law or occupational disease law.

"Implantable Hardware" means medical hardware that is implanted partially or totally into the body. Implantable Hardware includes, but is not limited to, artificial joints, pins, screws, bone plates, and spinal rods. Implantable Hardware does not include Durable Medical Equipment as that term is defined in this Policy.

"Injury" means an Accidental Bodily Injury that is sustained by the Insured person which is the direct result of an Accident. Injury is independent of a disease or a bodily infirmity or any other cause. The Insured must not be entitled to receive any Benefits under any workers' compensation law or occupational disease law for such Injury.

"Inpatient" means treatment that is provided while admitted to, and confined in, a Hospital for at least twenty-four (24) hours. Inpatient treatment includes services such as lodging and meals.

"Insured" means the Insured Employee or the Insured Dependent(s).

"Insured Dependent" means the Dependent of an Insured Employee for whom premium was paid.

"Insured Employee" means an Employee who is eligible for insurance as defined in this Plan and for whom premium was paid.

"Medicaid" means the programs that provide Hospital and medical benefits under Title XIX of the Federal Social Security Act as it is now in effect or as it is amended hereafter.

"Medically Necessary" means any services for health care, supplies, or accommodations that are provided to the Insured for treatment of an Illness or an Injury, which meets all of the following.

(a) They are consistent with the symptom(s) or the diagnosis.

(b) They are received in the most appropriate, cost effective, setting that can be used safely.

(c) They are not only for the convenience of the Insured or the Provider or any other person's convenience.

(d) They are appropriate with regard to the standards of good medical practice in the state.

(e) They could not be omitted without adversely affecting the Insured's condition or the quality of the medical care received.

"Medicare" means the programs that provide Hospital and medical benefits under Title XVIII of the Federal Social Security Act as it is now in effect or as it is hereafter amended. Employees and Dependent(s) who are eligible for any coverage under Medicare shall be deemed to have all the coverage that is provided thereunder.

"Mental Health Care Facility" means a facility that is licensed by the state or is otherwise authorized to provide mental health services according to state law. Such facility must provide a program for the treatment of Mental Illness pursuant to a written plan.

"Mental Health Care Practitioner" means an individual who is licensed by the state as a Physician or a surgeon, or an osteopathic Physician and who is engaged in the practice of mental health therapy; an Advanced Practice Registered Nurse, specializing in psychiatric mental health nursing; a psychologist qualified to engage in the practice of mental health therapy; a clinical social worker; a certified social worker; a marriage and family therapist; or a professional counselor.

"Mental Illness" means a clinically significant behavioral or psychological syndrome or pattern that occurs in a person and that is associated with present distress or a painful symptom. Mental Illness also means a disability or an impairment in one or more areas of functioning, or an increased risk that is significant of suffering death, pain, disability, or an important loss of freedom. Mental Illness includes the following disorders as defined by the American Psychiatric Association: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, and autism. Mental Illness does not include a development disorder; a speech disorder; a psychoactive substance use disorder; an eating disorder, except for bulimia and anorexia nervosa; an impulse control disorder, except for intermittent explosive disorder and trichotillomania.

"Occupational Therapy" means the use of any occupation or creative activity for remedial purposes in order to retrain the patient in work activities (school, home management and employment). Occupational Therapy is directed toward the coordination of finer, more delicate movements, such as coordination of the fingers, to the sick or injured person's highest attainable skills.

"Office Visit" means: (1) an evaluation, a consultation, or a physical examination that is performed by a medical doctor (M.D.), a doctor of osteopathy (D.O.), or a nurse practitioner (N.P.); (2) an initial psychiatric evaluation **only** when it is conducted by a provider licensed to perform that evaluation; and (3) an initial evaluation **only** when it is performed by a chiropractor or physical therapist for an Injury (limited to two per Calendar Year). The term Office Visit also includes minor surgical services that do not require the use of a surgical facility or suite. The term Office Visit also includes Home Health Care services.

"Open Enrollment" means the period between November 1 and December 31 during which an Employee or Dependent who previously waived coverage may enroll in the insurance Plan. An individual who enrolls in the Plan during the Open Enrollment period will become effective on January 1. An Employee or a Dependent who waives insurance coverage during the Open Enrollment period must wait until the next Open Enrollment period to enroll in the insurance Plan.

"Out-of-Pocket" means the maximum dollar amount per year of Eligible Charges that are payable by an Insured to Providers. An individual family member may not contribute more than one-half of the Family Out-of-Pocket maximum. Only Deductible and eligible co-insurance amounts that are paid by the Insured during the Calendar Year will be applied toward the satisfaction of the Out-of-Pocket maximum. Deductible amounts must be satisfied for each individual family member (unless the Family Deductible has been satisfied) even if the Family

Out-of-Pocket maximum amount has been satisfied. The Out-of-Pocket amounts are specified in the Schedule of Benefits.

"Owner" means an owner, a partner or a proprietor of the Policyholder. In order to be eligible for the optional 24-hour coverage, an Owner must be one who is not required by law to be covered by workers' compensation insurance, and who does not have such insurance in effect.

"Physician" means an individual who is licensed by the state to practice medicine and surgery in all of its branches. Physician also means an osteopathic Physician and surgeon.

"Plan" or **"Policy"** means this document and any riders that are issued hereunder.

"Policyholder" means the Employer.

"Practitioner" means any licensed physician, physician assistant, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, licensed professional counselor, acupuncturist, naturopathic physician, physical therapist, speech-language pathologist, audiologist, licensed addiction counselor, or advance practice registered nurse practicing within the scope of their respective licenses.

"Pre-certification" means the determination that being confined in the Hospital is Medically Necessary and that the proposed length of stay is appropriate. **Pre-certification does not guarantee the payment of claims. Pre-certification also does not determine whether Benefits are eligible.** Pre-certification for Urgent Care is **not** required, although it is recommended. Once the care is no longer Urgent Care, Pre-certification requirements will apply. Pre-certification is not required for treatment for Mental Illness, for alcoholism, and for drug addiction. Pre-certification is also not required for reconstructive breast surgery and for maternity delivery services that are within the federally allowed time limits. Pre-certification is still recommended for all of these conditions.

"Preferred Provider" means a health care Provider that has contracted with a Preferred Provider Organization to provide services to Insureds of the Company at negotiated rates.

"Preferred Provider Network", "Network" or "PPO" means a Network of Providers that contract with a Preferred Provider Organization to provide services to Insureds of the Company at negotiated rates.

"Prescription Drug" means a drug or medicine which can only be obtained by a Prescription Order or which is restricted to prescription dispensing by state law. A Prescription Drug must bear the legend "Caution, Federal Law Prohibits Dispensing Without a Prescription" or other similar type of wording.

"Prescription Order" means a written or an oral order for a Prescription Drug that is issued by a Provider who is acting within the scope of his/her professional license.

"Professional Charges" means charges that are made by a Physician, a doctor of podiatric medicine, or a dentist. Such charges include an Office Visit, a surgical procedure, assistance that is Medically Necessary, or a medical service at a Hospital.

"Provider" means a Hospital, a skilled nursing facility, an Ambulatory Service Facility, a Physician, a Practitioner, or other individual or organization. A Provider must be licensed by the state to provide medical or surgical services, supplies, and/or accommodations.

"Rehabilitative Care Services" coverage will be provided when the covered person needs help to keep, get back, or improve skills and functioning for daily living that have been lost or impaired because the person was sick, hurt or disabled. These services include, but are not limited to, physical and occupational therapy, speech-language pathology and psychiatric rehabilitation. These services may be provided in a variety of Inpatient and/or outpatient settings as prescribed by a Physician. Coverage for habilitative care and rehabilitative care are subject to the benefit requirements specified in the federal Affordable Care Act.

"Residential Care Facility/Institution" means a health care facility/institution that provides the following services for persons who do not need Inpatient nursing care.

(a) Resident beds or residential units.

(b) Supervisory care services. This includes general supervision and the daily awareness of resident functioning and continuing needs.

(c) Personal care services. This includes assistance with activities of daily living that can be performed by persons without professional skills or professional training.

(d) Directed care services. This includes programs or services that are provided to persons who are incapable of recognizing danger, summoning assistance, expressing need or making basic care decisions.

(e) Health related services. This includes services, other than medical services, that pertain to general supervision, protective, and preventive services.

This definition does not include a nursing care institution. This definition also does not include a Hospital, a Mental Health Care Facility, a Chemical Dependency Treatment Center, or an Extended Care Facility/Rehabilitation Care Facility, which are defined elsewhere in this Policy.

"Routine Physical Examination" means a physical examination where an Insured has no symptoms of an Illness or an Injury. Routine Physical Examination includes the examination and routine lab procedures that are required for the physical examination. Such procedures include, but are not limited to, cytological testing/pap smears, and prostate tests.

"Schedule of Benefits" is the attachment to this Policy that outlines the Benefits that are available under this Policy. The Schedule of Benefits is attached to and is made a part of this Policy.

"Semi-private Room Accommodation" means two-bed, three-bed, or four-bed room accommodations in a Hospital or other licensed health care facility.

"Special Enrollment" means an enrollment period, other than the Employer's initial enrollment period or the annual Open Enrollment period, when Employees and Dependents are eligible to enroll in the Plan pursuant to the enrollment provisions of the Plan.

"Spouse" means the person who is legally married to the Insured person.

"Total Disability" means the inability to perform the duties of any gainful occupation for which the Insured is reasonably fit to perform by training, experience and accomplishment.

"United States" means the United States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam and American Samoa.

"Urgent Care" means medical care or treatment where applying the time periods that are used for making decisions that are not for Urgent Care could seriously jeopardize the insured's life, health or ability to regain maximum function. Urgent Care also means medical care or treatment where applying the time periods that are used for making decisions that are not for Urgent Care would subject the insured to severe pain that cannot be adequately managed without the care or treatment, in the opinion of a Physician with knowledge of the insured's medical condition.

"Usual and Customary" means the charge that is associated with a medical or surgical supply, with a service, with a procedure or with a prescription drug which represents the normal charge level for that procedure in the geographic area of service. The normal charge level that is used to calculate the eligible allowance for a non-preferred provider is the 70th percentile. Usual and Customary allowances are derived from a national database. This database is updated at least annually. The geographic area of service is determined by the number of similar providers in a zip code range.

"Waiting Period" means the time that is between the Employee's date of hire and the date he/she begins participation in the Plan.

II. ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE:

This Plan covers all Employees and Dependents as those terms are defined in the Policy.

A. **ELIGIBILITY DATE FOR EMPLOYEES OF NEWLY ENROLLED EMPLOYER GROUPS:**

Employees are eligible to participate in the Plan if they worked an average of thirty (30) hours or more per week during the preceding month. Employees are eligible to participate on the Effective Date of the Employer's Plan. Employees must enroll in the Plan prior to the Effective Date of the Employer. Employees must submit an Enrollment card that has been completed properly to the Company. An Eligible Employee cannot enroll in the Plan until the next Open Enrollment period if he does not enroll prior to the Effective Date of the Employer's Plan.

B. **ELIGIBILITY DATE FOR NEWLY HIRED EMPLOYEES:** Newly hired Employees are eligible to participate in this Plan on the dates listed below.

1. If the Employer has selected a Waiting Period of 60 days or less, coverage will become effective on the first day of the month that <u>follows</u> the satisfaction of such Waiting Period.

2. If the Employer has selected a Waiting Period of 90 days, coverage will become effective on the first day of the month that precedes the satisfaction of such Waiting Period.

A new Employee must submit an enrollment card that has been completed properly to the Company before coverage can become effective. An eligible Employee cannot enroll in the Plan until the next Open Enrollment period if he does not enroll within thirty-one (31) days after satisfying the Waiting Period of the Employer.

For purposes of this subsection, a newly eligible Employee or a newly promoted Employee (e.g., an Employee who enters a class of Employees to whom this Policy is offered) is considered to be a newly hired Employee.

C. **ELIGIBILITY DATE FOR DEPENDENT(S):**

Eligible Dependents must submit an enrollment card that has been completed properly to the Company to enroll in the Plan. Eligible Dependents can participate in this Plan on the same day as the Employee if they enroll at the same time as the Employee. An Eligible Dependent cannot enroll in the Plan until the next Open Enrollment period if he does not enroll at the same time as the eligible Employee.

D. **SPECIAL ENROLLEES:**

The following individuals are eligible to enroll in the Plan outside of the Open Enrollment Period. An enrollment card that has been completed properly must be submitted to the Company within thirty-one (31) days of eligibility. Coverage will be effective on the first day of the first calendar month that follows the date that the enrollment materials are received by the Company.

1. Employees who declined participation in the Plan when they were first eligible because they maintained other health insurance and they have since involuntarily lost the other coverage. If the other coverage is provided under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), the Employee may only enroll after the COBRA coverage has been involuntarily exhausted. If the other coverage was provided through Medicaid or SCHIP, and coverage has been terminated due to a loss of eligibility, the coverage through this Plan must be requested within sixty (60) days after the termination.

2. Employees who marry or who acquire a Child through birth, adoption, or placement for the purpose of adoption.

3. Dependents of Employees who are Insured under the Plan, who declined participation in the Plan when they were first eligible because they maintained other health insurance and they have since involuntarily lost the other coverage. If the other coverage is COBRA coverage, the Dependent may only enroll after the COBRA coverage has been exhausted. If the other coverage was provided through Medicaid or SCHIP, and coverage has been terminated due to a loss of eligibility, the coverage through this Plan must be requested within sixty (60) days after the termination.

4. Eligible Dependents of Insured Employees who are acquired due to marriage, birth, adoption, or placement for the purpose of adoption, are subject to the following eligibility rules.

   (a) A spouse may enroll in the Plan at the time of marriage or when a Child is born, adopted or placed for the purpose of adoption.

   (b) Any newborn infant of any covered person is automatically covered, with no waiting or elimination period, from the moment of birth for a period of thirty-one (31) days. Coverage for a newborn infant includes immediate accident and sickness coverage, from and after the moment of birth. An adopted Child is automatically covered from the date the Child is placed for the purpose of adoption. Coverage for an adopted Child will continue unless the placement is disrupted prior to legal adoption. Coverage at the time of placement includes the necessary care and treatment of medical conditions that existed prior to the date of placement.

   Coverage can only be extended beyond the thirty-one (31) day period for an eligible Dependent Child(ren) as that term is defined in the Policy. The Insured Employee must enroll the eligible Child within thirty-one (31) days from the date of birth or the date of placement for adoption if the payment of a specific premium is required to provide coverage for a newborn Child or an adopted Child. The Insured Employee must pay all applicable premium within the thirty-one (31) day period, in order for the coverage of a newborn Child or a Child placed for the purpose of adoption to extend beyond the thirty-one (31) day period.

5. Eligible Employees or Dependents who are not enrolled in this Plan may enroll if they become eligible for a premium assistance subsidy through Medicaid or SCHIP. The Employee or the Dependent must request enrollment within sixty (60) days after they become eligible for the subsidy.

E. **ALTERNATE RECIPIENTS:** An alternate recipient is a child of an Employee who is recognized by a qualified medical child support order ("QMCSO") to have a right to enrollment under a group health plan with respect to such Employee, outside of the Open Enrollment period. If the medical child support order is determined by the Company to be a "qualified" order, the effective date of the coverage for the alternate recipient will be the first day of the first month following the date of determination. A copy of the QMSCO procedures for this Plan may be obtained free of charge, upon request.

F. **MAINTENANCE OF EMPLOYEE ELIGIBILITY:** Employees are eligible to participate in the Plan as long as they are Actively at Work in the regular business of an Employer. Active Employees must work an average of at least one hundred twenty (120) hours per month while they are receiving compensation for such service from the Employer.

G. **MAINTENANCE OF GROUP ELIGIBILITY:** The Company requires that 100% of all of the Employees participate if there are three (3) or less Employees that are eligible for the insurance. The Company requires that 75% of all of the Employees participate if there are four (4) or more Employees that are eligible for the insurance. The Company may terminate this Plan for failure to meet participation requirements on any renewal date. The Company will give written notice to the Policyholder at least thirty-one (31) days in advance.

III. TERMINATION OF INSURANCE BENEFITS

A. TERMINATION OF EMPLOYEE COVERAGE:

1. The insurance for an Employee under this Plan will terminate on the last day of the month in which the Employee no longer qualifies as an eligible Employee or when he/she leaves the employ of the Participating Employer. The insurance for the Dependents will terminate if the Employee's insurance terminates.

2. If the required monthly premiums are not timely received by the Company, coverage will be automatically terminated as of the end of the last day for which premium has been paid. Reinstatement of the coverage for a terminated insurance group may be allowed if all of the requirements of the Company have been met. All premiums are due on the first day of each calendar month. Premiums shall be considered delinquent on or before the 10th day of the month that such premiums are due.

3. The insurance for an Employee under the Plan may be rescinded or may terminate immediately if the he has performed an act or practice that constitutes fraud. The insurance for an Employee under the Plan may also be terminated if he/she has made an intentional misrepresentation of material fact under the terms of the coverage. The Company will give a 30-day advance notice to the Insured prior to such rescission or termination. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

B. TERMINATION OF DEPENDENT COVERAGE:

The coverage for a Dependent shall automatically terminate on the earliest of the dates that follow.

1. The date that the covered Dependent ceases to be eligible as a "Dependent" as that term is defined in the Policy.

2. The date that the coverage for the Employee under the Plan terminates.

3. The date that the period for which the last premium is made on account of an Employee's Dependent Coverage expires.

4. The insurance for a Dependent under the Plan may be rescinded or may terminate immediately if the Dependent has performed an act or practice that constitutes fraud. The insurance for a Dependent may also be terminated if he/she has made an intentional misrepresentation of material fact under the terms of the coverage. The Company will give a 30-day advance notice to the Insured prior to such rescission or termination. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

C. EXCEPTIONS TO THE TERMINATION OF DEPENDENT COVERAGE PROVISIONS:

1. Coverage for Dependents shall be continued in force until the last day of the month for which the premium was paid in the event of the Employee's death.

2. If a covered Dependent of an Employee is incapable of self-support because of mental retardation or a physical disability on the date his/her coverage would otherwise terminate on account of his/her age, his medical Benefits will be continued during the period of his/her incapacity. Satisfactory proof of the incapacity of the covered Dependent must be submitted to the Company within 31 days from the date coverage would otherwise terminate. The Company may subsequently require proof of his/her incapacity as specified in the Plan. This extension will continue until the earliest of the following.

   (a) The date that the Dependent ceases to be incapacitated.

   (b) The 31st day after the Company requests additional proof of incapacity if the Employee fails to furnish such proof.

   (c) The last day for which premiums have been paid.

IV. COVERED SERVICES: This Policy provides the Benefits listed below as set forth in the Schedule of Benefits.

A. **INPATIENT FACILITY SERVICES:** The Medical Necessity of the length of stay of all Inpatient facility confinements must be Pre-Certified. Pre-certification is recommended for Urgent Care and for Emergency services that are performed in the Emergency room of a Hospital, but it is **not** required. Once the care is no longer Urgent Care, the Pre-certification requirements will apply. Pre-certification is not required for treatment for Mental Illness, for alcoholism, and for drug addiction. Pre-certification is also not required for reconstructive breast surgery and for maternity delivery services that are within the federally allowed time limits. Pre-certification is still recommended for all of these conditions. The company that must be contacted for Pre-certification is shown on the insurance card. They must be contacted before all Inpatient facility admissions that are not emergencies. Emergency admissions must be reported within twenty-four (24) hours of the admission. Emergency admissions must be reported on the next business day if the admission occurs on a weekend or holiday. Benefits will be reduced for the Inpatient facility confinement by 10% for failure to comply. **Pre-certification does not guarantee that payment will be made nor does it determine that Benefits are eligible.** If an Insured receives an adverse Pre-certification determination in which Benefits are denied in whole or in part, he may contact the Company to request a review. The review will be conducted in accordance with the provisions that are established by applicable law.

   1. **Inpatient Hospital Services.** Eligible services include Semi-private Room Accommodations, which includes special diets and nursing services. Room accommodations are also eligible for intensive care. Eligible services also include necessary miscellaneous supplies such as, but not limited to, laboratory procedures; operating room; delivery room, recovery room; anesthetic supplies; surgical supplies; oxygen and use of equipment for its administration; x-ray; intravenous injections and setup; special diets; respiratory therapy, chemotherapy, radiation therapy, dialysis, physical therapy, speech therapy, Occupational Therapy, and drugs and medicines

which: (i) are approved for use in humans by the U.S. Food and Drug Administration for the specific diagnosis for which they are prescribed; (ii) are listed in the American Medical Association Drug Evaluation, Physicians' Desk Reference, or Drug Facts and Comparisons; and (iii) require a Physician's written prescription. The Plan limits Hospital stays to a maximum duration of three hundred sixty-five (365) days per Calendar Year. The services of a skilled nursing facility/convalescent home are eligible as an alternative to Inpatient Hospital services. The plan limits skilled nursing facility/convalescent home services to sixty (60) days per Calendar Year.

2. **Inpatient Mental Illness Care, including residential treatment.** Benefits for Mental Illness are paid as any other Illness. Inpatient services are care and treatment when the Insured is an Inpatient and must be provided in or by: (1) a Hospital; (2) a freestanding Inpatient facility; or (3) a Physician. Benefits include medically monitored and medically managed intensive Inpatient services and high-intensity residential services.

3. **Inpatient Chemical Dependency Treatment, including residential treatment.** Benefits for Chemical Dependency are paid as any other Illness. Inpatient services are care and treatment when the Insured is an Inpatient and must be provided in or by: (1) a Hospital; (2) a freestanding Inpatient facility; or (3) a Physician. Benefits include medically monitored and medically managed intensive Inpatient services and high-intensity residential services.

4. **Inpatient Extended Care Facility/Rehabilitation Care Facility.** Eligible treatment consists of room and board, which includes, but is not limited to, dietary and general, medical and rehabilitation nursing services. Eligible treatment also consists of miscellaneous services. Such services include, but are not limited to: (a) rehabilitation therapy services and supplies, which include, but are not limited to, physical therapy, occupational therapy, and speech therapy; (b) laboratory procedures; (c) diagnostic testing; (d) pulmonary services and supplies, which include, but are not limited to, oxygen and the use of equipment for its administration; (e) x-rays and other radiology; (f) intravenous injections and setups for intravenous solutions; (g) special diets when they are Medically Necessary; (h) operating room and recovery room; (i) anesthetic and surgical supplies; and (j) drugs and medicines which are approved for use in humans by the Food and Drug Administration for the specific diagnosis for which they are prescribed, that are listed in the American Medical Association Drug Evaluation, Physicians' Desk Reference or Drug Facts and Comparisons, and that require a written prescription by a Physician. The daily room charge is limited to a Semi-private room. Benefits are limited to a maximum of sixty (60) days in each Calendar Year. All other Covered Expenses will be paid in accordance with the Policy guidelines. Custodial Care is not considered to be Extended Care or Rehabilitation Care and it is not eligible for Benefits.

B. **OUTPATIENT HOSPITAL AND AMBULATORY PATIENT SERVICES:** Outpatient services, supplies and treatment that are provided in a Hospital will be paid as set forth in the Schedule of Benefits. Outpatient services, supplies and treatment that are provided by an Ambulatory Service Facility are payable as set forth in the Schedule of Benefits.

C. **OUTPATIENT MENTAL ILLNESS CARE:** Benefits for Mental Illness are paid as any other Illness. Outpatient services are care and treatment for Mental Illness when the Insured

is not an Inpatient and are provided by: (1) a Hospital; (2) a Mental Health Care Facility; (3) a Chemical Dependency Treatment Facility; (4) a Physician or prescribed by a Physician; (5) a psychologist; (6) a licensed social worker; (7) a licensed professional counselor; (8) an addiction counselor licensed by the state; or (9) a licensed psychiatrist. Treatment must be provided to diagnose and treat a recognized Mental Illness. Treatment must be reasonably expected to improve or restore the level of functioning that has been affected by the Mental Illness. Benefits will not be provided for marriage counseling, hypnotherapy, or for services given by a staff member of a school or halfway house.

D. **OUTPATIENT CHEMICAL DEPENDENCY TREATMENT:** Benefits for Chemical Dependency are paid as any other Illness. Outpatient services are care and treatment for Chemical Dependency when the Insured is not an Inpatient and are provided by: (1) a Hospital; (2) a Mental Health Care Facility; (3) a Chemical Dependency Treatment Facility; (4) a Physician or prescribed by a Physician; (5) a psychologist; (6) a licensed social worker; (7) a licensed professional counselor; (8) an addiction counselor licensed by the state; or (9) a licensed psychiatrist. Treatment must be provided to diagnose and treat a recognized chemical dependency. Treatment must be reasonably expected to improve or restore the level of functioning that has been affected by the chemical dependency. Benefits will not be provided for marriage counseling, hypnotherapy, or for services given by a staff member of a school or halfway house.

E. **GENERAL SURGICAL SERVICES:**

1. The Plan covers surgical procedures and the care of fractures and dislocations performed in an outpatient or Inpatient setting, which includes the usual care before and after surgery that are performed by the primary surgeon.

2. The Plan also covers one co-surgeon for each surgery. The services must be Medically Necessary. The co-surgeon must be licensed under a different specialty than the primary surgeon. The total amount allowed is limited to 125% of the allowance for the primary surgeon. That amount will be split equally between the primary surgeon and the co-surgeon.

3. The Plan also covers one surgical assistant for each surgery. The services of a surgical assistant are only covered if they are Medically Necessary. Payment is limited to 20% of the amount that is allowed for the primary surgeon.

4. Multiple or Bilateral Surgical Procedures. The value of the major procedure plus 50% of the value of the lesser procedure will be allowed when multiple or bilateral surgical procedures which add significant time or complexity to patient care are performed at the same time and through the same incision. The value of the major procedure plus 75% of the value of the lesser procedure will be allowed when multiple procedures are performed through separate incisions or in separate sites. Incidental procedures such as an appendectomy, scar excision, puncture of ovarian cysts, and simple lysis of adhesions, are covered under the principal amount payable. An additional Benefit is not available for those types of procedures.

5. The services of a surgical facility or a freestanding surgery center that is licensed, or that is certified by Medicare, by the state in which it is located and that has an effective peer

review program to assure quality and appropriate patient care are covered. The surgical procedure performed in a surgical facility or a freestanding surgery center is recognized as a procedure which can be safely and be effectively performed in an outpatient setting. A recovery care bed is also eligible when it is Medically Necessary and when it is provided for less than 24 hours.

6. The services of a Hospital for surgical procedures and the care of fractures and dislocations performed in an outpatient or Inpatient setting which includes the usual care before and after surgery are covered.

F. **ANESTHESIA SERVICES:** The Plan covers anesthesia service to achieve general or regional anesthesia. This service must be at the request of the attending Physician. This service must be performed by a Physician other than the operating Physician or the assistant. The services of a nurse anesthetist who is not employed by the Hospital and who bills for services that are provided are also covered. The services of a nurse anesthetist are covered only if they are Medically Necessary and if a Hospital employee or Physician is unavailable. Local anesthesia is covered as a part of the global fee for a surgical procedure.

G. **PHYSICIAN SERVICES:**

1. **Office Visits:** Office Visits that are provided by a Physician, a specialist, or other Practitioner are covered. Office visits include associated supplies and services that are Medically Necessary to treat an Illness or Injury, and covered services that are provided in the home by a covered Provider, are covered. Benefits include therapeutic injections.

2. **Physician Consultations:**

(a) The Plan covers Hospital Visits by a Physician if the Employee or Dependent is confined in a Hospital. The Plan also covers convalescent home facility Visits by a Physician and surgical facility Visits by a Physician. Physician Visits after a surgical procedure takes place that are considered to be an inclusive part of the surgery are not eligible for a separate Benefit.

(b) Consultations are covered if they are requested by the attending Physician. One consultation is allowed for each specialist and for each Disability.

(c) There is a limit of one Physician or Provider Visit allowed for each day. Benefits will expire after three hundred sixty-five (365) days of Hospital confinement per Disability.

(d) Concurrent Physicians Services:

(i) A patient who is hospitalized for a surgical procedure and who receives medical care from a Physician other than the surgeon for a different condition is entitled to Benefits for both the Hospital Physician and the surgical service.

(ii) A patient who is admitted to the Hospital for a medical condition and is then transferred to the Hospital's surgical service for the same condition but under the care of another Physician, is entitled to Hospital Physician care only from

the date of admission to the date of transfer to the surgical service. After that time, the patient is only entitled to the Benefit for surgical services unless the surgery performed is diagnostic, a myelogram, or an endoscopic procedure.

(iii) If the patient receives concurrent Hospital care from more than one Physician during the same admission (whether or not it is for the same condition), the patient is entitled to Benefits for the services of only the attending Physician. The services provided by the additional Physician will be covered if the Company determines that the services of more than one Physician were required due to the complexity of the patient's condition.

H. **HOSPICE CARE:** All services that are provided by a Hospice if: (a) the charge is incurred by an Insured person who is diagnosed by a doctor as terminally ill with a prognosis of six months or less to live; and (b) the Hospice provides a Plan of care which: (i) is prescribed by the doctor; (ii) is reviewed and approved by the doctor monthly; (iii) is not for any curative treatment; (iv) states the belief of the doctor and the Hospice that the Hospice care will cost less in total than any comparable alternative to Hospice care; and (v) is furnished to the Company.

Hospice care includes: (a) Inpatient and outpatient care; (b) home care; (c) nursing services – skilled and non-skilled; (d) counseling and other support services provided to meet the physical, psychological, spiritual and social needs of the terminally ill Insured; and (e) instructions for care of the Insured, and counseling and other support services for the Insured's immediate family.

I. **ORGAN TRANSPLANTS AND JOINT IMPLANTS:**

1. Organ Transplants and Joint Implants are covered as set forth in the Schedule of Benefits. All such services must be pre-authorized by the Company in writing. All transplants or implants may require a second opinion if deemed necessary by the Company. All transplants or implants may also require a third opinion if deemed necessary by the Company. If the required opinion(s) are not obtained, all Hospital payments will be reduced by 10%. The organs and body parts listed below are eligible for transplant or implant.

   (a) Heart.
   (b) Arteries.
   (c) Veins.
   (d) Intra-ocular lenses.
   (e) Corneas.
   (f) Kidneys.
   (g) Skin;
   (h) Tissues;
   (i) All joints of the body.
   (j) Heart/lung combined.
   (k) Liver.
   (l) Lung (single or double).
   (m) Pancreas.
   (n) Pancreas/kidney.

(o) Small bowel.
(p) Bone marrow, stem cell rescue, stem cell recovery, any and all other procedures that involve bone marrow or bone marrow components as an adjunct to high dose chemotherapy. This includes services that are related to any evaluation, treatment or therapy that involves the use of myeloablative chemotherapy with autologous hematopoietic stem cell and/or colony stimulating factor support (MC-AHSC/CSF).

For the purpose of this section, the following terms are defined. "Myeloablative Chemotherapy" means a dose of chemotherapy which is expected to destroy the bone marrow. "Autologous Hematopoietic Stem Cell" means an infusion of primitive cells that are capable of replication and differentiation into mature blood cells which are harvested from the Insured's blood stream or bone marrow prior to the administration of the myeloablative chemotherapy. "Colony Stimulating Factor" means a substance which increases the reproduction, differentiation, and maturation of blood cellular components.

All organs for transplants must be natural body organs. Artificial organs, nonhuman organs or experimental or investigational procedures are not eligible for Benefits. This exclusion does not apply to intra-ocular lens implants and artificial joint implants.

2. Diagnostic, medical and surgical expenses for a compatible live or cadaveric donor that are directly related to the transplant are eligible for Benefits. These expenses are only eligible if the recipient of the transplant is an Insured under this Policy. Expenses for both the donor and the recipient are only covered under the coverage of the recipient. This applies even if both the donor and the recipient are Insureds under this Plan. Donor charges are ineligible for Benefits if the recipient is not an Insured under this Plan. Donor search charges are ineligible for Benefits.

3. The Usual and Customary amount for Implantable Hardware, as defined in the Policy, shall be limited to the invoice cost plus 50%. This maximum allowable amount applies to services that are rendered at PPO and non-PPO facilities. An invoice showing the actual cost of the Implantable Hardware must be submitted to the Company.

J. **DIAGNOSTIC SERVICES:** Diagnostic x-ray examinations, laboratory and tissue diagnostic examinations and medical diagnostic procedures (machine tests such as EKG, EEG) are covered. Covered services include, but are not limited to, the following.

1. X-rays and other radiology. Some examples of other radiology include computerized tomography scan (CT scan), MRI, nuclear medicine and ultrasound

2. Laboratory tests. Some examples of laboratory tests include urinalysis, blood tests, and throat cultures.

3. Diagnostic testing. Some examples of diagnostic testing include electroencephalograms (EEG) and electrocardiograms (EKG or ECG).

K. **MATERNITY SERVICES:**

1. Benefits for maternity are paid on a female Insured the same as Benefits paid on any other Illness. Benefits include prenatal and postnatal care, delivery and all Inpatient

services for maternity care, the initial care of a newborn that is provided by a Physician at birth, standby care provided by a pediatrician at a cesarean section, and nursery care of newborn infants. In no circumstances will Maternity Benefits be restricted for any Hospital length of stay in connection with childbirth for the mother and the newborn Child to less than forty-eight (48) hours following a vaginal delivery or less than ninety-six (96) hours following a cesarean section. It is not necessary for a Provider to obtain pre-authorization from the Company for a length of stay that is within these time limitations. Although not required, the expectant mother may call the Pre-certification company during the first trimester. This is recommended so that a review for a possible high risk pregnancy can be performed.

2. Prenatal ultrasounds are limited to two (2) routine ultrasounds for each pregnancy. Additional ultrasounds are allowed if they are deemed to be Medically Necessary by the Physician due to a condition of risk to the mother or the child.

L. REHABILITATIVE AND HABILITATIVE SERVICES:

1. Physical therapy, speech therapy, and Occupational Therapy for rehabilitative purposes or for habilitative purposes are covered when Medically Necessary. Services must be rendered by a Provider who is operating within the scope of their license.

2. Professional services that are provided in an Extended Care Facility/Rehabilitation Care Facility are covered. Such services must be rendered by a covered Provider who is a physiatrist or by another Physician who directs the rehabilitation therapy of the Insured while in such facility. Such professional services include care planning and review, patient visits and examinations, consultation with other Physicians, nurses or staff, and all other professional services provided with respect to the Insured.

3. Cardiac rehabilitation therapy, such as, but not limited to, the use of common exercise equipment while under the care of a Physician is covered. The therapy must take place in a formal rehabilitation program at an accredited facility. The therapy must be prescribed by a Physician. Therapy must be rendered within ninety (90) days following cardiac Illness or surgery in order to be eligible.

4. Therapy for pulmonary rehabilitation is covered while under the care of a Physician. The therapy must take place in a formal rehabilitation program at an accredited facility. The therapy must be prescribed by a Physician. Therapy must be provided within the ninety (90) days following the diagnosis of pulmonary illness or surgery in order to be eligible.

5. Cochlear implants are covered if they are Medically Necessary.

6. Braces, splints, and orthopedic devices/orthotic devices are covered. Orthopedic devices/orthotic devices are supportive devices for the body or a part of the body, head, neck or extremities. Such devices include, but are not limited to, leg, back, arm and neck braces. Benefits will be provided for adjustments, for repairs or for replacements because of a change in the Insured's physical condition when they are Medically Necessary. Shoes or related supportive or corrective devices for the feet, including orthotics, are not covered.

7. The purchase or the rental (up to the purchase price) of Durable Medical Equipment, as defined in the Policy, is covered. There is no allowance for maintenance of any items that are purchased under this section.

8. The appropriate prosthetic device used to replace a body part that is missing because of an Accident, an Injury or an Illness is covered. Replacement of a prosthesis is eligible for payment if the prosthesis no longer meets the medical needs of the Insured due to physical changes or a deteriorating medical condition.

8. Expenses for the diagnosis and the treatment of autistic disorder, Asperger's disorder, or a pervasive developmental disorder not otherwise specified are covered. These disorders are defined by the Diagnostic and Statistical Manual of Mental Disorders. Benefits are limited to Children through eighteen (18) years of age. Coverage includes the following.

   (a) Habilitative or rehabilitative care that is prescribed by, provided by or ordered by a licensed Physician or a licensed psychologist. Care includes, but is not limited to, professional, counseling, and guidance services and treatment programs that are medically necessary to develop and restore, to the maximum extent practicable, the functioning of the Child.
   (b) Medications that are prescribed by a Physician.
   (c) Psychiatric care or psychological care that is rendered.
   (d) Therapeutic care that is provided by a speech-language pathologist, an audiologist, an occupational therapist, or a physical therapist who is licensed in this state.

   Interactive therapies that are derived from evidence-based research are covered. These therapies must be medically necessary. The therapies listed below are included in this provision.
   (a) Applied behavior analysis, which is also known as Lovaas therapy.
   (b) Discrete trial training.
   (c) Pivotal response training.
   (d) Programs that have intensive intervention.
   (e) Programs that have early intensive intervention for behavior.

   Applied behavior analysis that is covered under this section must be provided by an individual who is licensed by the behavioral analyst certification board. Applied behavioral analysis may also be provided by an individual who is certified by the department of public health and human services as a family support specialist with an autism endorsement.

   The Company may request that the treating Physician provide a written treatment plan. The treatment plan may consist of the diagnosis, the proposed treatment by type and by frequency, the anticipated duration of the treatment, the anticipated outcomes stated as goals, and the reason that the treatment is medically necessary.

   For the purposes of this provision, "medically necessary" means any care, treatment, intervention, service, or item that is prescribed, provided, or ordered by a Physician or a psychologist licensed in this state and that will or is reasonably expected to: 1) prevent the onset of an Illness, a condition, an Injury, or a Disability; 2) reduce or improve the physical, mental, or developmental effects of an Illness, a condition, an Injury, or a

Disability; or 3) assist in achieving maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and the functional capacities that are appropriate for a child of the same age.

9. Expenses for the diagnosis and the treatment of Down syndrome are covered. Benefits are limited to Children through eighteen (18) years of age. Coverage includes the following.

   (a) Habilitative or rehabilitative care that is prescribed by, provided by or ordered by a licensed Physician, including, but not limited to, professional, counseling, and guidance services and treatment programs that are medically necessary to develop and restore, to the maximum extent practicable, the functioning of the Child.
   (b) Medically necessary therapeutic care that is provided as follows: (1) up to 104 sessions per year with a licensed speech-language pathologist; (2) up to 52 sessions per year with a licensed physical therapist; and (3) up to 52 sessions per year with a licensed occupational therapist.

   Habilitative and rehabilitative care includes medically necessary interactive therapies that are derived from evidence-based research, including intensive intervention programs and early intensive behavioral intervention.

   Applied behavior analysis that is covered under this section must be provided by an individual who is licensed by the behavioral analyst certification board. Applied behavioral analysis may also be provided by an individual who is certified by the department of public health and human services as a family support specialist with an autism endorsement.

   When treatment is expected to require continued services, the Company may request that the treating Physician provide a written treatment plan, consisting of the diagnosis, the proposed treatment by type and by frequency, the anticipated duration of the treatment, the anticipated outcomes stated as goals, and the reason that the treatment is medically necessary. The treatment plan must be based on evidence-based screening criteria. The Company may request that the treatment plan be updated every 6 months.

   For the purposes of this provision, "medically necessary" means any care, treatment, intervention, service, or item that is prescribed, provided, or ordered by a Physician licensed in this state and that will or is reasonably expected to: 1) reduce or improve the physical, mental, or developmental effects of Down syndrome; or 2) assist in achieving maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Child and the functional capacities that are appropriate for a child of the same age.

M. **PREVENTIVE AND WELLNESS SERVICES INCLUDING CHRONIC DISEASE MANAGEMENT:**

1. Screening and tests with a rating of A or B in the U.S. Preventive Services Task Force for prevention and chronic care. Certain preventive medications including, but not limited to, aspirin, fluoride, iron, and tobacco cessation products and over-the-counter cessation aids are covered. These medications must be obtained with a written Prescription Order according to the guidelines as set forth in the U.S. Preventive

Services Task Force. Tobacco use counseling is also covered. For detailed information, refer to www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.

2. Immunizations for routine use in children, adolescents, and adults are covered. Benefits are subject to the guidelines that are recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control. This Benefit includes influenza immunizations.

3. Services, tests and screenings that are contained in the U.S. Health Resources and Services Administration Bright Futures guidelines for infants, children, and adolescents are covered. These guidelines are set forth by the American Academy of Pediatricians.

4. Services, tests, screening and supplies that are recommended in the U.S. Health Resources and Services Administration women's preventive and wellness guidelines are covered. Benefits include, but are not limited to, all contraceptive methods that are approved by the Food and Drug Administration ("FDA"), including the insertion or the extraction of FDA-approved contraceptive devices. Benefits also include tubal ligation and patient education and counseling for all women with reproductive capacity.

5. Other wellness services that are not set forth in the above guidelines are covered. Such services include well baby/child visits, and routine physical examinations and check-ups. For well baby/child care, the Plan covers a history, a physical examination, developmental assessment, guidance given to patients and parents to promote health, and laboratory tests. These services are covered from the moment of birth through seven (7) years of age. These services are covered according to the schedule of visits that are adopted by the American Academy of Pediatrics. Benefits are limited to one visit that is payable to one Provider for all of the services that are provided at each visit in the schedule.

6. Screening colonoscopies are covered. They are subject to the following guidelines in accordance with the American Cancer Society.

   (a) Once every ten (10) years beginning at age 50.

   (b) Once every five (5) years beginning at age 40 if colorectal cancer or adenomatous polyps were present in any first-degree relative (a parent, a sibling, or a child) before the relative's age of 60, or in two or more first-degree relatives at any age.

   (c) As frequently as is determined to be Medically Necessary for follow-up colonoscopies due to the presence of colorectal cancer or adenomatous polyps.

7. One baseline mammogram for women between the ages of 35 and 40 is covered. An annual mammogram for women 40 years of age or older, is covered.

8. Chronic disease management services are covered.

N. **PEDIATRIC VISION SERVICES:** The services that are listed below are covered for Children through the age of eighteen (18).

1. One routine vision screening and eye exam is covered each Calendar Year. Dilation is covered if it is professionally indicated. Refraction is also covered.

2. One pair of prescription lenses each Calendar Year. Benefits include polycarbonate lenses and scratch resistant coating. Lenses may include single vision, conventional lined bifocal or trifocal, or lenticular. Two pairs of glasses may not be ordered in place of bifocals.

3. One pair of frames each Calendar Year.

4. Contact lenses are covered once each Calendar Year. Contact lenses are in place of lenses and frames. This Benefit includes the evaluation for contact lenses. This Benefit also includes the fitting and follow-up care relating to contact lenses.

Visual therapy and lenses that don't need a prescription (plano) are ineligible for Benefits.

O. **PEDIATRIC DENTAL SERVICES:** The services that are listed below are covered for Children through the age of eighteen (18). Refer to the Schedule of Benefits for a list of the specific ADA codes for all eligible services. Benefits are eligible only when they are determined to be necessary for the prevention, diagnosis, care or treatment of a covered condition. Benefits must also meet dental protocols that are generally accepted.

1. **General Services.**

   a. Palliative (emergency) treatment, not to include pulpal debridement, for treatment of dental pain, is limited to once per day.

   b. Oral or parenteral conscious sedation, deep sedation, or general anesthesia that is done in the office is covered. Local anesthesia, regional blocks, and conscious sedation that is not in intravenous form are ineligible for Benefits.

   c. Treatment of complications after surgery (e.g., dry socket) is covered when it is Medically Necessary.

   Behavior management is ineligible for Benefits. Visits in the home or Extended Care Facility visits are ineligible for Benefits. Visits in the Hospital are ineligible for Benefits.

2. **Diagnostic and Preventive Services.**

   a. Periodic oral evaluations are covered. This Benefit includes prophylaxis. This Benefit is limited to one exam every six (6) months.

   b. Bitewing x-rays are limited to one set of films every six (6) months. Panoramic x-rays are limited to one set of films every sixty (60) months. An intraoral complete series is limited to once every sixty (60) months unless a panoramic x-ray has been performed in the same sixty (60) month period. Cephalometric films are allowed when necessary. Oral facial photographic images are allowed on a case-by-case basis.

c. Topical application of fluoride (excluding prophylaxis) is limited to twice each Calendar Year.

d. Sealants for permanent molars are limited to one sealant per tooth every three (3) years.

e. Fixed or removable space maintainers for missing primary teeth are covered.

3. **Restorative, Endodontic and Periodontic Services.** Benefits include, but are not limited to, the services listed below.

b. Fillings are covered. This includes amalgam and resin-based composites. Restorations, including veneers, are ineligible for Benefits when they are placed for cosmetic purposes only.

c. Oral surgery, including, but not limited to, extractions, general anesthesia, and IV sedation are covered.

d. Root canals are covered.

e. Apexification for apical closures and apicoectomy/periradicular surgery are covered.

f. Surgical periodontal services and postoperative care for gingivectomy/gingivoplasty are covered. If treatment is performed on four or more teeth, service is limited to one every thirty-six (36) months.

g. Therapeutic pulpotomy is covered. If a root canal is performed within forty-five (45) days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure.

h. Partial pulpotomy for apexogenesis is covered on a permanent tooth with incomplete root development. If a root canal is performed within forty-five (45) days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure.

i. Pulpal therapy is covered. Pulpal therapy is covered on primary teeth only and is limited to once per tooth per lifetime.

j. Periodontal scaling and root planing are limited to once per quadrant every twenty-four (24) month period. Periodontal maintenance following active periodontal therapy is limited to twice each Calendar Year.

k. Oral and maxillofacial surgery which is Medically Necessary is covered. This Benefit includes, but is not limited to, extractions, alveoplasty, and incision and drainage of an abscess.

4. **Prosthodontic Services.** Benefits include, but are not limited to, the services listed below.

    a. Inlays and onlays are covered. Stainless steel, porcelain, and metal/porcelain crowns are covered. Crowns are limited to one per tooth every five (5) years.

    b. Fixed bridgework is covered. Resin-based partial dentures are covered. Complete upper and lower dentures are also covered. A service is not covered if it includes the replacement of one or more natural teeth missing prior to the Effective Date. Replacements of bridges and dentures are eligible once every five (5) years.

    c. Rebasing and relining of partial or complete dentures is limited to once in a thirty-six (36) month period. Rebasing and relining is not covered if they are performed within the first six (6) months of the placement.

5. **Orthodontic Services.** Orthodontia that is determined to be Medically Necessary is covered. An eligible Insured must be enrolled in the Plan for twenty-four (24) months before Benefits are available. Services to alter the vertical dimension or to restore or maintain the occlusion are not covered. This includes, but is not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth, are not covered.

P. **GENERAL COVERED SERVICES AND SUPPLIES:** Except as otherwise limited by this Policy, the following services and supplies are covered as set forth in the Schedule of Benefits.

1. The professional and the surgical services of a Physician are covered.

2. Urgent care visits to treat an Injury or Illness are covered. This Benefit includes Provider services, facility costs and supplies.

3. Oxygen and the equipment for its administration are covered.

4. Blood transfusions, including the cost of blood, blood plasma, blood plasma expanders and packed cells are covered. Storage charges for blood are eligible when an Insured has blood drawn and stored for the Insured's own use for planned surgery.

5. Radiation therapy, chemotherapy, and renal dialysis/hemodialysis are covered. Radiation therapy means the use of x-ray, radium or radioactive isotopes that are ordered by the attending Physician and that are performed by a covered Provider for the treatment of disease. Chemotherapy means the use of drugs that are approved for use in humans by the U.S. Food and Drug Administration and that are ordered by the Physician for the treatment of disease.

6. Home infusion therapy is covered. Home infusion therapy means the preparation, administration or furnished of parenteral medications, or parenteral or enteral nutritional services to an Insured by a home infusion therapy agency. Eligible services include (i) education for the Insured, the Insured's caregiver, or a family member; (ii) pharmacy;

(iii) supplies; (iv) equipment; and (v) skilled nursing services when billed by a home infusion therapy agency.

7. Diagnostic colonoscopies are covered. Screening colonoscopies are covered under the preventive and wellness services section of the Plan.

8. The services of a licensed chiropractor are covered.

9. Home Health Care is covered for a period not to exceed one-hundred eighty (180) Visits in any one Calendar Year. Home Health Care must be provided by a licensed home health agency. Home Health Care must also be provided in the Insured's place of residence and must be prescribed by the Insured's attending Physician. Services provided for Home Health Care include the following.

   (a) Nursing.

   (b) Home health aide services.

   (c) Physical, Occupational and Speech therapy.

   (d) Hospice service.

   (e) Medical supplies and equipment suitable for use in the home.

   (f) Services for personal hygiene, grooming, and dietary assistance that are Medically Necessary.

   (g) Medical social worker.

9. Ambulance is covered if the services are reasonably necessary for an Accident or Illness. The services must be provided to the nearest Hospital providing the level of care needed.

10. The first lens for each eye that is purchased in conjunction with cataract surgery is covered.

11. The initial repair or the replacement of sound natural teeth that is performed by a Physician, dentist, oral surgeon or any other Provider if the services are Medically Necessary by reason of damage to or loss due to an Accident (other than from biting or chewing), or for osteotomies, tumors or cysts. Eligible expenses do not include orthodontics, dentofacial orthopedics or related appliances.

12. Circumcisions are covered.

13. Vasectomies are covered.

14. Acupuncture is covered.

15. Surgical treatment of Temporomandibular Joint Syndrome ("TMJ") is covered. Treatment must be Medically Necessary and must be in accordance with accepted medical practice as determined by the Company. The treatment plan must be specifically

authorized in writing by the Company prior to surgery. Treatment that is not surgical is not covered for malocclusion of the jaw, including services for TMJ, anterior and internal dislocations, derangements and myofascial pain syndrome.

16. The treatment of inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism and for which medically standard methods of diagnosis, treatment, and monitoring exist is covered. Expenses are covered to diagnose, to monitor, and to control the disorders by nutritional and medical assessment. Treatment consists of the services listed below.

    (a) Clinical services.
    (b) Biochemical analysis.
    (c) Medical supplies.
    (d) Prescription Drugs.
    (e) Corrective lenses for conditions that are related to the inborn error of metabolism
    (f) Nutritional management.
    (g) Medical foods that are administered enterally.

17. The Plan covers Inpatient care in a Hospital for a period of time that is determined to be Medically Necessary after a mastectomy, a lumpectomy, or a lymph node dissection. This time period is determined by the attending Physician in consultation with the patient.

18. The Plan covers (a) all stages of reconstruction of the breast on which a mastectomy has been performed; (b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (c) prostheses and physical complications of a mastectomy, including lymphedemas. Treatment must be determined in consultation with the attending Physician and the patient.

    For the purpose of this section, (a) "mastectomy" means the surgical removal of all or part of a breast; and (b) "reconstructive breast surgery" means surgery that is performed as a result of a mastectomy to reestablish symmetry between the breasts. The term includes but is not limited to, augmentation mammoplasty, reduction mammoplasty, and mastopexy.

    Benefits for reconstructive breast surgery include, but are not limited to, two prosthetic devices incident to a covered mastectomy and mastectomy bras. Physical complications of a mastectomy, such as lymphedemas are also covered. Benefits include outpatient chemotherapy that follows surgical procedures that are in connection with the treatment of breast cancer.

19. Drugs and medicines that require a Prescription Order and that are prescribed for the condition(s) for which they are approved for use by the Food and Drug Administration ("FDA") are covered. Generic, Brand and specialty Prescription Drugs that are Eligible are covered. Generic Prescription Drugs must be used whenever a Generic equivalent is available. If a Brand name drug is purchased instead of a Generic equivalent, the Insured is responsible for the price difference. This Benefit includes medication that is prescribed as part of a clinical trial, which is not the subject of the trial. This Benefit also includes specialty and biotech medications that are considered to be self-injectable (such as, but not limited to, Avonex, Betaseron, Enbrel, Fuzeon, Imitrex, Humira, Intron,

and Rebif), even if they are administered by a Provider. In accordance with the Policy provisions for determining medical necessity, some Prescription drugs are subject to maximum dispensing limitations at either a retail pharmacy or through the mail order program. These limits are based on prescribing guidelines that are clinically approved and are regularly reviewed to ensure medical necessity and appropriateness or care. Prescription Drugs that exceed the dosage that is recommended by the manufacturer or the dosage that is established by the FDA are not covered. The Company is entitled to any and all available rebates that are paid by Prescription Drug manufacturers.

Drugs and medicines that require a Prescription Order that have not been approved for use by the FDA for the specific condition for which they are being prescribed, but have been approved for use by the FDA for another condition, are eligible for Benefits if it is determined that they have been recognized as medically appropriate and effective for the treatment of the specific condition for which they are being prescribed in one or more of these medical reference publications: the American Medical Association Drug Evaluations; the American Hospital Formulary Services Drug Information; and Drug Information for the Health Care Provider.

Medical literature that has been reviewed by peers may also establish medical appropriateness. Medical literature must meet the following requirements to be acceptable.

At least two articles from major peer-reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which the drug has been prescribed.

No article from a major peer-reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which the drug has been prescribed.
The literature meets the uniform requirements for manuscripts subjected to biomedical journals established by the international committee of medical journal editors or is published in a journal specified by the United States Department of Health and Human Services as acceptable medical peer-reviewed medical literature.

20. Expenses for sleep studies and expenses for the treatment of sleep apnea are covered. This Benefit is payable as set forth in the Schedule of Benefits. Treatment to diagnose or to correct snoring is not covered.

21. The Usual and Customary amount for Implantable Hardware, as defined in the Policy, shall be limited to the invoice cost plus 50%. This maximum allowable amount applies to services that are rendered at PPO and non-PPO facilities. An invoice showing the actual cost of the Implantable Hardware must be submitted to the Company.

22. Expenses for epidural injections that are for back pain are limited to three (3) per month and no more than six (6) per Calendar Year.

23. Services to diagnose infertility are covered. Services are also covered if they are related to artificial insemination or are for medical care that is needed to correct an underlying cause of infertility.

24. Benefits to diagnose, to monitor, to treat, and to control diabetes are as follows.

    (a) Insulin.
    (b) Syringes.
    (c) Injection aids.
    (d) Devices for self-monitoring of glucose levels (including those for the visually impaired).
    (e) Test strips.
    (f) Visual reading and urine test strips.
    (g) One insulin pump* for each warranty period, including accessories to insulin pumps.
    (h) One prescriptive oral agent for controlling blood sugar levels for each class of drug approved by the United States Food and Drug Administration.
    (i) Glucagon emergency kits.

    *Eligible Benefits for insulin pumps are limited to one insulin pump per warranty period. Benefits will be based on the most appropriate and Medically Necessary pump that is available. Although not required, it is recommended that the Insured obtain Pre-certification from the Company prior to purchasing a pump in order to determine the Eligible Benefits before charges are incurred.

    Outpatient self-management training and education for the treatment of diabetes is also covered. Expenses are only eligible if they are Medically Necessary and are prescribed. Any education must be provided by a licensed health care professional with expertise in diabetes.

25. Educational services, other than those for diabetic education (which is covered as set forth elsewhere in the Plan) are covered. These services are covered if they are related to a medical condition. Benefits are limited to five (5) visits per Calendar Year.

26. Emergency room services, supplies and treatment are covered. Emergency care that is rendered by a non-Preferred Provider will be reimbursed as though the Insured had been treated by a Preferred Provider if the Insured could not reasonably reach a Preferred Provider. Emergency care is that as defined in the Policy.

27. Urgent Care and Emergency care is covered when traveling outside of the United States.

28. Prescription vitamins (including prenatal and pediatric vitamins), in single or in combination form are covered. Prescription calcium supplements and prescription hematinics are also covered. Coverage is available for injectable and non-injectable forms.

29. Services that are related to Phase I, II, III or IV of a clinical trial that is approved for the prevention, the detection or the treatment of cancer or other life-threatening condition or disease are covered. Services are only covered if they are otherwise eligible for Benefits under this Plan. Related services do not include: (1) the investigational item, device or service itself; (2) items and services that are provided solely to satisfy data collection and

analysis needs and that are not used in the direct clinical management of the Insured; and (3) a service that is clearly inconsistent with the standards of care for a particular diagnosis that are widely accepted and established.

30. Health care services that are provided by a health care provider or by a health care facility by means of telemedicine are covered. Benefits will only be available if the health care service would have been covered if it was rendered through an in-person consultation between the Insured and a health care provider. Telemedicine means the use of interactive audio, video or other telecommunications technology that is: (i) used by a health care provider or a health care facility to deliver health care services at a site other than where the patient is located; and (ii) delivered over a secure connection that complies with the Health Insurance Portability and Accountability Act of 1996. Telemedicine includes the use of electronic media for consultation relating to the health care diagnosis or treatment of a patient in real time or through the use of store-and-forward technology. Store-and-forward technology means electronic information, imaging and communication that is transferred, recorded, or otherwise stored in order to be reviewed at a later date by a health care provider or a health care facility at a distant site without the patient present in real time. Telemedicine does not include the use of audio-only telephone, e-mail or facsimile transmissions.

31. The following medical supplies for use outside of a Hospital are covered when they are Medically Necessary and when they are prescribed by a Provider: (i) sterile dressings for conditions such as cancer or burns; (ii) catheters; (iii) splints; (iv) colostomy bags and related supplies; and (v) supplies for renal dialysis equipment or machines.

V. GENERAL LIMITATIONS AND EXCLUSIONS APPLICABLE TO ALL BENEFITS: There are no Benefits available under this Policy for the items that are listed below.

1. Expenses for care or services that are provided before the Insured's Effective Date are not covered. Expenses for care or services that are provided after the termination of the Insured's coverage are not covered.

2. Expenses that are covered by any workers' compensation law; an Employers' liability law (or legislation of similar purpose); an occupational disease law; or for an Injury arising out of, or in the course of, employment for compensation, wages, or profit. This exclusion does not apply to an Owner who has elected the optional 24-hour coverage and has paid the applicable premium.

3. Expenses that are covered by programs that are created by the laws of the United States, any state, or any political subdivision of a state. Examples include, but are not limited to, services that are received from TRICARE or the Veteran's Administration (VA).

4. Expenses for any loss to which the contributing cause was the Insured's commission of, or attempt to commit, a felony are not covered. Expenses for any loss to which a contributing cause was the Insured's being engaged in an illegal occupation are not covered.

5. Care or treatment of an Accident, an Illness, or an Injury that is caused by, or arises out of the following is not covered: riot; war; an act of war while in the military, naval, or air

services of any country at war; declared or undeclared war; or acts of aggression committed by a person who is entitled to Benefits.

6. Examinations, reports, or appearances that are in connection with legal proceedings are not covered. This exclusion also applies to services, supplies, or accommodations that are provided pursuant to a court order, whether or not an Illness or an Injury is involved.

7. Treatments or procedures that are Experimental or Investigational are not covered. This exclusion also applies to any related services, supplies, or accommodations for these treatments or procedures.

8. Expenses in connection with transplants (except as specifically set forth in the Policy) are not covered. This exclusion applies whether the Insured is the donor or the recipient.

9. Expenses for care, treatment, or operations which are performed primarily for Cosmetic purposes are not covered. Complications of such procedures, are not covered. This exclusion does not apply when expenses are incurred as a result of an Injury or to treat a congenital anomaly. This exclusion also does not apply when expenses are incurred for reconstructive surgery after a mastectomy.

10. Expenses for treatment of obesity or for weight reduction are not covered. This exclusion includes, but is not limited to: bariatric surgery; stomach stapling; gastric bypass; balloon implant; similar surgical procedure; and Prescription Drugs that are for the purpose of weight loss or weight control. This exclusion does not include obesity screenings and counseling for adults and for children age six (6) and older as allowed under preventive and wellness services, which are covered as stated elsewhere in the Plan.

11. Expenses in connection with reversal of a gastric or intestinal bypass, balloon implant, gastric stapling, or other similar surgical procedure are not covered.

12. Expenses in connection with genetic studies, genetic testing, or genetic counseling are not covered.

13. Expenses for the care or treatment of mental conditions that are not classified as Mental Illness as defined in the Policy are not covered. This exclusion does not apply to services to diagnose a Mental Illness. The diagnosis of Mental Illness must be made pursuant to a personal examination of the patient by a Provider who is licensed to make such diagnosis.

14. Expenses made which are in excess of Usual and Customary allowances are not covered.

15. The care or treatment of marital or family problems; behavior disorder; chronic situational reactions; or social, occupational, religious or other social maladjustment. This exclusion includes drugs for the same.

16. Expenses that are for milieu therapy; modification of behavior; biofeedback; or sensitivity training are not covered.

17. The care or treatment of psychosexual dysfunction is not covered. This exclusion does not operate to deny Mental Illness care that is related to such condition. Such care is covered elsewhere in the Policy.

18. Expenses for the care or treatment of a learning disability; mental retardation; chronic organic brain syndrome; personality disorder; or for the treatment or care of psychiatric or psychosocial conditions for which reasonable improvement cannot be expected are not covered. This exclusion does not apply to services that are required to diagnose any of the above.

19. Expenses for the alleviation of chronic, intractable pain by a pain control center or under a pain control program are not covered. This exclusion applies if those expenses exceed the Usual and Customary expenses for Semi-private room accommodations.

20. Expenses for erectile dysfunction, including, but not limited to, penile prosthesis; penile implant; any device that restores sexual function (such as a pump); and Prescription Drugs for or related to sexual dysfunction are not covered.

21. Expenses for reversal of surgically performed sterilization are not covered.

22. Expenses for rest cures are not covered.

23. Expenses in connection with institutional care, which are, as determined by the Company, for the primary purpose of controlling or changing the environment of the Insured are not covered.

24. Expenses for the Custodial Care of a physically or a mentally disabled person where the care does not specifically reduce the Disability so that the person can live outside a medical care facility or nursing home are not covered.

25. Expenses for facility charges at an Ambulatory Service Facility or a Hospital when the facility is not approved by the Joint Commission on Accreditation of Hospitals ("JCAH") are not covered.

26. Expenses for an Illness or an Injury that is the result of the Insured voluntarily taking action that leads to the Illness or Injury by using or abusing any illegal drug; for Injuries that are the result of the Insured voluntarily taking action that leads to the Injury by operating a motor vehicle while exceeding the legal limit of intoxication; and for Injuries that are the result of the Insured voluntarily taking action that leads to the Injury by abusing Prescription Drugs that are not taken in accordance with a Physician's Prescription Order are not covered.

27. Expenses for which the Insured or his guardian is not legally obligated to pay are not covered.

28. Expenses are not covered for any services or products unless the services or products are both of the following.

    (a) They are Medically Necessary.

    (b) They are prescribed by a Physician or a Practitioner who is acting within the scope of their license.

29. Expenses for training, for educating, or for counseling a patient are not covered. This exclusion does not apply when such services are incidentally provided (without a separate expense) in connection with other Covered Services. This exclusion also does not apply when the services are Medically Necessary and they are specifically prescribed by a Physician. This exclusion also does not apply to eligible educational and to counseling services that are covered under the preventive and wellness section of the Policy.

30. Expenses for a private school; a public school; or a halfway house are not covered.

31. Expenses for transportation are not covered. This exclusion does not apply to Ambulance services that are Medically Necessary. This exclusion includes, but is not limited to, any of the events that are listed below.

    (a) Ambulance services when the Insured could be safely transported by means other than by Ambulance.

    (b) Air ambulance services when the Insured could be safely transported by ground Ambulance or by means other than by Ambulance.

    (c) Ambulance services that do not go to the nearest facility that is expected to have the appropriate services for the treatment of the Injury or Illness involved.

32. Expenses that are incurred for diagnostic purposes that are not related to an Injury or Illness unless they are otherwise provided for by the terms of the Plan or in the Schedule of Benefits.

33. Expenses for: (i) Routine Physical Examinations for Insureds which exceed the guidelines set forth in this Policy or the Schedule of Benefits; (ii) x-ray or laboratory procedures when there are no symptoms of an Illness or an Injury, unless they are covered as part of the Routine Physical Examination Benefit; or (iii) mental examinations or psychological tests when there are no symptoms of Mental Illness. This exclusion does not apply to expenses that are specifically set forth in the Schedule of Benefits or to mandated benefits.

34. Expenses for appointments that are scheduled and that are not kept are not covered.

35. Expenses for telephone consultations are not covered unless they are provided in accordance with the provisions for telemedicine as covered elsewhere in the Policy. This exclusion applies whether the expenses are initiated by the Insured or the Provider.

36. Expenses for the care and treatment of: teeth; gums; alveolar process; intraoral alveolar abscess; dentures; dental appliances; or supplies that are used in such care and treatment, are not covered except as specifically provided for by the terms of the Plan. Such expenses may be considered for Benefits under the dental Policy if dental coverage has been selected and premiums have been paid. This exclusion does not apply to care that is eligible pursuant to the pediatric dental services provisions set forth elsewhere in this Plan.

37. Expenses in connection with the nonsurgical treatment of Temporomandibular Joint Syndrome ("TMJ"); upper or lower jaw augmentation; reduction procedures (orthognathic surgery); or appliances or restorations that are necessary to increase vertical dimensions or restore occlusion are not covered. This exclusion includes, but is not limited to, injection of

the joints; prosthodontic treatment; full mouth rehabilitation; orthodontic treatment; bone resection; restorative treatment; splints; physical therapy; and bite guards are not covered.

38. Expenses for charges that are incurred with respect to the eye for diagnostic procedures are not covered. This exclusion includes, but is not limited to: eye refraction; the fitting of eye glasses or contact lenses; and orthoptic evaluation or training. Such expenses may be considered for Benefits under the vision Policy if that coverage has been selected and premiums have been paid. This exclusion does not apply to lens implants (either donor or artificial) for cataracts. This exclusion also does not apply when services are required as part of an examination to diagnose an Illness or an Injury (other than refractive errors of vision). This exclusion also does not apply to the extent such care is eligible pursuant to the pediatric vision services provisions set forth elsewhere in this Plan.

39. Expenses for surgery on the eye to improve refraction and treatment for refractive error of vision are not covered. This exclusion includes, but is not limited to, radial keratotomy; orthokeratology; corneal carving; corneal slicing; and LASIK.

40. Expenses for hearing examinations; hearing aids, or the fitting of hearing aids; or any devices that are used to aid or enable hearing are not covered. This exclusion does not apply when such services are required as part of an examination to diagnose an Illness or an Injury. This exclusion does not apply to cochlear implants that are Medically Necessary.

41. Expenses are not covered for the following.

    (a) Treatment of flat feet; fallen arches; weak or strained feet; instability; or imbalance of the foot; (this exclusion **does not apply** to Medically Necessary surgery that is performed to correct these conditions).

    (b) The casting for and the fitting of supportive devices (including orthotics).

    (c) Routine treatment of toenails, including the cutting or the removal by any method (other than the removal of the nail matrix or root), corns, or calluses. Removal of the nail matrix or root is covered when it is prescribed by a Physician for a metabolic or a peripheral vascular disease.

42. Expenses for corrective shoes (unless they are an integral part of a lower body brace) or for special shoe accessories.

43. Expenses for services that are provided by an immediate relative of the Insured. Expenses for services that are provided by an individual who customarily lives in the same household with the Insured.

44. Expenses for acupressure, homeopathy, hypnotherapy, rolfing, and holistic medicine are not covered.

45. Expenses for radioallergosorbent (“RAST”) testing are not covered.

46. Expenses for preventative medication (except as set forth elsewhere in the Plan), vitamins without a prescription, mineral and nutrient supplements, fluoride supplements, food supplements, and sports therapy equipment are not covered.

47. Expenses for anabolic steroids; weight-reduction drugs; growth hormones; and hematinics without a prescription are not covered.

48. Expenses for services, supplies, and treatment that are for hair loss. This exclusion includes, but is not limited to, the use of minoxidil and Rogaine.

49. Expenses for experimental drugs; non-legend drugs; anti-wrinkle agents; and Tretinoin, all dosage forms (for example, Retin A) for Insureds who are over twenty-five (25) years of age are not covered.

50. Expenses for autopsy procedures are not covered.

51. Expenses for treatment or services that are rendered in connection with invitro fertilization; for all procedures to preserve sperm and ova; for Prescription Drugs to induce fertility; for gamete intrafallopian transfer ("GIFT"); and for any other procedures that are designed to help or treat infertility, are not covered unless stated elsewhere under the Policy. This exclusion does not apply to artificial insemination.

52. Expenses for the care of elective surgery; for complications of elective surgery; or for complications of an ineligible procedure are not covered.

53. Expenses for massage therapy are not covered.

54. All shipping, handling, delivery, sales tax, or postage charges, except as incidentally provided, are not covered.

55. Expenses for an elective abortion are not covered. This exclusion includes any medications and Prescription Drugs that are for the purpose of causing an abortion. An "elective abortion" means an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed.

56. Expenses that are incurred as the result of the Insured committing a fraudulent insurance act are not covered.

57. Drugs and medicines that are available over-the-counter, or that do not require a Prescription Drug Order are not covered.

VI. COBRA, USERRA AND COVERAGE DURING DISABILITY:

A. The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"):

Federal law provides that the Employee and/or his Dependents may be entitled to continue the insurance after the termination of the group health benefits if there is a qualifying event. The maximum period of coverage is up to thirty-six (36) months. This provision only applies if the Employer employs more than 20 Employees on an average business day during the previous Calendar Year. Some states also require employers with fewer than 20 employees

to offer to the Insureds continuation of their group health coverage. Your Employer can provide you with the complete details of the available coverage. The Company does not assume the responsibility for the Employer's duties under COBRA.

COBRA coverage is available if any of the following qualifying events occurs.

1. A termination of employment.
2. A reduction of hours.
3. The death of employee.
4. The Employee becomes entitled to Medicare benefits.
5. A divorce or legal separation.
6. The Dependent child ceases to be a dependent under the Plan.

In the case of a divorce, a legal separation, or a Dependent ceasing to be a Dependent, it is the responsibility of the Employee to notify the Employer in writing within 60 days of the qualifying event. The Employee must send a copy of the notice to the Company. Election of the continuation coverage must be in writing and must be done within 60 days after the Employer sends notice of the right to elect the continuation coverage. If the election is not made within this 60 day period, the Employee and/or any qualified Dependents will lose the right to COBRA continuation coverage.

When COBRA coverage is available, any person who was on the insurance before the termination has the right to select COBRA coverage independently. A newborn Child or a Child that is placed for adoption during a period of COBRA continuation coverage is also eligible for coverage for the remaining period of continuation coverage. This only applies if a newborn Child or a Child that is place for adoption is enrolled according to the terms of the Policy. The continuation of coverage provided by the vision and the dental plans is optional when the the medical coverage is chosen.

Coverage may be continued for up to 36 months for the Spouse and/or the Dependent Child(ren) if the group health coverage is lost due to the Employee's death, a divorce, a legal separation, the Employee becoming entitled to Medicare, or loss of status as a Dependent Child under the Plan.

Coverage may be continued for up to 18 months if the group health coverage terminates due to the Employee's termination of employment or a reduction in hours. There are three exceptions as described below.

1. The continuation period for all qualified beneficiaries may become 29 months from the date of the termination of employment or a reduction in hours. This continuation period only applies if an Employee or Dependent is disabled (as determined by the Social Security Administration) at any time during the first 60 days after one of those qualifying events. For the 29-month continuation period to apply, written notice of the disability determination must be provided to the Employer. This written notice must be provided within both the 18-month coverage period and within 60 days after the date of the determination.

2. The continuation period for a Spouse and/or Dependent Child(ren) may become 36 months from the date of the initial termination of employment or reduction in hours. This continuation period only applies if a second qualifying event that gives rise to a 36-

month period for the Spouse and/or Dependent Child(ren) (for example, the Employee dies or becomes divorced) occurs within the 18-month or 29-month continuation coverage period. For the 36-month continuation period to apply, written notice of the second qualifying event must be provided to the Employer. This notice must be provided within 60 days after the date of the event.

3. If the qualifying event occurs within 18 months after the Employee becomes entitled to Medicare, then the maximum coverage period for the Spouse and/or Dependent Child(ren) is 36 months from the date that the Employee became entitled to Medicare.

Premium payments for COBRA continuation coverage for the Employee and for any of the qualified Dependents for the "initial premium months" are due by the 45th day after electing the continuation coverage. The "initial premium months" are the months that end on or before the 45th day after the election of the continuation coverage. All subsequent premiums are due on the first day of the month and are subject to a 31-day grace period.

COBRA coverage will automatically terminate when any of the following events listed below occurs.

1. The employer no longer provides group health coverage for any employees.
2. The premium for the COBRA coverage is not paid during the required time period.
3. The insured becomes entitled to Medicare.
4. The insured becomes covered under another group health plan with no preexisting condition limitation.
5. The maximum COBRA coverage period expires.

B. **The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"):** Federal law provides that the Employee and his dependents are entitled to continue health insurance coverage for a period of up to twenty-four (24) months if the Employee is absent from employment due to service in the uniformed services. Election of the continuation coverage must be made in writing within sixty (60) days of the date that commences with any leave for military service.

Continuation coverage will automatically terminate if the Employee fails to pay the required premium. Coverage will also automatically terminate if the Employee loses his rights under USERRA as a result of undesirable conduct. Undesirable conduct includes being court martialed and being dishonorably discharged.

The Insured Employee and his Dependents will be entitled to the protections of both COBRA and USERRA when coverage is lost under the group health Plan because the Employee leaves work to perform military service, and the group health Plan is subject to COBRA. When the requirements of COBRA and USERRA differ, the Employee and his/her Dependents are entitled to protection under the law that gives the greater benefit.

The term "uniformed services" means the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

C. **Coverage During Periods of Disability:**

The Company must be notified in writing within thirty (30) days of the date of the Disability for this provision to apply.

In the event that the group Policy terminates for any reason while Benefits are being paid and it is established that the Insured was totally Disabled when such insurance terminated, Benefits for expenses that are incurred in connection with the Injury or the Illness that caused the Disability will be continued. Benefits will continue during such Total Disability until the earliest of the events listed below.

(a) Twelve (12) months from the date on which the insurance terminated.
(b) The Employee or the Dependent(s) ceases to be totally Disabled.
(c) The Disabled person becomes Insured or covered under any other group medical benefit or service plan or self-funded plan.

VII. COORDINATION OF BENEFITS, THIRD PARTY LIABILITY AND PERSONS COVERED BY MEDICARE:

A. **COORDINATION OF BENEFITS:**

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one plan.

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan pa**ys** is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

DEFINITIONS

A. A plan is any of the following that provides benefits or services for medical care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan. There is no COB among those separate contracts.

Plan includes any of the following.

(a) Group and nongroup health insurance contracts.
(b) Health maintenance organization (HMO) contracts.
(c) Closed panel plans or other forms of group or group type coverage (whether they are insured or uninsured).
(d) Medical care components of long-term care contracts, such as skilled nursing care.
(e) Medicare or any other federal governmental plan, as permitted by law.

Plan does not include any of the following.

(a) Coverage for hospital or other fixed indemnity coverage.
(b) Coverage for accidents only.
(c) Coverage for specified disease or accident coverage.
(d) Limited benefit health coverage, if it is determined by the commissioner to be "excepted benefits" as defined in Montana law.
(e) School accident type coverage.
(f) Benefits for non-medical components of long-term care policies.
(g) Medicare supplement policies.
(h) Medicaid policies.
(i) Coverage under other federal governmental plans, unless it is permitted by law.

Each contract for coverage under (1) or (2) is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

B. This Plan means, in a COB provision, the part of the contract that provides the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract that provides health care benefits is separate from this Plan. A contract may apply one COB provision to certain benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether this Plan is a primary plan or secondary plan when the person has health care coverage under more than one plan.

When this Plan is primary, it determines payment for its benefits first before those of any other plan without considering the benefits of any other plan. When this Plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits do not exceed 100% of the total Allowable expense.

D. Allowable expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any plan that covers the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan that covers the person is not an allowable expense. Any expense that a provider is prohibited from charging a covered person, by law or in accordance with a contractual agreement, is not an allowable expense.

The following are examples of expenses that are not allowable expenses.

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense. This does not apply if one of the plans provides coverage for a private hospital room.

(2) If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or a relative value schedule reimbursement methodology or other similar methodology, any amount that is in excess of the highest reimbursement amount is not an allowable expense.

(3) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount that is in excess of the highest of the negotiated fees is not an allowable expense.

(4) If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans.

(5) If the provider has contracted with the secondary plan to provide the service for a specific negotiated fee or a payment amount that is different than the primary plan's payment arrangement, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits. This applies if it is permitted by the contract of the provider.

(6) The amount of any benefit reduction that is made by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. A closed panel plan is a plan that provides health care benefits to covered persons primarily in the form of services that are rendered through a panel of providers that have contracted with or are employed by the plan. This type of plan excludes coverage for services that are rendered by other providers, except in cases of emergency or a referral by a panel member.

F. The custodial parent is the parent awarded who is awarded custody by a court decree. In the absence of a court decree, the custodial parent is the parent with whom the Child resides for more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows.

A. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other plan.

B. (1) Except as provided in paragraph (2), a plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary. This does not apply if the provisions of both plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by the certificateholder is a secondary plan. An example of this type of situation is coverage for major medical services that is superimposed over a base plan with hospital and surgical benefits. Another example is insurance-type coverage that is written in connection with a closed panel plan to provide out-of-network benefits.

C. A Plan may consider the benefits that are paid or that are provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.

D. Each plan determines its order of benefits using the first of the following rules that apply.

(1) Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, a member, a policyholder, a subscriber or a retiree is the primary plan. The plan that covers that person as a dependent is the secondary plan. If the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan that covers the person as a dependent, and is primary to the Plan that covers the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two plans is reversed. This means that the plan that covers the person as an employee, a member, a policyholder, a subscriber or a retiree is the secondary plan and the other plan is the primary plan.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan the order of benefits is determined as follows.

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married, the following applies.

• The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

• If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

(b) For a dependent child whose parents are divorced, are separated or not living together, whether or not they have ever been married, the following applies.

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This rule shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

(ii) If a court decree states that both of the parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of (a) above shall determine the order of benefits.

(iii) If a court decree states that the parents have joint custody but does not specify that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of (a) above shall determine the order of benefits.

(iv) If there is not a court decree that allocates responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows.

• The plan that covers the **Custodial parent**.

• The plan that covers the spouse of the **Custodial parent**.

• The plan that covers the **non-custodial parent**.

• The plan that covers the spouse of the **non-custodial parent**.

(c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan that covers that same person as a retired or laid off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid off employee. If the other plan does not have this rule, and as a result, the plan**s** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by a state or other federal law is covered under another plan, the plan covering the person as an employee, a member, a subscriber or a retiree, or covering the person as a dependent of an employee, a member, a subscriber or a retiree is the primary plan. The COBRA or the state or other federal continuation coverage is the secondary plan. 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. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The plan that covered the person as an employee, a member, a policyholder, a subscriber or a retiree longer is the primary plan. The plan that covered the person the shorter period of time is the secondary plan.

(6) If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans that meet the definition of plan. This Plan will not pay more than it would have paid had it been the primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the

benefits it would have paid in the absence of other health care coverage and apply that amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. The secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine the benefits that are payable under this Plan and other plans. The Company may get the facts it needs from, or give them to, other organizations or persons. The Company does not need to tell, or get the consent of, any person to do this. Each person that claims benefits under this Plan must give the Company any facts it needs to apply those rules and determine the benefits that are payable.

FACILITY OF PAYMENT

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the Company may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services. In this case, "payment made" means the reasonable cash value of the benefits that are provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by the Company is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services that are provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits that are provided in the form of services.

B. **THIRD PARTY LIABILITY:** In the event that the Insured sustains any Illness or Injury for which a third party may be responsible, the following provisions shall apply.

1. To the extent that is necessary for reimbursement of Benefits that are paid to or on behalf of the Insured, the Company is entitled to subrogation against a judgment or recovery received by the Insured from a third party who is found liable for a wrongful act or omission that caused the Injury necessitating the Insured’s payments. This recovery shall be up to the amount of Benefits that are paid for the Illness or the Injury.

2. If the Insured intends to institute an action for damages against a third party, he shall give the Company reasonable notice of his intention to institute the action.

3. The Company shall pay a proportionate share of the reasonable expenses of the third party action. This payment shall include attorney's fees.

4. The right of subrogation of the Company shall not be enforced until the Insured has been fully compensated for his Injuries.

C. **PERSONS COVERED BY MEDICARE:**

1. This Plan will pay its Benefits before Medicare pays in the following situations.

   (a) An active Employee who is age sixty-five (65) or older, and who is with a group of twenty (20) or more Employees, as that term is defined in the Medicare secondary payer rules.

   (b) A Dependent spouse who is age sixty-five (65) or older, of an active Employee who is employed with a group of twenty (20) or more Employees, as that term is defined in the Medicare secondary payer rules.

   (c) The first thirty (30) months during which Medicare is the secondary payer to a group health plan and the Insured is receiving treatment for end-stage renal disease (ESRD).

2. If the Dependent spouse is also actively employed and is enrolled under a group health plan provided by the spouse's Employer, this Plan shall then be secondary to that coverage and Medicare becomes the third payer.

3. This Plan will pay its Benefits only after Medicare has paid its Benefits in the following situations.

   (a) For all other Insured persons.

   (b) After the first thirty (30) month time period during which Medicare was the secondary payer to a group health plan and the Insured received treatment for end-stage renal disease (ESRD).

VIII. GENERAL POLICY INFORMATION

A. **COMPUTATION OF EMPLOYER PREMIUMS:** The initial premium that is due and each subsequent premium that is due shall be the sum of both of the following calculations.

1. The number of Insured Employees that are in each classification multiplied by the applicable rate for each person.

2. The number of Insured Dependents, if any, that are in each classification multiplied by the additional rate that applies for each person. The rates that apply are available from the Company upon request.

The Company reserves the right to change the rate for any insurance that is provided under this Plan on either of the following dates.

1. On any premium due date if the rate for such insurance has been in effect for at least twelve (12) months. Premium rates can be increased more frequently if the failure to do so would violate the laws of the state of Montana. They can also be increased more frequently if the failure to do so would cause the financial impairment of the insurer to the extent that further transaction of insurance by the insurer would injure or be hazardous to its Policyholders or to the public.

2. On any date that the provisions of this Plan are changed as to the Benefits provided or the classes of persons that are Insured.

The Company shall give written notice at least sixty (60) days in advance to the Policyholder of a change in rates.

Premiums may also be computed by any method that is mutually agreeable to the Company and the Policyholder. Any alternative method must produce about the same total amount as the above methods.

B. **PAYMENT OF PREMIUMS:** All premiums that are due under this Plan, and any adjustments, are payable by the Policyholder on or before their respective due dates. Premiums are payable at the home office of the Company. The payment of any premium shall not maintain the insurance under this Plan in force beyond the day that immediately precedes the next due date, except as otherwise provided herein.

C. **GRACE PERIOD:** A grace period of thirty-one (31) days will be allowed for the payment of any premium due. The grace period doesn't apply if the Policyholder gives a written notice of discontinuance prior to the premium due date.

D. **TERMINATION OF POLICY:** This Plan is guaranteed renewable if the participation requirements of the Plan are maintained. The Company will provide notice of cancellation for non-payment of premium to the Policyholder at least fifteen (15) days in advance. The notice will specify the date of cancellation. If the Policyholder fails to pay any premium within the grace period, this Plan shall automatically terminate on the last day of such grace period. The Policyholder shall be liable to the Company for the payment of all premiums that are then due and unpaid, including a pro rata premium for the grace period. If the Policyholder gives written notice to the Company that this Plan is to be terminated before the end of the grace period, this Plan shall be terminated on the later of the date of receipt of such notice, or the date specified by the Policyholder. The Policyholder shall be liable to the Company for the payment of all premiums that are then due and are unpaid. That amount shall include a pro rata premium for the period that commences with the last premium due date that ends with such date of termination.

E. **RECORD OF EMPLOYEES INSURED:** The Company shall maintain a record which shall show at all times the names of all Insured Employees and the beneficiary that is designated by each Employee, if any. This record shall also show the date when each Employee became Insured and the Effective Date of any change in coverage. This record

shall also show any other information that may be required to administer the insurance. The Company shall furnish a copy of this record to the Policyholder, upon request. The Policyholder shall give the Company any information that is required to administer the insurance. This information shall include, but is not limited to, information for enrolling Employees, changes in coverage, and termination of insurance. Any records of the Employer and/or the Policyholder that may have a bearing on this insurance shall be open for inspection by the Company at a reasonable time.

F. **EMPLOYEES CERTIFICATE:** The Employer is the Plan Administrator as that term is defined in the Employee Retirement Income Securities Act ("ERISA"), 29 U.S.C. §§ 1001, *et. seq.* The Company will issue Certificates directly to the Insured Employee. The Company may also issue Certificates to the Policyholder to deliver to each Insured Employee. The Certificates shall describe the Policy Benefits and to whom the Benefits will be paid. The Certificates shall also describe any Policy limitations or requirements that affect the Insured Employee. The word "Certificate" as used in this Plan shall include all applicable Schedules of Benefits, and any riders, and supplements. Such Certificates are a summary of the Plan only and shall not constitute a part of, or amendment to, this Plan. If the provisions of this Plan and the Certificates conflict, the terms of this Plan shall govern.

G. **FREE CHOICE OF PROVIDER:** The Employee shall have free choice of any legally qualified Physician or Practitioner, as those terms are defined in the Policy. This Plan will have no affect on the relationship of the patient and the Provider.

H. **EXPERIENCE RATING REFUNDS:** This Plan shares in the surplus earnings of the Company. Surplus earnings is defined as the amount of earnings in excess of earnings that are required to maintain the highest Risk-Based Capital ("RBC") level established by law and the amount that is required to maintain an appropriate level of financial reserve as determined by the board of directors in its sole discretion. Earnings is defined as earned revenue that is in excess of incurred Benefits and expenses using statutory accounting methods that are prescribed or that are permitted by law.

In any Calendar Year in which there are surplus earnings as a result of favorable claims experience, such earnings may be refunded to eligible participating Employers as an experience rating refund. The board of directors will determine in its discretion if it is appropriate and if it is advisable to return the earnings to the Policyholders. The method and the timing of the refund is determined by the board of directors. To be eligible to participate in the refund, a participating Employer must be a Policyholder at the time that the refund is made.

I. **NON-ASSESSABLE PLAN:** This Plan is non-assessable. If for any reason the Company is unable to maintain the required reserves or to pay justified claims for Benefits, Benefits may be reduced in accordance with an equitable plan approved by law.

J. **ANNUAL MEETING:** The annual meeting of the Company shall be held on the first Friday in December. The meeting will be held at the home office of the Company.

K. **ENTIRE CONTRACT:** This Plan and all attachments hereto, including the applications of the Policyholder, and the Insured Employees constitute the entire contract between the parties. All statements that are made by the Policyholder or by the Insured Employees and

Dependents shall, in the absence of fraud, be deemed representations and not warranties. No statement made by an Insured Employee or his/her shall affect the insurance or be used in defense to a claim hereunder unless such statement is formalized in writing and a copy of such statement is furnished to such Employee or to his beneficiary.

L. **AMENDMENT AND ALTERATION OF CONTRACT:** This Plan may be amended at any time, subject to the laws of the state of Montana. The Plan may be amended by a written agreement between the Policyholder and the Company without the consent of the Insured Employees or their beneficiaries. The Plan may also be amended on the renewal date of the Plan upon sixty (60) days written notice from the Company to the Policyholder. If an Insured is confined in a Hospital or in an Extended Care Facility on the effective date of the amendment, Benefits shall not be affected until the date of discharge. No change in the Plan shall be valid until it is approved by a duly authorized officer of the Company and unless such approval be endorsed hereon or attached hereto. No agent has the authority to change any Plan or waive any provision thereof.

M. **NOTICE AND PROOF OF CLAIM:** A written or an electronic claim must be submitted to the Company within three-hundred sixty-five (365) days of the Date Incurred for which Benefits arising out of each Injury or Illness may be claimed. Unless otherwise excused as provided below, failure to timely file such claim shall release the Company from any liability to pay such claim. The notice must have sufficient information to be able to identify the Insured Employee or Insured Dependent. Notice that is given to any authorized agent of the Company shall be deemed to be notice to the Company. Failure to furnish notice within the time provided in the Plan shall not invalidate any claim if it is shown that it was not reasonably possible to furnish such notice and that such notice was furnished as soon as was reasonably possible.

The Company, upon receipt of the notice required by the Plan, will furnish to the claimant such forms as are usually furnished by the Company for filing proof of loss. If such forms are not furnished within fifteen (15) days after the Company receives such notice, the claimant shall be deemed to have complied with the requirements of the Plan of filing proof of loss.

N. **EXAMINATION:** The Company shall have the right and opportunity to have the person of any individual whose Injury or Illness is the basis of a claim examined when and so often as it may reasonably require during pendency of a claim. The Company shall also have the right and opportunity to make an autopsy in the case of death where it is not forbidden by law.

O. **PAYMENT OF CLAIM:** Benefits provided in the Plan will be paid promptly after receipt of due proof. All Benefits are payable to the Employee or his legal assignee. If any such Benefits remain unpaid at the death of the Employee, if the Employee is a minor, or if the Employee is, in the opinion of the Company, legally incapable of giving a valid receipt and discharge for any payment, the Company may, at its option, pay such Benefit to the Employees legal heirs. Any payments made will constitute a complete discharge of the Company's obligations to the extent of such payment. The Company will not be required to see the application of the money so paid.

P. **MEDICAL RECORDS:** The Company shall have the right to request and receive, without cost or expense, medical records relating to the care and the treatment of any Insured who claims Benefits under this Plan, prior to paying any Benefits under this Plan. The Insured does fully authorize, empower, and direct his Provider to furnish the Company with such complete reports and medical records when he requests any Benefits.

Q. **OVERPAYMENTS:** If for any reason the Company pays any amounts to or on behalf of the Insured for (i) services not covered under this Plan; (ii) services which exceed amounts to be paid as Benefits under this Plan; or (iii) services on behalf of a person believed to be a Dependent who is not covered under this Plan, the Company may, at its discretion, recover overpayments from one or more of the persons it has paid or for whom it has paid. The Company may also recover overpayments from future claim payments made to the same provider for services that are rendered to the same Insured if the provider or other person has previously authorized this type of recovery in writing.

The time limits listed below apply for requesting overpayments.

1) The Company has twelve (12) months following payment of a claim to perform any review or audit for reconsidering the validity of a claim and to request reimbursement for payment of an invalid claim or overpayment of a claim.

2) Regardless of the period allowed by the Company for submission of claims for payment, the Company may perform a review or audit to reconsider the validity of a claim. The Company may request reimbursement for an invalid or overpaid claim within twelve (12) months from the date upon which the Company receives notice of a determination, adjustment, or agreement regarding the amount payable with respect to a claim by any of the following.

a) Medicare.
b) A workers' compensation insurer.
c) Another health insurance issuer or group health plan.
d) A liable or potentially liable third party.
e) A foreign health insurer under an agreement among plans operating in different states when the agreement provides for payment by the Montana health insurance issuer as host plan to Montana providers for services provided to an individual under a plan issued outside of the state of Montana.

3) If the Company pays a claim in which the Company 1) suspects the health care provider or the Insured of insurance fraud related to the claim; and 2) has reported the fraud related to the claim to the insurance commissioner, the time limitation on the Company as described in subsection 1 above does not start running until the date that the commissioner determines that insufficient evidence of fraud exists.

4) The time limitation on the Company as described in subsection 1 above does not commence running until the Company has actual knowledge of an invalid claim, claim overpayment, or other incorrect payment. This applies if the Company has paid a claim incorrectly because of an error, misstatement, misrepresentation, omission, or concealment, other than insurance fraud, by the health care provider or other person. Regardless of the date upon which the Company obtains actual knowledge of an invalid claim, claim overpayment, or other incorrect payment, the Company is not permitted to

request reimbursement or to offset another claim payment for reimbursement of the claim more than twenty-four (24) months after payment of the claim.

R. **LEGAL PROCEEDINGS:** No action of law or in equity shall be brought to recover on the Plan prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements of the Plan. No such action shall be brought at all after the expiration of any applicable statutes of limitations within which proof of loss is required by the Plan.

S. **TIME LIMITATION:** If any time limitation of the Plan with respect to giving notice of claim, furnishing proof of loss, or bringing of an action at law or in equity, is less than that permitted by the law of the state in which the Policy is delivered, such limitation shall be extended to agree with the minimum period permitted by such law.

T. **INTERPRETATION:** Whenever the context of this Plan requires, the singular shall include the plural, the plural shall include the singular, the whole shall include any part thereof, and any gender shall include both genders. The captions which precede parts of this Plan are for reference only and shall not affect the manner in which any provision hereof is construed. Words that are capitalized throughout this document shall have the meaning prescribed to them in the Definitions section of this document.

U. **SUPERSEDED PLAN:** If this Plan supersedes a health care Plan that was previously issued by the Company, Benefits that were furnished under the previous Plan shall apply to the maximums of this Plan as though such Benefits had been furnished under this Plan.

V. **CONFORMITY WITH MONTANA STATUTES:** The provisions of this Policy conform to the minimum requirements of Montana law. These provisions take control over any conflicting statutes of any state in which the insured resides on or after the Effective Date of this Policy.

W. **PREFERRED PROVIDER ORGANIZATION ("PPO"):** Eligible services that are obtained from a Preferred Provider will be processed according to the Preferred Provider discounted rate, and will be reimbursed at a higher percentage level. A directory of PPO Providers is available from the Company, free of charge. You may also obtain services from a non-preferred Provider. Eligible Benefits for a non-preferred Provider will be processed according to the usual and customary rate and will be reimbursed at a lower percentage level.

In the event that a Preferred Provider agreement is terminated, the Preferred Provider shall continue the treatment of an Insured who was receiving care in an Inpatient facility at the time the agreement was terminated until one of the following events occurs: (1) the Insured is discharged from the facility; (2) the PPO's medical director determines that the care of the Insured can be safely transferred to another facility; or (3) WMI makes arrangements to transfer the Insured's care to another Preferred Provider facility.

X. **RIGHTS UNDER ERISA:** If the Insured has any questions about the Plan, he or she should contact the Company. If the Insured has any questions about this statement or his or her rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA), he or she should contact the nearest area office of the Pension and Welfare Benefits Administration, U.S. Department of Labor listed in the telephone directory. The Insured may

also contact the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, at 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Y. **QUALIFIED MEDICAL CHILD SUPPORT ORDER ("QMCSO")**: A QMCSO is a court judgment, decree, or order, or a state administrative order that has the force and effect of law. A QMSCO is typically issued as part of a divorce or as part of a state child support order proceeding. A QMCSO requires that health plan coverage be provided to a child of the Employee. A copy of the Company's QMSCO procedures may be obtained free of charge, upon request.

Z. **CLAIM AND APPEAL PROCEDURES:**

Following is a description of how the Plan processes claims and appeals. A claim is defined as any request for a Plan Benefit that is made by an Insured or a representative of an Insured, and that complies with the Plan's procedures for making a claim. There are two types of claims: pre-service and post-service. The different types of claims are described below. Each type of claim has a specific time period for approval and for request for further information. Each type of claim also has a specific time period for denial. Each type of claim also has a specific time period for appeal reviews. Time periods begin at the time that a claim is filed. "Days" refers to calendar days, unless otherwise specified.

An insured individual has the right to contact the Montana Commissioner of Insurance and Securities for assistance at any time, including with internal and external appeals. They may be contacted in writing at 840 Helena Avenue, Helena, MT 59601. They may also be contacted by telephone at (800) 332-6148 or (406) 444-2040.

Utilization Review

Utilization review means a review to determine the Medical Necessity and the appropriateness of health care services, procedures or settings. The Insured has the right to request utilization review, including in cases that involve Urgent Care services. Utilization review for the length of stay of all Inpatient facility confinements is required and is conducted by MedWatch. They may be contacted by telephone at (800) 432-8421. For utilization review for other types of services and procedures, the Insured may contact the Company at (800) 748-5340. The time periods in which utilization review will be conducted are the same as outlined in the sections below titled Pre-Service Claim, Pre-Service Urgent Care Claim, Pre-Service Concurrent Urgent Care Claim, and Post-Service Claim, as applicable. Utilization review requests involving Urgent Care may be submitted orally; utilization review requests for other types of claims must be submitted in writing to the Company.

If an Insured receives an Adverse Benefit Determination on a utilization review, he may submit an appeal in accordance with the appeals procedures that are outlined under this section.

Pre-Service Claim

A pre-service claim is any claim that involves the cost for medical care that has not already been rendered to the Insured. Pre-certification is required for pre-service claims that involve

an Inpatient facility confinement in order to receive Benefits. The utilization review company that conducts Pre-certification is MedWatch, and they may be contacted by telephone at (800) 432-8421. The Insured will receive a notification of the benefit determination for a pre-service claim within fifteen (15) days after the receipt of the request. The plan may extend this time period for an additional fifteen (15) days for reasons beyond the plan's control. The Insured will be notified in writing prior to the expiration of the initial fifteen (15) day period of the circumstances requiring the extension of time and of the date by which a decision will be rendered. If the extension is necessary due to the Insured's failure to submit information necessary to make a determination on the claim, the written notice will describe the required information necessary to complete the request and the Insured will be given at least forty-five (45) days to respond. A notification of the benefit determination will be sent within fifteen (15) days after the receipt of the additional information. If a request for a pre-service claim that fails to meet the filing procedures is received, notice will be sent to the Insured regarding the proper procedures to be followed for filing a request. This notice will be sent as soon as possible but no later than five (5) days after the date of the failure.

Pre-Service Urgent Care Claim

Pre-certification for pre-service claims that involve Urgent Care is **not** required, although it is recommended. Once the care is no longer Urgent Care, the Pre-certification requirements will apply. If Pre-certification is performed for a pre-service claim that involves Urgent Care, the benefit determination will be made within seventy-two (72) hours. If a request for an Urgent Care pre-service claim that fails to meet the filing procedures is received or is incomplete, notice will be sent to the Insured regarding the proper procedures to be followed for filing a request. This notice will be provided as soon as possible but no later than twenty-four (24) hours after the receipt of the request. The Insured will be given at least forty-eight (48) hours to provide the necessary information. A benefit determination will be provided within forty-eight (48) hours after receiving the necessary information.

Pre-Service Concurrent Urgent Care Claim

For concurrent review Urgent Care requests involving a request by the Insured to extend the course of treatment beyond the initial period of time or treatments, a determination will be made no later than twenty-four (24) hours after the date of receiving the request, as long as the request was filed at least twenty-four (24) hours prior to the expiration of the approved period of time or number of treatments. An ongoing course of treatment for which Pre-certification has been received may not be subsequently reduced or terminated unless written notice is provided to the Insured sufficiently in advance to allow the Insured to appeal the determination and obtain a decision prior to the reduction or termination. If an adverse benefit determination is received, the health care service or treatment that is the subject of the adverse determination will be continued without liability to the Insured pending a determination made under the internal appeals process.

Post-Service Claim

A post-service claim is any claim that involves the cost for medical care that has already been rendered to the insured. Post-service claims will never be considered to be claims that involve Urgent Care.

In the event of a post-service claim, the Insured will receive a notification of the benefit determination within thirty (30) days after the receipt of the request. The plan may extend this time period for an additional fifteen (15) days for reasons beyond the plan's control. The plan will notify the Insured in writing prior to the expiration of the initial thirty (30) day period of the circumstances requiring the extension of time and of the date by which a decision will be rendered. If the extension is necessary due to the Insured's failure to submit information necessary to make a determination on the claim, the written notice will describe the required information necessary to complete the request and the Insured will be given at least forty-five (45) days to respond. A notification of the benefit determination will be sent within fifteen (15) days after the receipt of the additional information.

Notice to Insured of Adverse Benefit Determination

Adverse benefit determination means a rescission or a denial of, a reduction of, a termination of, or a failure to provide or make payment for, in whole or in part, a Benefit. Adverse benefit determination includes any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a participant's eligibility to participate in the plan. In the event of an adverse benefit determination, the plan will provide a written or an electronic notification that sets forth the following information.

a) Information sufficient to identify the benefit request or claim involved and, if applicable, the date of service, the health care provider and the claim amount.
b) A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the procedure code and its corresponding meaning.
c) The specific rationale behind the adverse determination, including the denial code and its corresponding meaning, as well as a description of the insurer's standard, if any, that was used in denying the benefit request or claim.
d) A reference to the specific Plan provision on which the determination is based.
e) A description of any additional material or information necessary for the Insured to complete the benefit request, including an explanation of why the material or information is necessary to complete the request.
f) A description of the Plan's appeal procedures, including expedited appeals procedures, if applicable, including any time limits applicable to those procedures.
g) A statement that any internal rule, guideline, protocol or other similar criteria that was relied on to make the adverse benefit determination will be provided to the Insured, upon request and free of charge, including instructions on how to request such information.
h) A statement that an explanation of the scientific or clinical judgement for making the adverse benefit determination if the adverse determination is based on a medical necessity or an experimental or investigational provision of the Plan will be provided to the Insured, upon request and free of charge, including instructions on how to request such information.
i) A statement explaining the availability of further assistance from the commissioner's office and the right of the Insured to contact the commissioner's office at any time for assistance, including the commissioner's contact information.
j) A statement explaining the right of the Insured to file suit in court pursuant to §502 of the Employee Retirement and Income Security Act ("ERISA") upon completion of the insurer's internal and external appeal review procedures.

If the adverse benefit determination is a rescission, the notice shall provide, in addition to the information above, the following information. Such notice will be provided at least thirty (30) days in advance of implementing the rescission decision.

a) Clear identification of the alleged fraudulent act, practice, or omission or the intentional misrepresentation of material fact.
b) An explanation of why the act, practice, or omission was fraudulent or was an intentional misrepresentation of material fact.
c) The date when the advance notice period ends and the date to which the coverage is retroactively rescinded.
d) Notice that the Insured may immediately file an appeal with the insurer requesting a review of the rescission.
e) A description of the insurer's appeals procedures, including any time limits applicable to these procedures.

Internal Appeals Process

The Plan provides two levels of internal appeal review. Both of these levels must be exhausted before an Insured can file suit in court. In the event of an adverse benefit determination, the Insured has 180 days from the receipt of the notification in which to file a first level appeal. Appeals involving Urgent Care may be made orally; all other appeals must be made in writing. Notification of a pre-service claim appeal must also be given to the Company. Appeals should be filed to the appropriate entity as listed below.

For pre-service claims:

Name:	MedWatch	Phone: (800) 432-8421
Address:	P.O. Box 952679	Fax: (407) 333-8928
	Lake Mary, FL 32795-2679	

For post-service claims:

Name:	Marilyn Gettings	Phone: (801) 263-8000
Title:	Claims Manager	Fax: (801) 263-1189
Address:	WMI Mutual Insurance Company	
	P.O. Box 572450	
	Salt Lake City, UT 84157	

An Insured may submit comments, documents, records and other information that relates to the claim. Upon request, an Insured will be given access to, and copies of, all documents, records, and other information relevant to the claim that were used in the initial benefit determination. This information will be provided free of charge.

If an Insured receives an adverse decision on the first level of appeal, he may submit the appeal for a second level of review. The appeal for a second level of review must be submitted within sixty (60) days of receipt of the first level decision. Any additional information that applies must be submitted at the same time.

Each level of review may be performed either internally or independently, as described herein. In the case of a pre-service claim, each level of appeal will be responded to within

fifteen (15) days after the receipt of the appeal, unless the appeal is for a pre-service Urgent Care claim, in which case the appeal will be responded to within seventy-two (72) hours. In the case of a post-service claim, each level of appeal will be responded to within thirty (30) days after the receipt of the appeal. The time period within which a determination on appeal is required to be made will begin at the time that an appeal is received.

The Insured may review the claim file and present evidence and testimony as part of the internal claims and appeal process. If the plan considers, relies upon, or generates any new evidence in connection with a claim, the evidence will be provided to the Insured. If the plan bases an appeal decision on any new or additional rationale, the rationale will be provided to the Insured. This information will be provided to the Insured free of charge. The information will be provided prior to the required date for the notice of the final internal adverse benefit determination. A reasonable opportunity will be given to the Insured to respond prior to the notice date.

Reviews of all appeals of adverse benefit determinations, except those described in the following paragraph, will be conducted internally by a person or a committee of persons. This person or committee of persons will not be the individual who made the initial adverse benefit determination, and will not be the subordinate of that individual.

An independent review will be conducted for an appeal of an adverse benefit determination that is based on a medical judgment. This includes a determination that a particular treatment, a drug or other item is experimental or is investigational. This also includes a determination that a particular treatment, a drug or other item is not Medically Necessary or is not appropriate. For this review, the plan will consult with an independent health care professional. This professional will not be affiliated with the Company. This professional will not be involved in the initial benefit determination. This professional will have the appropriate training and the expertise in the field of medicine that is involved in the medical judgment. The independent health care professional shall take into consideration all comments, documents, records, and other information regarding the review request without regard to whether the information was submitted or considered in making the initial adverse determination. An Insured does not have the right to attend the review, but the Insured is entitled to submit written comments, documents, records and other material relating to the request for benefits for the reviewer to consider, and to receive from the insurer, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Insured's request for benefits. There will not be a fee charged to the Insured for an independent review.

Notice of Internal Appeal Review Decision

Written notice will be provided to the Insured upon the review decision within the required timeframes and will contain the following information.

a) Information sufficient to identify the benefit request or claim involved and, if applicable, the date of service, the health care provider and the claim amount.
b) A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the procedure code and its corresponding meaning.
c) If the review involved an independent review, the titles and qualifying credentials of the health care professional that participated in the review, and a statement from the health care professional of their understanding of the Insured's grievance.

d) If the review involved an independent review, the decision of the health care professional that conducted the review and the contract basis or medical rationale on which the decision was based.
e) A reference to the evidence or documentation used as the basis for the decision.

If the review decision upholds the adverse determination, the following information will be included in the notice in addition to the above information.

a) All specific reasons that uphold the adverse determination, including the denial code and its corresponding meaning, as well as a description of the insurer's standard, if any, that was used in reaching the denial.
b) A reference to the specific Plan provision on which the determination is based.
c) A statement that the Insured is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Insured's benefit request.
d) A statement that any internal rule, guideline, protocol or other similar criteria that was relied on to make the adverse benefit determination will be provided to the Insured, upon request and free of charge.
e) A statement that an explanation of the scientific or clinical judgement for making the adverse benefit determination if the adverse determination is based on a medical necessity or an experimental or investigational provision of the Plan will be provided to the Insured, upon request and free of charge.
f) A description of the procedure for requesting a second level of appeal review, if applicable, or a description of the procedure for requesting an external review, if applicable.
g) A statement explaining the availability of further assistance from the commissioner's office and the right of the Insured to contact the commissioner's office at any time for assistance, including the commissioner's contact information.
h) A statement explaining the right of the Insured to file suit in court pursuant to §502 of the Employee Retirement and Income Security Act ("ERISA") upon completion of the insurer's internal appeal review procedures.

External Review

A third appeal level known as an external review level is also available. This level is available once the internal appeals process is exhausted. The plan may waive the requirement for exhaustion in writing. Exhaustion is also waived if the Plan fails to comply with any of the requirements of the internal appeals process. An insured individual has the right to contact the Montana Commissioner of Insurance and Securities for assistance at any time. They may be contacted in writing at 840 Helena Avenue, Helena, MT 59601. They may also be contacted by telephone at (800) 332-6148 or (406) 444-2040. The external review level can only be used for adverse benefit determinations that are based on medical necessity, appropriateness of care, health care setting, level of care, or effectiveness of care. This review level can also be used for adverse benefit determinations for services that are experimental or are investigational. When filing a request for an external review, the Insured is required to authorize the release of any medical records that may be required for the purpose of reaching a decision on the external review. An independent review organization (IRO) will conduct the external review and they, not the Company, will make the final benefit determination.

There are two options for an external review: (a) standard review; and (b) expedited review. Expedited review may not be provided for reviews involving post-service claims. The expedited review option is available if both of the following are met.

(a) The adverse benefit determination involves a medical condition for which the standard external review timeframe would seriously jeopardize the life or health of the Insured.
(b) The adverse benefit determination concerns an admission, the availability of care, a continued stay, or a health care service for which the Insured received emergency services, but has not been discharged from a facility, or concerns an experimental/investigational service or treatment.

Standard External Review for Adverse Benefit Determinations involving Medical Necessity

An Insured must submit a request for a standard external review in writing within four (4) months from the date of the final adverse benefit determination. Within five (5) business days of receiving the request, the plan will conduct a preliminary review to determine if all of the following are met.

a) The Insured is or was a covered individual at the time the service or treatment was requested, in the event of a pre-service claim, or was a covered individual at that time that the service or treatment was provided in the event of a post-service claim.
b) The service or treatment that is the subject of the adverse determination is a covered service under the Plan but is not covered due to a determination that the service or treatment does not meet the Plan's requirements for medical necessity, appropriateness of care, health care setting, level of care, or effectiveness of care.
c) The Insured exhausted the internal appeals process.
d) The Insured has provided all of the information necessary to process the external review.

Within one (1) day after completing the preliminary review, the plan will notify the Insured if the request is eligible for external review. If the request is not complete, the notice describe the information that is necessary to complete the review. If the request is not eligible for external review, a notice will be provided to the Insured that explains the reason for ineligibility and will contain a statement informing the Insured of the right to appeal to the commissioner.

Within one (1) business day of determining that a request is eligible for external review, the plan will randomly assign an independent review organization (IRO) from the list of IRO's compiled and maintained by the commissioner to conduct the review. Within one (1) business day of assigning the IRO, the plan will notify the Insured that an external review has been initiated. The notice will also inform the Insured that he/she may submit to the IRO in writing within ten (10) business days following receipt of the notice any additional information to consider in the review.

Within five (5) business days after assigning the IRO, the plan shall provide to the IRO the medical records, documents and any information used in the making the adverse benefit determination. Failure by the plan to provide such documents and information may not delay the conduct of the external review, and the IRO may terminate the external review and make

a decision to reverse the adverse benefit determination. The IRO will notify the Insured and the plan within one (1) business day if it makes this decision.

If the IRO receives any information submitted by the Insured, it shall forward such information to the insurer within one (1) business day. The plan may then reconsider its benefit determination. If the plan reverses its determination, notice will be provided to the Insured and to the IRO within one (1) business day after making the decision. The IRO then must terminate its external review.

In conducting the standard external review, the IRO will consider the following information and documents.

a) The Insured's medical records.
b) The attending professional's recommendation.
c) Consulting reports from appropriate health care professionals, and any other documents submitted by the Insured or the Plan.
d) The terms of coverage under the Insured's Plan to ensure that the IRO's decision is not contrary to the terms and conditions of the Plan.
e) The most appropriate practice guidelines, which must include generally accepted practice guidelines, evidence-based standards, or any other practice guidelines developed by the federal government or national or professional medical societies, boards, and associations.
f) Any applicable clinical review criteria developed and used by the insurer or its utilization review organization.
g) The opinion of the IRO's clinical peer after considering the provisions of the subsections above to the extent the documents or information is available.

The IRO shall provide written notice to the Insured and the plan of its decision to uphold or reverse the adverse benefit determination within forty-five (45) days after the receipt of the request for standard external review. The written notice shall include the following information.

a) A general description of the reason for the request for the external review.
b) The date the IRO received the assignment to conduct the external review.
c) The time period over which the external review was conducted.
d) The date of the IRO's decision.
e) The principal reasons for the decision.
f) The rationale for the decision.
g) References to the evidence of documentation, including the evidence-based standards considered in making the decision.

If the IRO reverses the plan's adverse benefit determination, the plan will immediately approve the coverage that was the subject of the adverse determination.

Expedited External Review for Adverse Benefit Determinations involving Medical Necessity

A request for an expedited external review may be made by telephone or other expeditious manner. The same rules that apply to a standard external review apply to an expedited external review, however, the timeframes for decisions and notifications is shorter.

An Insured may request an expedited external review in the following situations.

a) If the Insured received an adverse benefit determination and: (1) the Insured has filed a request for an internal Urgent Care appeal review; and (2) the adverse determination involves a medical condition for which the timeframe for completion of an internal Urgent Care review would seriously jeopardize the life or health of the Insured or would jeopardize the Insured's ability to regain maximum function; or
b) If the Insured received a final adverse benefit determination and: (1) the adverse determination involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Insured or would jeopardize the Insured's ability to regain maximum function; and (2) the adverse determination concerns an admission, availability of care, continued stay, or health care service for which the Insured received emergency services but has not been discharged from a facility.

Immediately upon receipt of a request for expedited external review, the plan will determine if the request is eligible for external review considering the same requirements as those for preliminary review for standard external reviews. After completing the preliminary review, the plan will notify the Insured if the request is eligible for external review. If the request is not complete, the notice describe the information that is necessary to complete the review. If the request is not eligible for external review, a notice will be provided to the Insured that explains the reason for ineligibility and will contain a statement informing the Insured of the right to appeal to the commissioner.

Immediately after determining that a request is eligible for external review, the plan will randomly assign an independent review organization (IRO) from the list of IRO's compiled and maintained by the commissioner to conduct the review. Upon assigning the IRO, the plan shall provide to the IRO the medical records, documents and any information used in the making the adverse benefit determination electronically, by telephone, by fax or any other expeditious manner.

The IRO will provide the Insured and the plan with notice of its decision as expeditiously as possible, but no more than seventy-two (72) hours after receiving the request for an expedited external review. If the notice provided is not in writing, the IRO must provide written confirmation to the Insured and the plan within forty-eight (48) hours after verbally conveying the decision. The written notice will contain the same information that is required for a standard external review. If the IRO reverses the plan's adverse benefit determination, the plan will immediately approve the coverage that was the subject of the adverse determination.

Standard External Review for Adverse Benefit Determinations involving Experimental/Investigational Services or Treatment

An Insured must submit a request for a standard external review in writing within four (4) months from the date of the final adverse benefit determination. Within five (5) business

days of receiving the request, the Plan will conduct a preliminary review to determine if all of the following are met.

a) The Insured is or was a covered individual at the time the service or treatment was requested, in the event of a pre-service claim, or was a covered individual at that time that the service or treatment was provided in the event of a post-service claim.
b) The service or treatment that is the subject of the adverse determination is a covered service under the Plan but is not covered due to a determination that the service or treatment is experimental or investigational for a particular medical condition.
c) The service or treatment is not explicitly listed as an excluded benefit under the Insured's Plan.
d) The Insured's treating health care provider has certified that one of the following is applicable: (i) standard health care services or treatments have not been effective in improving the condition of the Insured; (ii) standard health care services or treatments are not medically appropriate for the Insured; or (iii) there is no available standard health care service or treatment covered by the insurer that is more beneficial than the recommended or requested service or treatment.
e) The Insured's treating health care provider has recommended a health care service or treatment that the physician certifies, in writing, is likely to be more beneficial to the Insured, in the physician's opinion, than any available standard health care service or treatment, or a physician who is licensed, board-certified, or eligible to take the examination to become board-certified and is qualified to practice in the area of medicine appropriate to treat the Insured's condition has certified in writing that scientifically valid studies using accepted protocols demonstrate that the requested service or treatment is likely to be more beneficial to the Insured than any available standard health care service or treatment.
f) The Insured exhausted the internal appeals process.

Within one (1) day after completing the preliminary review, the plan will notify the Insured if the request is eligible for external review. If the request is not complete, the notice describe the information that is necessary to complete the review. If the request is not eligible for external review, a notice will be provided to the Insured that explains the reason for ineligibility and will contain a statement informing the Insured of the right to appeal to the commissioner.

Within one (1) business day of determining that a request is eligible for external review, the plan will randomly assign an independent review organization (IRO) from the list of IRO's compiled and maintained by the commissioner to conduct the review. Within one (1) business day of assigning the IRO, the plan will notify the Insured that an external review has been initiated. The notice will also inform the Insured that he/she may submit to the IRO in writing within ten (10) business days following receipt of the notice any additional information to consider in the review.

Within one (1) business day after receiving the assignment, the IRO shall select a clinical peer, or multiple peers if medically appropriate under the circumstances, to conduct the external review. In selecting clinical peers, the IRO shall select physicians or other health care providers who: (i) are experts in the treatment of the Insured's medical condition; (ii) are knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical conditions of the Insured; (iii) hold a non-restricted professional license in a state of the

United States and, for physicians, a current certification by a recognized American medical specialty board in one or more areas appropriate the subject of the external review; and (iv) have no history of disciplinary actions or sanctions, including participation restrictions or a loss of staff privileges either taken or pending by any hospital, government agency, governmental unit, or any regulatory body if the disciplinary actions or sanctions raise a substantial question as to the clinical peer's physical, mental or professional competence or moral character.

Within five (5) business days after assigning the IRO, the plan shall provide to the IRO the medical records, documents and any information used in the making the adverse benefit determination. Failure by the plan to provide such documents and information may not delay the conduct of the external review, and the IRO may terminate the external review and make a decision to reverse the adverse benefit determination. The IRO will notify the Insured and the plan within one (1) business day if it makes this decision.

If the IRO receives any information submitted by the Insured, it shall forward such information to the insurer within one (1) business day. The plan may then reconsider its benefit determination. If the plan reverses its determination, notice will be provided immediately to the Insured, to the IRO and to the commissioner after making the decision. The IRO then must terminate its external review.

In conducting the standard external review, each clinical peer will consider the following information and documents, to the extent that the information is available and appropriate.

a) The Insured's medical records.
b) The attending physician's or health care professional's recommendation.
c) Consulting reports from appropriate health care professionals, and any other documents submitted by the Insured, the plan or the Insured's treating physician or health care provider.
d) The terms of coverage under the Insured's Plan to ensure that the clinical peer's decision is not contrary to the terms and conditions of the Plan.
e) Whether: (i) the recommended or requested service or treatment has been approved by the Food and Drug Administration; (ii) the recommended or requested service or treatment is typically covered by other insurers or payers, such as Medicare; or (iii) medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested service or treatment is more likely than not to be more beneficial to the Insured than any available standard health care services or treatments and that the adverse risks of the recommended or requested service or treatment would not be substantially increased over those of available standard health care services or treatments.

Within twenty (20) days after being selected, each clinical peer shall provide an opinion to the IRO on whether the recommended or requested service or treatment should be covered. Each clinical peer's opinion must be in writing and must include the following information.

a) A description of the Insured's medical condition.
b) A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested service or treatment is more likely than not to be more beneficial to the Insured than any available standard health care services or treatments and that the adverse risks of the recommended or requested

service or treatment would not be substantially increased over those of available standard health care services or treatments.

c) A description and analysis of any evidence-based standard.
d) Information on whether the clinical peer's rationale for the opinion is based on the Insured's pertinent medical records or the attending physician's or health care professional's recommendation.

Within twenty (20) days after receiving the opinion of each clinical peer, the IRO shall make a decision and provide written notice to the Insured, the plan and the commissioner. If a majority of the clinical peers respond that the recommended or requested service or treatment should be covered, the IRO shall make a decision to reverse the adverse benefit determination. If a majority of the clinical peers respond that the recommended or requested service or treatment should not be covered, the IRO shall make a decision to uphold the adverse benefit determination. If the clinical peers are evenly split as to whether the recommended or requested service or treatment should be covered, the IRO shall obtain the opinion of an additional clinical peer to help the IRO make a decision. The selection of the additional clinical peer may not extend the time within which the IRO is required to make a decision.

The written notice from the IRO shall include the following information.

a) A general description of the reason for the request for the external review.
b) The written opinion of each clinical peer, including the opinion of each clinical peer as to whether the recommended or requested service or treatment should be covered and the rationale for the reviewer's recommendation.
c) The date the IRO received the assignment to conduct the external review.
d) The time period over which the external review was conducted.
e) The date of the IRO's decision.
f) The principal reasons for the decision.
g) The rationale for the decision.

If the IRO reverses the plan's adverse benefit determination, the plan will immediately approve the coverage that was the subject of the adverse determination.

Expedited External Review for Adverse Benefit Determinations involving Experimental/Investigational Services or Treatment

A request for an expedited external review may be made orally if the Insured's treating health care provider certifies in writing that the recommended or requested service or treatment that is the subject of the request would be significantly less effective if not promptly initiated. The same rules that apply to a standard external review apply to an expedited external review, however, the timeframes for decisions and notifications is shorter.

An Insured may request an expedited external review in the following situations.

a) If the Insured received an adverse benefit determination and: (1) the Insured has filed a request for an internal Urgent Care appeal review; and (2) the adverse determination involves a medical condition for which the timeframe for completion of an internal Urgent Care review would seriously jeopardize the life or health of the Insured or would jeopardize the Insured's ability to regain maximum function; or

b) If the Insured received a final adverse benefit determination and: (1) the adverse determination involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Insured or would jeopardize the Insured's ability to regain maximum function; and (2) the adverse determination concerns an admission, availability of care, continued stay, or health care service for which the Insured received emergency services but has not been discharged from a facility.

Immediately upon receipt of a request for expedited external review, the plan will determine if the request is eligible for external review considering the same requirements as those for preliminary review for standard external reviews. After completing the preliminary review, the plan will notify the Insured if the request is eligible for external review. If the request is not complete, the notice describe the information that is necessary to complete the review. If the request is not eligible for external review, a notice will be provided to the Insured that explains the reason for ineligibility and will contain a statement informing the Insured of the right to appeal to the commissioner.

Immediately after determining that a request is eligible for external review, the plan will randomly assign an independent review organization (IRO) from the list of IRO's compiled and maintained by the commissioner to conduct the review. Upon assigning the IRO, the plan shall provide to the IRO the medical records, documents and any information used in the making the adverse benefit determination electronically, by telephone, by fax or any other expeditious manner.

Within one (1) business day after receiving the assignment, the IRO shall select a clinical peer, or multiple peers if medically appropriate under the circumstances, to conduct the external review. Within five (5) days after being selected, each clinical peer shall provide an opinion to the IRO, either orally or in writing, on whether the recommended or requested service or treatment should be covered. If the notice provided is not in writing, the clinical peer must provide written confirmation to the IRO within forty-eight (48) hours after verbally conveying the decision. Within forty-eight (48) hours after receiving the opinion of each clinical peer, the IRO shall make a decision and provide oral or written notice to the Insured, the plan and the commissioner. If the notice provided is not in writing, the clinical peer must provide written confirmation to the IRO within forty-eight (48) hours after verbally conveying the decision. If a majority of the clinical peers respond that the recommended or requested service or treatment should be covered, the IRO shall make a decision to reverse the adverse benefit determination. If a majority of the clinical peers respond that the recommended or requested service or treatment should not be covered, the IRO shall make a decision to uphold the adverse benefit determination. If the clinical peers are evenly split as to whether the recommended or requested service or treatment should be covered, the IRO shall obtain the opinion of an additional clinical peer to help the IRO make a decision. The selection of the additional clinical peer may not extend the time within which the IRO is required to make a decision.

The written notice will contain the same information that is required for a standard external review. If the IRO reverses the plan's adverse benefit determination, the plan will immediately approve the coverage that was the subject of the adverse determination.

Binding Nature of the External Review Decision

An external review decision is binding on the insurer and the Insured except to the extent that the Insured has other remedies available under applicable federal or state law. An Insured may not file a subsequent request for external review involving the same adverse benefit determination for which the Insured already received an external review decision.

IX. PRIVACY AND SECURITY POLICY

We at WMI Mutual Insurance Company respect the privacy and security of your protected health information ("PHI"). We only use and disclose this type of information as permitted by law, in order to provide you with quality service and to administer our business functions. We do not use or disclose your information outside of the exceptions allowed by law.

- **Protected health information.** PHI is health information that relates to the past, present or future health status or health care of an individual and that identifies an individual or could be used to identify an individual. This information includes both financial information, such as payment history, policy number and social security number. This information also includes health information, such as medical history, medical records and claims.

- **Sources of Information.** Some of the sources from which we gather your personal information are your application or enrollment form, transactions that you conduct with us, and claims and medical records that are received from health care providers.

- **Disclosure of Information.** It is necessary for us to use PHI in order to administer our normal business functions. Examples of these functions are claims processing, underwriting, premium billing, actuarial services, and customer service. PHI regarding a Spouse or dependent children will be disclosed to the insured Employee (or the insured former employee) in the form of an explanation of benefits when a claim is processed. We may also disclose PHI to third parties that help us administer our business functions, as permitted by law. We obtain assurances from these business associates that they will also protect the privacy of your information. The types of third parties that we disclose information to include, but are not limited to, the following.

  (a) Your agent or agency.
  (b) Health care providers.
  (c) The pharmacy benefits manager.
  (d) The utilization manager.
  (e) Preferred provider organizations.
  (f) Persons that conduct actuarial services.
  (g) A government agency or other organization pursuant to an audit of our records.
  (h) Claims investigators and medical consultants.

- **Security.** We maintain procedural, physical and electronic safeguards to protect the confidentiality of your personal information. Access to personal information is restricted to only those employees and service providers who need this information in order to provide products and services to you.

- **Individual rights.** You have the right to request restrictions on the uses and disclosures of your PHI, however, we are not required to agree to such restrictions. You have the right to inspect and copy your PHI and to request that corrections be made to such information. You

have a right to an accounting of any disclosures that are made outside of the exceptions that are allowed by law.

- **Complaint procedure.** If you believe that your privacy rights have been violated, you may file a written complaint with WMI. You may also file a written complaint with the Office of Civil Rights, Region VIII, U.S. Department of Health and Human Services, 1961 Stout Street, Room 1185 FOB, Denver, CO 80294-3538. The complaint must describe the violation that occurred. The complaint must be filed within 180 days of the known date of violation. You will not be retaliated against for filing a complaint.

WMI MUTUAL INSURANCE COMPANY

P.O. Box 572450
Salt Lake City, UT 84157-2450
(801) 263-8000 & (800) 748-5340
FAX (801) 263-1247