NEVADA GROUP HEALTH INSURANCE CERTIFICATE BOOKLET

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I. DEFINITIONS: (the following terms are defined for guidance only and do not create coverage.)

"Accident" or **"Accidental Bodily Injury"** shall mean the sustaining of physical damage to the body as the result of an unexpected occurrence, that is independent of disease or bodily infirmity and for which the Insured is not entitled to receive any benefits under a workers' compensation or occupational disease law. Physical damage resulting from a normal body movement such as stooping, bending, twisting, or chewing is not considered an Accident.

"Actively at Work" and **"Active Work"** means being in attendance in person at the usual and customary place or places of business acting in the performance of the duties of the Employee's occupation on a full-time basis devoting full efforts and energies thereto. Notwithstanding the foregoing, an Employee shall be deemed Actively at Work on each day of a regular paid vacation, or 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, provided 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, however, work must begin before coverage will become effective.

"Alcohol/Substance Abuse Dependency Treatment Center" means a treatment facility that is licensed or approved as a treatment center by the state and that provides a program for the treatment of alcoholism or substance abuse pursuant to a written plan approved and monitored by a Physician.

"Ambulance" means a vehicle for transporting the sick or injured, staffed with appropriately certified or licensed personnel and equipped with emergency medical care and supplies and equipment such as oxygen, 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, licensed and accredited by the Joint Commission for Accreditation of Hospitals ("JCAH"), and/or certified by Medicare with permanent facilities equipped and operated primarily for the purpose of performing ambulatory surgical procedures and with continuous Physician services whenever an Insured is in the facility but does not provide services or other accommodations for Insureds to stay overnight.

"Benefits" means the payments 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), are 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 prepared by the Company, including all riders and supplements, if any, which sets forth a summary of the insurance to which an Employee and his Dependents are entitled, to whom the benefits are payable, and any exclusions, limitations, or requirements that may apply.

“**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 performed to improve appearance or to correct a deformity without restoring a physical bodily function. Psychological factors, such as poor body image and difficult peer relations, do not constitute a bodily function.

“Covered Expenses” means those Expenses incurred by an Insured Employee or Dependent for treatment of an Injury or Illness for which the Plan provides Benefits. The term Covered Expenses also includes expenses for wellness Benefits provided under the Policy.

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

“Custodial Care” means services, supplies or accommodations for care which:

(a) Do not provide treatment of an Injury or sickness; or

(b) Could be provided by persons without professional skills or qualifications;

(c) Are provided primarily to assist the Insured in daily living; or

(d) Are for convenience, contentment or other non-therapeutic purposes; or

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

“Date Incurred” means the date services were provided.

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

“**Dependent(s)”** includes any of the following:

(a) The Spouse of an Insured Employee;

(b) The Insured Employee’s (or the Insured Employee’s Spouse’s) Child(ren) who are under age twenty-six (26);

(c) A Child who has reached the limiting age for termination of coverage, but who (1) is Disabled and dependent upon the Insured; and (2) was claimed as a Dependent on the Employee’s income tax return for the previous Calendar Year, provided that the Child was enrolled in this Plan at the time of reaching the limiting age. Subsequent written proof of the continuance of such incapacity and such dependence must be furnished at such intervals as the Company may

reasonably require during the first two years following such Child(ren)'s attainment of the limiting age but not more than once each year thereafter.

"Disability or Disabled," as applied to Employees, means the Employee's continuing inability, because of an Injury or Illness, to perform substantially the duties related to his employment for which he is otherwise qualified. The term **"Disability or Disabled,"** as applied to Dependents, shall mean a physiological or psychological condition which prevents the Insured 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 following requirements:

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

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

(c) It is primarily and customarily used for a medical purpose rather than for convenience or comfort.

(d) It is prescribed by a Physician or 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 pertains to the Employer's Plan, means the date the Employer's Plan becomes in force. As pertains to an Employee or Dependent, the term "Effective Date" shall mean the date the Employee or Dependent becomes Insured.

"Eligible Charges" means those charges incurred by an Insured Employee or 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 sudden change in a patient's condition such that immediate medical or surgical intervention is required and the absence of such intervention could be expected to result in imminent deterioration of health or permanent physical harm or death.

"Employee" means any person who is in an Employee/Employer relationship, is Actively at Work in the regular business of an Employer and who works an average of one hundred twenty (120) hours per month and who receives compensation for his service from the Employer. An Employee of the subsidiaries and affiliates, if any, of the Employer named on the face of this Plan, shall be deemed an Employee of the Employer and service with any such subsidiaries and affiliates shall be deemed service with the Employer, if in compliance with hours worked. For the purpose of this definition, an owner, sole proprietor, partner, officer or director shall be considered an "Employee" provided that 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, that contracts with the Company to provide insurance Benefits to its Employees, that has eligible Employees 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 a period of at least three years by the U.S. Food and Drug Administration, the American Medical Association, the Surgeon General, or any other medical society recognized by the Company, and any services, supplies, or accommodations provided in connection with such procedures.

"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) to individuals convalescing from Injury or 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, substance abuse or alcoholism, is not considered an "Extended Care Facility/Rehabilitation Care Facility."

"Family Deductible" means two (2) times the individual Deductible. 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. No individual family member may contribute more than one-half of the Family Out-of-Pocket maximum and 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 eligible Deductible and co-insurance amounts that are paid by the Insured or Dependent during the Calendar Year will be applied toward the satisfaction of the Out-of-Pocket maximum. Amounts paid for non-covered care or treatment 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), are multisource products that have lower costs than Brand Drugs, and are no longer protected by patents.

"Home Health Care" means services provided by a licensed home health agency to an Insured in his place of residence that is 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 service, medical supplies and equipment suitable for use in the home, and Medically Necessary personal hygiene, grooming, and dietary assistance.

"Hospice" means a licensed agency operating within the scope of such license providing palliative care and treatment of patients with a life expectancy of six (6) months or less where the focus is the acknowledgment of death and dealing with it in both its physical and psychological aspects. Such services are covered if the Hospice:

(a) Is engaged in providing nursing services and other medical services under the supervision of a Physician;

(b) Maintains a complete medical record on each patient;

(c) Is not engaged in providing Custodial Care, care or treatment of Mental Illness, or care or treatment for drug or alcohol abuse or dependency; and

(d) Qualifies as a reimbursable service under Medicare.

"Hospital" means a Facility which is licensed and accredited by the Joint Commission for Accreditation of Hospitals ("JCAH"), which operates within the scope of such license, and which makes use of at least clinical, laboratory, diagnostic x-ray services, and major surgical facilities.

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

"Illness" means a bodily disorder resulting from disease, sickness, or malfunction of the body, or a congenital malformation which causes functional impairment, not entitling the Employee or Dependent(s) to receive any benefits under any workers' compensation or occupational disease law.

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

"Injury" for which Benefits are provided, means Accidental Bodily Injury sustained by the Insured which is the direct result of an Accident, independent of disease or bodily infirmity or any other cause, which occurs while insurance coverage is in force, for which the Insured is not entitled to receive any Benefits under any workers' compensation or occupational disease law.

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

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

"Insured Dependent(s)" means the Dependent(s) of an Insured Employee for whom premium is paid.

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

"Medicaid" means the programs providing Hospital and medical Benefits under Title XIX, "Grants to States for Medical Assistance Programs", of the Federal Social Security Act as now in effect or amended hereafter.

"Medical Claims Review Committee" means that body of the Company which provides for claims appeal.

"Medically Necessary" means any services for health care, supplies, or accommodations provided to the Insured for treatment of Illness or Injury, which:

(a) Are consistent with the symptom(s) or diagnosis;

(b) Are received in the most appropriate, cost effective, setting that can be used safely;

(c) Are not used solely for the convenience of the Insured or Provider or any other person's convenience; and

(d) Are appropriate with regard to standards of good medical practice in the state and could not have been omitted without adversely affecting the Insured's condition or the quality of medical care received.

"Medicare" means the programs providing Hospital and medical benefits under Title XVIII of the Federal Social Security Act as now in effect or hereafter amended. Employees and Dependent(s) who are eligible for any coverage under Medicare shall be deemed to have all the coverage 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 and that provides a program for the treatment of Mental Illness pursuant to a written plan.

"Mental Health Care Practitioner" means an individual licensed by the state as a Physician or surgeon, or osteopathic Physician 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 any mental condition or disorder that falls under any of the diagnostic categories listed in the Diagnostic and Statistical Manual, as periodically revised. Mental Illness does not include the following when diagnosed as the primary or substantial reason or need for treatment: marital or family problem; social, occupational, religious, or other social maladjustment; conduct disorder; chronic adjustment disorder; chronic organic brain syndrome; personality disorder; specific developmental disorder or learning disability; or mental retardation.

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

"Office Visit" means: (1) an evaluation, consultation, or physical examination that is performed by a medical doctor (M.D.), doctor of osteopathy (D.O.), or a nurse practitioner (N.P.); (2) an initial psychiatric evaluation **only** when conducted by a provider licensed to perform that evaluation; and (3) an initial evaluation **only** when 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, and 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 of the following year. An Employee or 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 payable by an Insured to Providers. No individual family member may contribute more than one-half of the Family Out-of-Pocket maximum. Only Deductible and co-insurance amounts that are paid by an Insured person during the Calendar Year will be applied toward the satisfaction of Out-of-Pocket amounts. Amounts paid for non-covered care or treatment do not apply toward Out-of-Pocket amounts. 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.

"Owner" means an owner, partner or proprietor of the Policyholder. In order to be eligible for the optional 24-hour coverage endorsement, an Owner must be one who is not required by law to be covered by workers' compensation insurance, and who has no such insurance in effect.

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

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

"Policyholder" means the Employer named on the Certificate.

"Practitioner" means an individual who is licensed by the state to provide medical or surgical services which are similar to those provided by Physicians. Practitioners include podiatrists, chiropractors, psychologists, certified midwives, certified registered nurse anesthetists, dentists, and other professionals practicing within the scope of their respective licenses.

"Pre-certification" means the determination that a Hospital confinement is Medically Necessary and that the proposed length of stay is appropriate. **Pre-certification does not guarantee payment or determine Benefit eligibility.** Although recommended, Pre-certification for Urgent Care is **not** required. However, once the care is no longer Urgent Care, Pre-certification requirements will apply.

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

"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 discounted rates.

"Prescription Drug" means a Drug or medicine which can only be obtained by a Prescription Order and bears the legend: "Caution, Federal Law Prohibits Dispensing without a Prescription" or other similar type of wording, or which is restricted to prescription dispensing by state law. The term Prescription Drug **does not** include insulin, diabetic testing equipment, and supplies for insulin, which are covered elsewhere in the Policy.

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

“Professional Charges” means charges made by a Physician, Doctor of podiatric medicine, or dentist for an Office Visit, surgical procedure, Medically Necessary assistance, or Hospital medical service.

“Provider” means a Hospital, Skilled Nursing Facility, Ambulatory Service Facility, Physician, Practitioner, or other individual or organization which is licensed by the state to provide medical or surgical services, supplies, and accommodations.

“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 (general supervision, including the daily awareness of resident functioning and continuing needs);

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

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

(e) Health related services (services, other than medical services, pertaining to general supervision, protective, and preventive services).

This definition does not include a nursing care institution. This definition also does not include a Hospital, Mental Health Care Facility, Alcohol/Substance Abuse Dependency Treatment Center, or 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 Illness or Injury. Routine Physical Examination includes the examination and routine lab procedures required for the physical examination, including, but not limited to, cytologic testing/pap smears, and prostate tests.

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

“Semi-Private 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 annual Open-Enrollment period, when certain eligible Employees and Dependents are allowed 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 or the state registered domestic partner of the Insured Employee. The Employer has the option to determine whether coverage will be offered for a state registered domestic partner.

“Total Disability” means inability to perform the duties of any gainful occupation for which the Insured is reasonably fit 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 application of the time periods for making non-urgent care decisions could 1) seriously jeopardize the insured’s life, health or ability to regain maximum function or 2) in the opinion of a physician with knowledge of the insured’s medical condition, would subject the insured to severe pain that cannot be adequately managed without the care or treatment. The determination of whether care is Urgent Care is to be made by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. The determination can also be made by a physician with knowledge of the insured’s medical condition.

“Usual and Customary” means the charge associated with a medical or surgical supply, service, procedure or prescription drug which represents the normal charge level for that procedure in the geographic area of service.

“Visit” includes each attendance of the Physician to the patient regardless of the type of professional services rendered, whether it might otherwise be termed consultation, treatment, or described in some other manner.

“Waiting Period” means the time between the Employee’s date of hire and the date the Employee 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 who worked an average of thirty (30) hours or more per week during the preceding month are eligible to participate in the Plan. Those Employees are eligible to participate on the Effective Date of the Employer’s Plan. Employees must enroll in the Plan prior to the Employer’s Effective Date. Employees must submit a properly completed Enrollment card to the Company. An Eligible Employee who does 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 following 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 preceding the satisfaction of the such Waiting Period.

    A new Employee must submit a properly completed enrollment card 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 Dependents:** Eligible Dependents must submit a properly completed enrollment card 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 the Open Enrollment Period. A properly completed enrollment card 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 at that time and 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. Coverage for the Employee is effective on the first day of the month following the date of enrollment. If the other coverage was provided under Medicaid or SCHIP, and coverage has been terminated due to a loss of eligibility, coverage through this Plan must be requested within sixty (60) days after the termination.

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

3. Eligible Dependents of Employees Insured under the Plan, when the Eligible Dependent declined participation in the Plan when the Dependent was first eligible because other health insurance was maintained at that time and the Dependent has since involuntarily lost the other coverage. If the other coverage is COBRA coverage, the Dependent may only enroll after the COBRA coverage has been involuntarily exhausted. Coverage for the Dependent is effective on the first day of the month following the date of enrollment. If the other coverage was provided under Medicaid or SCHIP, and coverage has been terminated due to a loss of eligibility, coverage through this Plan must be requested within sixty (60) days after the termination.

4. Eligible Dependents of Insured Employees 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) A newborn Child of an Insured Employee is automatically covered from the moment of birth for a period of thirty-one (31) days, and an adopted Child is automatically covered from the date the Child is placed for the purpose of adoption for a period of thirty-one

(31) days. If the payment of a specific premium is required to provide coverage for the newborn or adopted Child, the Insured Employee must enroll the eligible Child and pay all applicable premium within thirty-one (31) days from the date of birth or placement for adoption, in order for the coverage of a newborn or adopted Child to extend beyond the thirty-one (31) day automatic coverage period.

(c) A newborn Child or newly adopted Child of an uninsured eligible Employee is not automatically covered from the moment of birth or placement for the purpose of adoption. The Child may be enrolled as of the first day of the month following the date of birth or the date of placement for the purpose of adoption if the Child enrolls within thirty-one (31) days of birth and if the eligible Employee enrolls at the same time.

5. Eligible Employees or Dependents who are not enrolled in this Plan may enroll upon becoming eligible for a premium assistance subsidy under Medicaid or SCHIP. The Employee or Dependent must request enrollment within sixty (60) days after eligibility for the subsidy is determined.

E. **Alternate Recipients:** An alternate recipient is a child of an Employee who is recognized under a qualified medical child support order ("QMCSO") as having 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 alternate recipient's coverage will be the first day of the first month following the date of determination. A copy of the Plan's QMSCO procedures 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 fewer Employees that are eligible for the insurance. The Company requires that 75% 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'S COVERAGE:** An Employee's coverage will terminate on the earliest of the dates that follow.

1. The last day of the month in which the Employee leaves the employ of the participating Employer.

2. The date that the Employee ceases to be an eligible Employee as that term is defined in this Plan.

3. The date of the termination of the Employer's Policy.

4. An Employee's insurance under this Plan may terminate immediately if he has performed an act or practice that constitutes fraud. An Employee's insurance under the Plan may also be terminated if he has made a material misrepresentation of 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'S COVERAGE:** The Dependent's coverage 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 Employee's coverage under the Plan terminates.

3. The date of the termination of the Employer's Policy.

4. The date that the period for which the last premium is paid for an Employee's Dependent Coverage expires.

5. A Dependent's insurance under this Plan may terminate immediately if he has performed an act or practice that constitutes fraud. A Dependent's insurance may also be terminated if he has made a material misrepresentation of 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:**

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 an Employee's covered Dependent is incapable of self-support because of mental retardation or physical handicap on the date his coverage would otherwise terminate on account of age and within thirty-one (31) days of that date the Employee submits to the Company satisfactory proof of his incapacity, his medical Benefits will be continued during the period of his incapacity. The Company may subsequently require proof of his incapacity as specified in the Plan. This extension will continue until the earliest of:

   (a) the date he ceases to be incapacitated;

   (b) the thirty-first (31st) day after the Company requests additional proof of his incapacity, if the Employee fails to furnish such proof; or

   (c) the last day in 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 but it is **not** required. Once the care is no longer Urgent Care, the Pre-certification requirements will apply. 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, or as soon as reasonably possible. 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. Room accommodations are also eligible for intensive care. Supplies related to the stay are also eligible if they are medically necessary. Treatment may be provided by a skilled nursing facility as an alternative to Inpatient Hospital services. Professional services, pharmacy services, and prescriptions filled in the skilled nursing facility pharmacy are eligible services. The plan limits skilled nursing facility services to one hundred (100) days per Calendar Year.

2. **Inpatient Mental Illness Care, including residential treatment**. Eligible care must be rendered in a Mental Health Care Facility as defined in the Policy in order to be eligible for Benefits. Treatment rendered in a Mental Health Care Facility must also meet all other criteria for eligibility and is subject to all other terms and provisions of the Policy in order for Benefits to be provided.

3. **Inpatient Alcohol/Substance Abuse Treatment, including residential treatment**. Eligible treatment must be rendered in an Alcohol/Substance Abuse Dependency Treatment Center as defined in the Policy to be eligible for Benefits. Treatment must also meet all other criteria for eligibility subject to all other terms and provisions of the Policy in order for Benefits to be provided.

4. **Inpatient Extended Care Facility/Rehabilitation Care Facility**. The eligible amount for the daily room charge incurred at an Extended Care or Rehabilitation Care Facility is limited to the most common daily Semi-private room charge of the facility. All other Covered Expenses will be paid in accordance with the policy guidelines. The Benefit is limited to a maximum of sixty (60) days in any one Calendar Year. Custodial Care is not considered to be Extended Care or Rehabilitation Care and is ineligible for Benefits.

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

C. **OUTPATIENT MENTAL ILLNESS CARE:** Eligible outpatient care must be rendered by a Mental Health Care Practitioner or in a Mental Health Care Facility as those terms are defined in the Policy in order to be eligible for Benefits. Treatment rendered must also meet all other criteria for eligibility subject to all other terms and provisions of the Policy in order for Benefits to be provided. Treatment that is not otherwise excluded in this policy, and which is within the scope of practice of a licensed marriage and family therapist or a social worker, is also covered.

D. **OUTPATIENT ALCOHOL/SUBSTANCE ABUSE TREATMENT:** Eligible outpatient treatment must be rendered by a Provider or Practitioner or in an Alcohol/Substance Abuse Dependency Treatment Center as those terms are defined in the Policy in order to be eligible for Benefits. Treatment must also meet all other criteria for eligibility and is subject to all other terms and provisions of the Policy in order for Benefits to be provided.

E. **GENERAL SURGICAL SERVICES:**

1. The Plan covers surgical procedures 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 also be licensed under a different specialty than the primary surgeon. The total amount allowed is limited to 125% of the primary surgeon's allowance. 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's charges.

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.

F. **ANESTHESIA SERVICES:** The Plan covers anesthesia service to achieve general or regional (but not local) 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. Services of a nurse anesthetist who is not employed by the Hospital and who bills for services that are provided are also covered. Services of a nurse anesthetist are covered only if they are Medically Necessary and if a Hospital employee or Physician is unavailable.

G. **PHYSICIAN SERVICES:**

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

2. **Physician Consultations:**

(a) The Plan covers Hospital Physician Visits if the Employee or Dependent is confined in a Hospital. This Benefit ends on the day that a surgical procedure takes place.

(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 for each day.

(d) Concurrent Physician 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 care 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 Benefits 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 surgical 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 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 provided by a Hospice if: (a) the charge is incurred by an Insured person 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) services and supplies furnished by a Home Health agency or licensed Hospice, including Custodial Care; (b) confinement in a Hospice as long as charges do not exceed 150% of the average Semi-Private room daily rate in short term Hospitals in the area in which the Hospice is located; and (c) palliative and supportive medical and nursing services.

Hospice bereavement services are eligible for Benefits. Benefits are limited to five (5) visits per Calendar Year. Treatment must be completed within six (6) months of the date of death.

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 Benefits.

   (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) Bone marrow, stem cell rescue, stem cell recovery, any and all other procedures involving bone marrow or bone marrow components as an adjunct to high dose chemotherapy, including services related to any evaluation, treatment or therapy involving the use of myeloablative chemotherapy with autologous hematopoietic stem cell and/or colony stimulating factor support (MC-AHSC/CSF).

   For the purpose of this provision, the following terms are defined as follows: (i) "Myeloablative Chemotherapy" means a dose of chemotherapy which is expected to destroy the bone marrow; (ii) "Autologous Hematopoietic Stem Cell" means an infusion of primitive cells 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; (iii) "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 or any mechanical or electronic organs of any type 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 a recipient's coverage. 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.

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 rendered at PPO and non-PPO facilities. An invoice showing the actual cost of the Implantable Hardware must be submitted to the Company.

4. Benefits include travel, daily lodging and daily meals.

5. Only organs and body parts that are specifically listed in this section are eligible for transplant or implant Benefits.

J. **DIAGNOSTIC LABORATORY TESTS, X-RAY EXAMINATIONS AND IMAGING:** The services listed below are covered when they are authorized by a Physician and when they are required as the result of Injury or Illness.

1. Laboratory services, supplies, and tests are covered. This Benefit includes genetic testing.

2. Radiology services, including x-ray, MRI, CT scan, PET scan, and ultrasound imaging are covered.

K. **MATERNITY SERVICES:**

1. Maternity expenses are paid on a female Insured the same as Benefits paid on any other Illness. In no circumstance will maternity Benefits be restricted for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section. It is not necessary for a Provider to obtain authorization from the Company for a length of stay within these time limitations. Although not required, the expectant mother can 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 and postnatal care and services, including screening, are covered. 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 Child.

L. **REHABILITATIVE AND HABILITATIVE SERVICES:**

1. Physical therapy, speech therapy, and Occupational Therapy for rehabilitative purposes are covered when Medically Necessary. Services must be rendered by a Provider who is operating within the scope of their license. Treatment is limited to sixty (60) visits per Calendar Year, on a combined basis.

2. Physical therapy, speech therapy, and Occupational Therapy for habilitative purposes are covered when Medically Necessary. Services must be rendered by a Provider who is

operating within the scope of their license. Treatment is limited to sixty (60) visits per Calendar Year, on a combined basis.

3. Cardiac rehabilitation therapy, such as, but not limited to, 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 after 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 ninety (90) days after the diagnosis of pulmonary illness or surgery in order to be eligible.

5. Braces, splints, prostheses, orthotics, and orthopedic appliances are covered. Supplies or apparatuses used to support, align or correct deformities or to improve the function of moving parts are also covered. Prosthetics for artificial limbs are limited to a single purchase of a type of prosthetic device every three (3) years. This includes repair and replacement. Orthopedic shoes and shoe inserts are not eligible for coverage.

6. 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 purchased under this section.

7. Expenses for the screening for, diagnosis of, and treatment of autism spectrum disorders, for an Insured who is under the age of eighteen (18), or, if enrolled in high school, until the Insured reaches the age of twenty-two (22). Treatment must be identified in a written treatment plan consisting of diagnosis, proposed treatment by type and frequency, the anticipated duration of treatment, the anticipated outcomes stated as goals, and the reason that the treatment is Medically Necessary. Treatment must be prescribed by a licensed Physician, licensed psychologist, licensed behavior analyst or other provider that is supervised by the licensed Physician, licensed psychologist or licensed behavior analyst. Coverage consists of the following:

   (a) Medically Necessary habilitative or rehabilitative care, which means counseling, guidance and professional services and treatment programs, including, without limitation, applied behavior analysis, that are Medically Necessary to develop, maintain, and restore, to the maximum extent practicable, the functioning of the Insured.
   (b) Prescription care, which means medications prescribed by a licensed Physician and any health-related services deemed Medically Necessary to determine the need or effectiveness of the medications.
   (c) Psychiatric or psychological care, which means direct or consultative services provided by a psychiatrist or psychologist licensed in the state in which the psychiatrist or psychologist practices.
   (d) Behavioral therapy, which means any interactive therapy derived from evidence-based research, including, without limitation, discrete trial training, early intensive behavioral intervention, intensive intervention programs, pivotal response training and verbal behavior provided by a licensed psychologist, licensed behavior analyst, licensed assistant behavior analyst or autism behavior interventionist.

(e) Therapeutic care, which means services provided by licensed or certified speech pathologists, occupational therapists, and physical therapists.

M. **PREVENTIVE AND WELLNESS SERVICES INCLUDING CHRONIC DISEASE MANAGEMENT:** The services listed below are covered.

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, and iron, and tobacco cessation products, are covered. These medications must be obtained with a Prescription Order according to the guidelines set forth in the U.S. Preventive Services Task Force.

2. Immunizations that are 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 as 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 insertion or extraction of FDA-approved contraceptive devices. Benefits also include tubal ligation.

5. Other wellness services that are not set forth in the above guidelines, including well baby/child visits, routine physical examinations and check-ups are covered.

6. For female Insureds and Dependents age nineteen (19) through age twenty-six (26), routine HPV immunizations are eligible for Benefits subject to the guidelines of the Centers for Disease Control. HPV immunizations for female Insureds and Dependents who are age eighteen (18) or younger are covered under the Benefits for routine childhood immunizations as stated elsewhere in the Schedule of Benefits.

7. Prostate cancer screening tests, consisting of a PSA blood test and a digital rectal exam, are covered when ordered by the Insured's Physician or Practitioner. Benefits are subject to the following guidelines in accordance with the American Cancer Society:

   (a) Once each Calendar Year, beginning at age 50, for men who have at least a 10 year life expectancy.

   (b) Once each Calendar Year, beginning at age 45, if prostate cancer was diagnosed in a first-degree relative (father, brother, or son) before the relative's age of 65.

(c) Once each Calendar Year, beginning at age 40, if prostate cancer was diagnosed in two or more first-degree relatives (father, brother, or son) before the relative's age of 65.

8. A colonoscopy is covered, 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 (parent, sibling, or child) before the relative's age of 60, or in two or more first-degree relatives at any age.

9. A baseline mammogram for women between the ages of 35 and 40, and an annual mammogram for women 40 years of age or older is covered upon the recommendation of the Insured's Physician or Practitioner.

10. Chronic disease management services are covered.

N. **PEDIATRIC VISION SERVICES:** The services 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. Benefits include dilation, if professionally indicated, and refraction.

2. One comprehensive low vision evaluation is covered every five years.

3. One pair of prescription lenses each Calendar Year. Lenses may include single vision, conventional lined bifocal or conventional lined trifocal, or lenticular. Two pairs of glasses may not be ordered in lieu of bifocals.

4. One pair of frames each Calendar Year.

5. Contact lenses are covered once each Calendar Year. Contact lenses are in lieu of lenses and frames.

O. **PEDIATRIC DENTAL SERVICES:** The services listed below are covered for Children through the age of eighteen (18). Benefits are subject to all other Policy provisions. 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 generally accepted dental protocols. Refer to the Nevada Division of Insurance website at http://doi.nv.gov/uploadedFiles/doinvgov/_public-documents/Healthcare-Reform/NV_CheckUp_Dental.pdf for a detailed list of pediatric dental codes.

1. **General Services.**

   a. Palliative (emergency) treatment is covered. Treatment includes, but is not limited to, services to control bleeding, to relieve significant pain, to eliminate acute

infection, and procedures that are required to prevent pulpal death and/or the imminent loss of teeth.

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 post-surgical complications (e.g., dry socket) which is Medically Necessary is covered.

2. **Diagnostic and Preventive Services.**

   a. Periodic oral evaluations are covered. This Benefit includes prophylaxis and oral hygiene instruction. 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 thirty-six (36) months.

   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 per lifetime.

   e. Fixed or removable space maintainers for missing primary teeth are covered. Benefits are limited to two (2) units in a twelve-month period, and four (4) units per lifetime.

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

   a. Fillings, including amalgam and resin-based composites are covered. Benefits are limited to once per tooth every thirty-six (36) months. Restorations, including veneers, are ineligible for Benefits when they are placed for cosmetic purposes only.

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

   c. Root canals are covered. Root canals on baby teeth (pulpotomy) are limited to once every thirty-six (36) months.

   d. Periodontal scaling and root planing are limited to four units during a twelve (12) month period.

   e. 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. Stainless steel, porcelain, and metal/porcelain crowns are covered. Crowns are limited to one per tooth per lifetime.

    b. Fixed bridgework is covered. Resin-based partial dentures and complete upper and lower dentures are also covered. Replacements of bridges and dentures are eligible once every five (5) years.

    c. Implants that are Medically Necessary are covered.

5. **Orthodontic Services.** Orthodontia that is determined to be medically necessary by a dentist is eligible for Benefits. Retainers are limited to two (2) per lifetime.

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. A Physician's professional and surgical services 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 and blood plasma are covered.

5. Back and spine manipulations and modalities are covered. Benefits are limited to twenty (20) visits per Calendar Year.

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

7. Home Health Care is covered for an Insured who is homebound and who would otherwise require hospitalization. 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, including private duty nursing.

    (b) Physical therapy.

    (c) Occupational therapy.

    (d) Speech therapy.

    (e) Hospice service.

(f) Medical supplies and equipment that are suitable for use in the home.

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

Physical therapy, Occupational therapy and speech therapy are limited to the number of outpatient visits as set forth elsewhere in the rehabilitative and habilitative section of the Plan.

8. Benefits for eligible Inpatient or outpatient respite care are covered. Respite care must be provided for an Illness or Injury that is otherwise covered under the Policy.

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. Benefits for air ambulance are payable only for a life-threatening Emergency when an Insured can not be safely transported by ground ambulance.

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

11. Prompt repair that is performed by a Dentist to the extent such services are Medically Necessary by reason of damage to or loss of sound natural teeth due to Accidental Injury (other than from chewing); or for osteotomies, tumors, or cysts.

12. Circumcisions are covered if performed within thirty (30) days of birth.

13. The Plan covers treatment for inherited metabolic diseases characterized by deficient metabolism, or malabsorption originating from congenital defects or defects arising shortly after birth, of amino acid, organic acid, carbohydrate or fat. This Benefit includes enteral formulas for use at home and special food products that are prescribed or ordered by a Physician as Medically Necessary. A special food product is one that is specifically formulated to have less than one gram of protein per serving and is intended to be consumed under the direction of a Physician.

14. The Plan covers Hospital inpatient care for a period of time that is determined to be Medically Necessary by the attending Physician after a mastectomy, a lumpectomy, or a lymph node dissection.

15. The Plan covers reconstructive breast surgery resulting from a mastectomy. The Plan covers all stages of one reconstructive breast surgery on the nondiseased breast to establish symmetry with the diseased breast after definitive reconstructive breast surgery on the diseased breast has been performed.

    "Mastectomy" means the Medically Necessary surgical removal of all or part of a breast.

    For purposes of this section, the term "reconstructive surgery" shall mean a surgical procedure performed following a mastectomy on one breast or both breasts to establish symmetry between the two 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, mastectomy bras, physical complications of a mastectomy, including lymphedemas, and benefits for outpatient chemotherapy following surgical procedures.

16. 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, unless otherwise excluded as set forth elsewhere in the Policy. Eligible Generic, Brand and specialty Prescription Drugs 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. Prescribed, anticancer medications that are administered orally and that are used to kill or slow the growth of cancerous cells are paid as medical expenses and are not paid as Prescription Drug Benefits. 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 coverage for early refills of topical ophthalmic products due to inadvertent wastage by the patient, and synchronized medication packs that are dispensed by a pharmacy. 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 clinically approved prescribing guidelines and are regularly reviewed to ensure medical necessity and appropriateness of care. Prescription drugs that exceed the manufacturer's recommended dosage or the dosage 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 the following 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 requirements listed below to be acceptable.

    a) 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.
    b) 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.
    c) 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.

17. Expenses for sleep studies and expenses for the treatment of sleep apnea are covered. Treatment to diagnose and to correct snoring is not covered.

18. 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 rendered at PPO and non-PPO facilities. An invoice showing the actual cost of the Implantable Hardware must be submitted to the Company.

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

20. Benefits for the medically necessary treatment and management of diabetes are as follows.

    (a) Blood glucose monitors, including commercially available blood glucose monitors designed for patients use and for persons who have been diagnosed with diabetes.
    (b) Blood glucose monitors for the legally blind, which includes commercially available blood glucose monitors designed for patient use with adaptive devices and for person who are legally blind and have been diagnosed with diabetes.
    (c) Test strips for glucose monitors, which include test strips whose performance achieved clearance by the FDA for marketing.
    (d) Visual reading and urine testing strips, which includes visual reading strips for glucose, urine testing strips for ketones, or urine test strips for both glucose and ketones.
    (e) Lancet devices and lancets for monitoring glycemic control.
    (f) Insulin, which includes commercially available insulin preparations, including insulin analog preparations available in either vial or cartridge.
    (g) Injection aids, including those adaptable to meet the needs of the legally blind, to assist with insulin injection.
    (h) Syringes, which includes insulin syringes, pen-like insulin injection devices, pen needles for pen-like insulin devices and other disposable parts required for insulin injection aids.
    (i) Insulin pumps, which includes insulin infusion pumps.
    (j) Medical supplies for use with insulin pumps and insulin infusion pumps to include infusion sets, cartridges, syringes, skin preparation, batteries and other disposable supplies needed to maintain insulin pump therapy.
    (k) Medical supplies for use with or without insulin pumps and insulin infusion pumps to include durable and disposable devices to assist with the injection of insulin and infusion sets.
    (l) Prescription oral agents or each class approved by the FDA for treatment of diabetes, and a variety of drugs, when available, within each class.
    (m) Glucagon kits.

21. Diabetes self-management training and patient management is covered. Medical nutrition therapy is covered. Services must be medically necessary and must be prescribed by an attending physician.

22. Services for the treatment of Temporomandibular Joint Syndrome are covered. Services for upper or lower jaw augmentation, orthognathic surgery, and reduction procedures are covered. Dental services that are necessary due to an Accidental Injury are covered.

23. 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.

24. Emergency care when traveling outside of the United States is covered.

25. 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.

26. Services related to Phase I, II, III or IV of an approved trial for the prevention, detection or treatment of cancer or other life-threatening condition or disease are covered provided the services 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 widely accepted and established standards of care for a particular diagnosis.

27. Treatments for artificial insemination services for infertility are covered. Lab studies and diagnostic procedures are included in this Benefit. Benefits are limited to six (6) cycles per Insured per lifetime.

28. Bariatric surgery for extreme obesity, including complications in connection with such surgery, is covered in the following circumstances. This Benefit is limited to one (1) procedure per lifetime.

    (a) The Insured has a body mass index (BMI) of greater than 40kg/m2.
    (b) The Insured has a BMI of greater than 35kg/m2 with significant co-morbidities.
    (c) Documented evidence is provided that dietary attempts at weight control are ineffective.
    (d) The Insured has attended a medically supervised weight loss program within the last twenty-four (24) months for at least three (3) months with documented failure of weight loss.
    (e) The Insured is at least age eighteen (18).

29. Hearing aids are covered. Benefits are limited to a single purchase. Repairs and replacements are limited to once every three (3) years.

30. Health care services that are provided through telemedicine are covered. Telehealth means the delivery of services from a Provider of health care to a patient at a different location through the use of information and audio-visual communication technology, not including standard telephone, facsimile or electronic mail. 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.

31. Private duty nursing is covered when it is provided by a Hospital, an Ambulatory Service Facility, a skilled nursing facility or a Hospice care facility.

V. GENERAL LIMITATIONS AND EXCLUSIONS APPLICABLE TO ALL BENEFITS:

There are no Benefits available under this Policy for the items listed below.

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

2. Expenses that are covered by any workers' compensation law; employers' liability law (or legislation of similar purpose); occupational disease law; or for 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 created by the laws of the United States, any state, or any political subdivision of a state.

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, Illness or Injury that is caused by, or arising out of the following: riot; war; an act of war while in military, naval, or air services of any country at war; declared or undeclared war; armed aggression; or acts of aggression committed by the person 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 Illness or 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 this Policy) are not covered. This exclusion applies whether the Insured is the donor or recipient.

9. Expenses for care, treatment or operations which are performed primarily for Cosmetic purposes and expenses for complications of such procedures are not covered. This exclusion does not apply when expenses are incurred as a result of an Injury. 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: stomach stapling; gastric bypass; balloon implant; similar surgical procedure; and Prescription Drugs for the purpose of weight loss or weight control. This exclusion does not include bariatric surgery, which is 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 or genetic counseling are not covered.

13. Expenses for care or treatment of mental conditions unless and until there exists a confirmed diagnosis of Mental Illness as defined in the Policy are not covered. The diagnosis of Mental Illness must be made pursuant to a personal examination of the patient by a Provider that is licensed to make such diagnosis.

14. Expenses that are in excess of the Usual and Customary amount that is accepted as payment for the same service within a geographic area are not covered.

15. 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 for milieu therapy; modification of behavior; biofeedback; or sensitivity training are not covered.

17. Expenses for electrosleep therapy or electronarcosis are not covered.

18. Expenses for care or treatment of psychosexual dysfunction are not covered. This exclusion does not operate to deny Mental Illness care related to such condition, which is covered elsewhere in the Policy.

19. Expenses for sex change surgery or sex reassignment surgery are not covered. This exclusion does not operate to deny any services that are part of a sex reassignment surgery if those services are eligible for coverage for other insured individuals for other medical conditions.

20. Expenses for care or treatment of learning disability; developmental disorder; mental retardation; chronic organic brain syndrome; personality disorder; or for 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 required to diagnose any of the above.

21. Expenses for the alleviation of chronic intractable pain by a pain control center or in a pain control program are not covered. This exclusion applies if those expenses exceed the Usual and Customary expenses for Semi-Private room accommodations. Expenses also cannot be in excess of either one (1) hour of psychotherapy for each day or ninety minutes of group therapy for each day.

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

23. Expenses for reversal of surgically performed sterilization or resterilization are not covered.

24. Expenses for rest cures are not covered.

25. 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.

26. Expenses for Custodial Care of a physically or 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.

27. 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.

28. Expenses for services incurred for intentional self-destruction or self-Injury or any attempt at self-destruction are not covered. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical condition (including both physical and mental health conditions).

29. Expenses for an Illness or Injury resulting from the Insured's use or abuse of any illegal drug are not covered.

30. Expenses are not covered for: (1) Injuries that result directly or indirectly, in whole or in part, from the Insured operating any motorized vehicle, including watercraft, while exceeding the legal limit of intoxication; or (2) Injuries that result directly or indirectly, in whole or in part, from the Insured's abuse of Prescription Drugs not taken in accordance with a Physician's Prescription Order.

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

32. Expenses are not covered for any services or products unless the services or products are the following:

    (a) Medically Necessary.

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

34. Expenses for training, educating, or 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.

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

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

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

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

37. 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.

38. Expenses for (i) Routine Physical Examinations for Insureds which exceed the guidelines set forth in this Policy or the Schedule of Benefits; or (ii) mental examinations or psychological tests when there are no symptoms of Mental Illness.

39. Expenses for appointments scheduled and not kept are not covered.

40. Expenses for telephone consultations are not covered. This exclusion applies whether the expenses are initiated by the Insured or the Provider.

41. Expenses for the care and treatment of: teeth; gums; alveolar process; dentures; dental appliances; or supplies used in such care and treatment, are not covered except as specifically provided for by the terms of the Plan or in the Schedule of Benefits. 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.

42. Expenses for services incurred for the drainage of an intraoral alveolar abscess are not covered.

43. Expenses for charges that are incurred with respect to the eye for diagnostic procedures (including, but not limited to: eye refraction; the fitting of eyeglasses or contact lenses; and orthoptic evaluation or training) are not covered. 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 Injury (other than refractive errors of vision). Such expenses may be considered for Benefits under the Vision Policy if that coverage has been selected and premiums have been paid. This exclusion also does not apply to care that is eligible pursuant to the pediatric vision services provisions set forth elsewhere in this Plan.

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

45. Expenses for hearing examinations; cochlear implants; or any devices 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 Injury. This exclusion does not apply to hearing aids, which are covered elsewhere in the Plan.

46. 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) 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 prescribed by a Physician for a metabolic or peripheral vascular disease.

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

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

49. Expenses for acupuncture or acupressure are not covered.

50. 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.

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

52. Expenses for services, supplies, and treatment for hair loss. This exclusion includes, but is not limited to, the use of Minoxidil and Rogaine.

53. 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.

54. Expenses for autopsy procedures are not covered.

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

56. Expenses for circumcisions that are not performed within thirty (30) days of birth are not covered.

57. Expenses for massage therapy are not covered.

58. Expenses for an elective abortion are not covered. This exclusion includes any medications and Prescription Drugs that are for the purpose of causing 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.

59. Expenses that are incurred as the result of the Insured or any insured person committing a fraudulent insurance act are not covered.

60. Care that is rendered outside of the United States, except Urgent Care or Emergency care, is not covered.

61. Drugs and medicines that are available over the counter, or that do not require a Prescription Drug Order are not covered. This exclusion does not apply to contraceptive methods approved by the FDA as covered elsewhere in the preventive and wellness services provision of the Policy.

62. Expenses that result from clearly identifiable and preventable medical errors that result in death, loss of a body part, or a serious disability are not covered. Such errors include, but are not limited to, surgery on the wrong body part, the incorrect surgical procedure being performed, the retention of a foreign object in a patient after a surgical procedure, medication errors, administration of the incorrect blood type, and bedsores that are acquired in the Hospital.

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

VI. COBRA, USERRA, AND COVERAGE DURING DISABILITY:

A. **The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"):** If the Insured's Employer employs more than 20 Employees on an average business day during the previous Calendar Year, federal law provides that the Employee and/or his Dependents may be entitled to continue insurance Benefits after termination of group health benefits upon a qualifying event for specific periods of up to thirty-six (36) months. Some states also require employers with fewer than 20 employees to offer to the insured individuals continuation of their group health coverage. Your Employer can provide you with complete details of the available coverage. WMI Mutual Insurance Company does not assume responsibility for the Employer's duties under COBRA.

   COBRA continuation coverage is available upon the occurrence of any of the following qualifying events:

1. Termination of benefits.
2. Reduction of hours
3. Death of employee.
4. Employee become entitled to Medicare benefits.
5. Divorce or legal separation.
6. Dependent child ceases to be a dependent under the plan.

In the case of divorce, 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, and to send a copy of the notice to the Company. Election of the continuation coverage must be in writing within 60 days after the Employer sends notice of the right to elect continuation coverage. If 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 termination has the right to select COBRA coverage independently. A newborn Child or a Child placed for adoption during a period of COBRA continuation coverage is also eligible for coverage for the remaining period of the continuation coverage, provided that they are enrolled according to the terms of the Policy. The continuation of coverage provided by the vision and dental plans is optional when the major medical coverage is chosen.

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

Coverage may be continued for up to 18 months if group health coverage terminates due to the employee's termination of employment or reduction in hours. However, there are three exceptions:

1. If an Employee or Dependent is disabled (as determined by the Social Security Administration) at any time during the first 60 days after the date of termination of employment or reduction in hours, then the continuation period for all qualified beneficiaries is 29 months from the date of termination of employment or reduction in hours. For the 29-month continuation period to apply, written notice of the determination of disability must be provided to the Employer within both the 18-month coverage period and within 60 days after the date of the determination.
2. If a second qualifying event occurs during the 18-month or 29-month continuation coverage period which would give rise to a 36-month period for the spouse and/or Dependent Child(ren) (for example, the Employee dies or becomes divorced) then the maximum coverage period for a spouse and/or Dependent Child(ren) becomes 36 months from the date of the initial termination of employment or reduction in hours. For the 36-month continuation period to apply, written notice of the second qualifying event must be provided to the Employer 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 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 continuation coverage. All subsequent premiums are due on the first day of the month, subject to a 31-day grace period.

Continuation coverage will automatically terminate when any of the following events occurs:

1. The employer no longer provides group health coverage for any employees.
2. The premium for 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 continuation coverage period expires.

B. **The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"):** If an Insured Employee is absent from employment due to service in the uniformed services, 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. Election of the continuation coverage must be made in writing within sixty (60) days of the date of commencement of any leave for military service.

Continuation coverage will automatically terminate if the Employee fails to pay the required premium, or if the Employee loses his rights under USERRA as a result of undesirable conduct, including court-martial and dishonorable discharge.

When an Insured Employee loses coverage under the group health Plan because the Employee leaves work to perform military service, and the group health Plan is subject to COBRA, the Employee and the Employee's Dependents will be entitled to protections of both COBRA and USERRA. When the requirements of COBRA and USERRA differ, the Employee and the Employee's 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.

1. Disability related expenses: In the event 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 incurred in connection with the Injury or Illness that caused the Disability will be continued. Benefits will continue during such Total Disability until the earliest of the events that are listed below.

(a) Twelve (12) months from the date on which insurance terminated.

(b) The Employee or 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.

2. Non-Disability related expenses: Coverage for an Insured Employee and his Dependents under this section shall continue during such time as the Insured Employee or Dependent is on leave without pay as a result of a Total Disability. The coverage shall be identical to the coverage in existence prior to such Disability, except insofar as it shall exclude any Injury or Illness related to the Total Disability which is covered as set forth in this Policy. The coverage shall continue until the earliest of the following dates:

   (a) The employment of the Employee is terminated;

   (b) The Employee or Dependent obtains another policy of health insurance;

   (c) The group Policy of insurance is terminated; or

   (d) The expiration of a period of twelve (12) months.

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

A. COORDINATION OF BENEFITS:

1. This Coordination of Benefits ("COB") provision applies to this Plan when an Insured also has health care coverage or pediatric dental care coverage under another plan such as:

   (a) Group insurance or group-type coverage, whether insured or uninsured, prepaid plans, group practice or individual practice coverage, or an individual health insurance policy. This also includes coverage for students other than school Accident-type coverage, or HMO plans; or

   (b) Coverage under a governmental plan required or provided by law, except a state plan under Medicaid or under any plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.

2. In the event benefits apply under two or more health care plans, the order of benefit determination rules should be consulted and the following provisions shall apply:

   (a) The Benefits under this Plan shall not be reduced when, under the order of benefit determination rules, this Plan determines Benefits before another health care plan, but may be reduced when, under those rules, another health care plan determines its benefits first, whether or not a claim is made under the other health care plan.

(b) If the other health care plan does not contain a coordination of benefits provision, the benefits of that coverage will be determined before any Benefits under this Plan are determined.

(c) If the other health care plan contains a coordination of benefits provision, the rules establishing the order of benefit determination are as follows:

1. The benefits of the health care plan which covers the person (to whom the claims relate) as other than a Dependents shall be determined before the benefits of a health care coverage which covers such a person as a Dependent.

2. When a Child(ren) is a patient and where the parents are not separated or divorced, the benefits of the health care plan of the parent whose birthday, that is, month and day of the month, falls earlier in a year are determined before those of the health care plan of the parent whose birthday falls later in the year.

   NOTE: If the other health care plan does not have a coordination of benefits rule based on the parents' birthdays, but instead has a rule based upon the gender of the parent, and if, as a result, it and this Plan do not agree on the order of benefits, the rule in the other health care plan will determine the order of benefits.

3. When a Child(ren) is a patient and where the parents are separated or divorced, the following rules apply:

   a. benefits are determined first by the health care plan of the parent with custody of the Child(ren);

   b. then by the health care plan of the Spouse (if any) of the parent with custody of the Child(ren); and

   c. finally, by the health care plan of the parent not having custody of the Child(ren)

   NOTE: If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the Child(ren), and the entity obligated to pay or provide the benefits of the health care plan of that parent has actual knowledge of those terms, the benefits of that health care plan are determined first. This does not apply with respect to any claim determination period or year during which benefits are actually paid or provided before the entity has that actual knowledge. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the Child, the order of benefit determination rules outlined in Section VII, A(2)(c)(2) shall apply.

4. When the person (to whom the claim relates) is an Employee who is laid off or retired, or is a Dependent of such an Employee, the benefits of the other health care plan shall be determined before those of this Plan. If the other health care

plan does not have this rule, and if, as a result, there is not an agreement between this Plan and the other health care plan on the order of benefits, this rule is ignored.

5. If the individual is insured under two health plans where none of the above applies, the benefits of the plan which has covered the individual for the longer period of time shall be determined first.

6. If the other plan is for pediatric dental care, that plan is the primary plan and this plan is always secondary.

(d) Overpayment: In the event the Company provides Benefit payments to the Insured or on his behalf in excess of the amount which would have been payable by reason of coverage under another health care coverage, the Company shall be entitled to recover the amount of such excess from one or more of the Insured Employee or the Insured Dependent, including from future claim payments due for services incurred by the Insured or any Insured member of the Insured's family, without regard to the identity or nature of the Provider of care, insurance companies, or other organizations.

NOTE: A health care plan, as listed above, which provides benefits in the form of services may recover the reasonable cash value of providing those services, if applicable under the above rules, to the extent that Benefits are for Covered Services and have not already been paid or provided by this Plan.

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

1. The Company shall be entitled to the proceeds of any settlement or judgment that results in a recovery from the third party. This recovery shall be up to the amount of Benefits that is paid for the Illness or Injury. The Company's rights of recovery can only be enforced after the Insured has been made whole for his Injuries or Illness.

2. If the Insured does not seek recovery from the responsible third party, the Insured shall hold the rights of recovery against the third party in trust for the Company. The rights of recovery held in trust shall be up to the amount of Benefits paid in connection with the Illness or Injury.

3. The Company shall pay out of such proceeds that are actually recovered a proportionate share of any reasonable expenses incurred in collecting from the third party.

4. Receipt by the Insured, or on behalf of the Insured, of any Benefits in connection with the Illness or Injury shall constitute the Insured's unconditional agreement to each and all of the provisions set forth in this Plan.

C. **PERSONS COVERED BY MEDICARE:**

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

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

(c) The time period required by federal law 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 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 Benefits only after Medicare has paid its benefits in the following situations.

(a) For all other Insured persons.

(b) After the time period required by federal law 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 applicable rate for each person based on the classifications as determined by the premium rates in effect on such premium due date. The applicable rates are available from the Company upon request.

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

1. On any premium renewal due date by giving written notice to the group Policyholder at least sixty (60) days prior to such premium due date.

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

Premiums may also be computed by any method that is mutually acceptable to the Company and the Policyholder. Any alternative method must produce approximately 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. The payment of any premium shall not maintain the insurance under this Plan in force beyond the day immediately preceding the next due date except as otherwise provided herein.

C. **GRACE PERIOD:** A grace period of thirty-one (31) days will be allowed for payment of any premium due unless the Policyholder gives 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. 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 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 unpaid. That amount shall include a *pro rata* premium for the period that commences with the last premium due date and ending with such date of termination.

   This Plan may also terminate immediately if the Employer has performed an act or practice that constitutes fraud, or has made an intentional misrepresentation of material fact under the terms of the coverage.

E. **RECORD OF EMPLOYEES INSURED:** The Company shall maintain a record which shall show at all times the names of all Insured Employees, the beneficiary 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 Policyholder that may have a bearing on this insurance shall be open for inspection by the Company at a reasonable time.

F. **EMPLOYEE'S 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 to the Policyholder to deliver to each individual Insured Employee. The Company may also deliver the Certificate directly to the Insured Employee. The Certificates shall describe the Policy Benefits and to whom 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 of insurance 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 Provider. This Plan will have no affect on the relationship of the patient and Provider.

H. **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, made by an Insured or a representative of an Insured, 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, request for further information or denial, as well as specific time periods for appeal reviews. Time periods begin at the time that a claim is filed, and "days" refers to calendar days.

Pre-Service Claim

A pre-service claim is any claim for a benefit under the plan where the plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care (*i.e.*, claims subject to pre-certification). In the event of a pre-service claim, the Insured will receive a notification of the benefit determination within fifteen (15) days after the receipt of the request. If additional information is needed, the Insured will be notified within that time and 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 there is an ongoing course of treatment (*i.e.*, concurrent care), a notification of determination as to extending the course of the treatment will be sent within fifteen (15) days after receipt of the request. If there will be a reduction or termination of the previously approved concurrent care benefit before the end of the treatment period, a notification will be sent at least fifteen (15) days prior to the end of the treatment.

Although recommended, Pre-certification for pre-service claims involving Urgent Care is **not** required. However, once the care is no longer Urgent Care, Pre-certification requirements will apply and the pre-service claim will be subject to the time periods as described above.

Post-Service Claim

A post-service claim is any claim that involves the cost for medical care that has already been provided to the insured. Post-service claims will never be considered to be claims involving 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. If additional information is needed, the Insured will be notified within that time and 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 denial, reduction, termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including 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. The plan will provide written or electronic notification that sets forth the reason for the adverse benefit determination.

Appeals

In the event of an adverse benefit determination, the Insured has 180 days from the receipt of the adverse benefit determination notification in which to file an appeal. An Insured may submit comments, documents, records and other information relating to the claim, and will, upon request, be provided free of charge, access to, and copies of, all documents, records, and other information relevant to the claim that were used in the initial benefit determination. The Company provides two levels of appeal review, which may be performed either internally or independently, as described herein. Both of these levels must be exhausted before an Insured can file suit in court. If an Insured receives an adverse decision on the first level of appeal, he may submit the appeal for a second level of review within sixty (60) days of receipt of the first level decision, along with any additional applicable information. 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. 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.

For pre-service claims, both levels of appeal must be submitted in writing to the utilization review company that performed the Pre-certification and a copy must be submitted to the Company. For post-service claims, both levels of appeal must be submitted in writing to the Company. The benefit determination on review will be communicated in writing and will set forth the reasons for the decision and the provisions of this Plan upon which the decision was based.

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 who is neither the individual who made the initial adverse benefit determination nor the subordinate of that individual. The time period within which a determination on appeal is required to be made will begin at the time that an appeal is filed.

If the appeal of an adverse benefit determination is based on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, an independent review will be conducted. For this review, the plan will consult with an independent health care professional, who is not affiliated with the Company, who was not involved in the initial benefit determination, and who has appropriate training and expertise in the field of medicine involved in the medical judgment. There will be no fee charged to the Insured for an independent review.

If an Insured receives an adverse decision upon the exhaustion of both of the required levels of internal or independent review, he has the right to file suit in court pursuant to §502 of the Employee Retirement and Income Security Act ("ERISA").

Independent External Review

If the Company issues a final adverse benefit determination of an Insured's request to provide or pay for a health care service or supply, he may have the right to have the decision reviewed by health care professionals who have no association with the Company. An Insured has this right only if the denial decision involved:

- The medical necessity, appropriateness, health care setting, or level of care or effectiveness of a health care service or supply, or
- The determination the health care service or supply was experimental or investigational.

An Insured must first exhaust the Company's internal grievance and appeal process. Exhaustion of that process includes completing all levels of appeal, or unless the Insured requested or agreed to a delay, the Company's failure to respond to a standard appeal within 30 days in writing. The Company may also agree to waive the exhaustion requirement for an external review request.

A request for an external review must be submitted to:

Office for Consumer Health Assistance
555 E. Washington Avenue, Suite 4800
Las Vegas, NV 89101

An Insured may also call the Office for Consumer Health Assistance for help at (702) 486-3587 or (888) 333-1597.

An Insured may represent himself in his request or he may name another person, including his treating health care provider, to act as his authorized representative for his request.

An Insured's external review request must include a completed form authorizing the release of any of his medical records the independent review organization ("IRO") may require to reach a decision on the external review.

If an Insured's request qualifies for external review, the Company's final adverse benefit determination will be reviewed by an IRO selected by the Office for Consumer Health Assistance. The Company will pay the costs of the review.

The decision of an IRO concerning a request for external review must be based on: (a) documentary evidence, including any recommendation of the physician of the Insured; (b) medical or scientific evidence, including, without limitation: (i) professional standards of safety and effectiveness for diagnosis, care and treatment that are generally recognized in the United States; (ii) any report published in literature that is peer-reviewed; (iii) evidence-based medicine, including, without limitation, reports and guidelines that are published by professional organizations that are recognized nationally and that include supporting scientific data; and (c) the terms and conditions for benefits set forth in the Policy.

For the purposes of this section, "Medical or Scientific Evidence" means evidence found in the following sources:

1) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
2) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Library of Medicine of the National Institutes of Health for indexing in Index Medicus (MEDLINE) and Elsevier for indexing in Excerpta Medica (EMBASE);
3) Medical journals recognized by the Secretary of Health and Human Services pursuant to section 1861(t)(2) of the Social Security Act, 42 U.S.C. § 1395x;
4) The following standard reference compendia:
    a) AHFS Drug Information published by the American Society of Health-System Pharmacists;
    b) Drug Facts and Comparisons published by Wolters-Kluwers Health;
    c) Accepted Dental Therapeutics published by the American Dental Association; and
    d) The United States Pharmacopoeia's Drug Quality and Information Program;
5) Findings, studies or research conducted by or under the auspices of the Federal Government and nationally recognized federal research institutes, including, without limitation:
    a) The Agency for Healthcare Research and Quality;
    b) The National Institutes of Health;
    c) The National Cancer Institute;
    d) The National Academy of Sciences of the National Academies;
    e) The Centers for Medicare and Medicaid Services;
    f) The Food and Drug Administration; and
    g) Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or
6) Any other source of medical or scientific evidence that is comparable to the sources listed in subsections 1 to 5 above, inclusive.

Standard External Review Request for Adverse Benefit Determinations involving Medical Necessity: An Insured, an authorized representative, or the physician of the Insured, must file a written external review request within four months after the date the Company issues a final notice of denial.

Within five business days after receiving an Insured's request for external review, the Office for Consumer Health Assistance ("OCHA") shall notify the Insured, the authorized representative or the physician of the Insured, and the Company that the request has been filed.

As soon as practicable after receiving the request, the OCHA shall assign an IRO to conduct the review. Within five business days after receiving notification that an IRO has been assigned, the Company shall provide to the IRO all documents and materials relating to the adverse determination. Within five days after receiving the documents and materials, the IRO shall notify the Insured, the physician of the Insured, and the Company if any additional information is required to conduct the external review.

Within 15 days after receipt of the information necessary to make a determination, the IRO shall approve, modify or reverse the adverse determination. The IRO shall submit a copy of its determination, including the reasons therefore, to the Insured, the physician of the Insured, to the authorized representative of the Insured, if any, and to the Company.

Expedited External Review Request for Adverse Benefit Determinations involving Medical Necessity: The OCHA shall approve or deny a request for an external review of an adverse benefit determination in an expedited manner not later than seventy-two (72) hours after it receives proof from the provider of health care of the Insured that:

1. The adverse benefit 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; or
2. Failure to proceed in an expedited manner may jeopardize the life or health of the Insured or the ability of the Insured to regain maximum function.

If the OCHA approves a request for external review, it shall assign the request to an IRO not later than 1 business day after approving the request. Within twenty-four (24) hours after receiving notice of the OCHA assigning the request, the Company shall provide to the IRO all documents and materials relating to the adverse benefit determination. The IRO shall complete its external review not later than forty-eight (48) hours after receiving the assignment, unless the Insured and the Company agree to a longer period. Within twenty-four (24) hours after completing the review, the IRO shall notify the Insured, the physician of the Insured, the authorized representative, if any, and the Company by telephone, of its determination, and shall submit a written decision of its external review not later than forty-eight (48) hours after completing the review.

Standard and Expedited External Review Request for Adverse Benefit Determinations involving Experimental/Investigational Services or Treatment: An Insured, an authorized representative, or the physician of the Insured, must file a request for external review within four months after the date the Company issues a final notice of denial. A request for standard external review must be filed in writing. A request for an expedited external review may be filed in writing or may be filed orally if the Insured's treating physician certifies, in writing, that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

Within one business day after receipt of the request for a standard review (immediately in the case of an expedited review), the OCHA shall notify the Company. Within five business days after receipt of the notice from the OCHA (immediately in the case of an expedited review), the Company shall conduct and complete a review of the request to determine whether:

1. The individual is or was an Insured in the health benefit plan at the time the health care service was recommended or requested or, in the case of a retrospective review, was an Insured in the health benefit plan at the time the health care services or treatment was provided;

2. The recommended or requested health care service or treatment that is the subject of adverse benefit determination: (a) would be a covered benefit under the health benefit plan but for the Company's determination that the health care service or treatment is experimental or investigation for a particular medical condition; and (b) is not explicitly listed as an excluded benefit under the health benefit plan;
3. The Insured's treating physician has certified that one of the following situations is applicable: (a) standard health care services or treatments have not been effective in improving the Insured's condition; (b) standard health care services or treatments are not medically appropriate for the Insured; or (c) there is no available standard health care service or treatment covered by the Company that is more beneficial than the recommended or requested health care service or treatment;
4. The Insured's treating physician: (a) 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 services or treatments; or (b) who is a licensed, board certified or board eligible physician 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 health care service or treatment requested is likely to be more beneficial to the Insured than any available standard health care services or treatments;
5. The Insured has exhausted the Company's internal grievance process, unless the Insured is not required to exhaust the Company internal grievance process; and
6. The Insured has provided all the information and forms required to process the review.

Within one business day after completion of the eligibility review, the carrier shall notify the OCHA and the Insured in writing whether the request is complete and whether the request is eligible for independent review. If the request is not complete, the carrier shall inform the Insured and the OCHA in writing what information or materials are needed to make the request complete. If the request is not eligible for independent review, the carrier shall inform the Insured and the OCHA in writing the reasons for ineligibility and shall inform the Insured that the determination may be appealed to the OCHA.

Within one business day after receipt of the notice from the Company that the external review request is eligible, the OCHA shall assign an IRO, shall notify the Company of the name of the IRO, and shall notify the Insured, in writing, that the Insured may submit in writing to the IRO any additional information that the IRO shall consider when conducting the review. Within one business day after receipt of the request, the IRO shall select one or more clinical reviewers to conduct the review. Each clinical reviewer shall provide to the IRO a written opinion within twenty (20) calendar days (within five calendar days for an expedited review). The IRO shall make a decision based on the clinical reviewer's opinion within twenty (20) calendar days (within forty-eight (48) hours for an expedited review) of receiving the opinion and shall notify the Insured, the Company, and the OCHA. Upon receipt of a notice reversing the adverse benefit determination, the Company shall within one business day approve the coverage that was the subject of the adverse benefit determination.

Binding Nature of the External Review Decision: If the Insured's plan is subject to federal ERISA laws (generally, any plan offered through an employer to its employees), the external review decision by the IRO will be final and binding on the Company. The Insured may have additional review rights provided under federal ERISA laws.

I. **CONFORMITY WITH LAW:** If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

J. **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 the earnings required to maintain minimum compulsory surplus required by law. Earnings is defined as the excess of earned revenue over incurred Benefits and expenses using statutory accounting methods that are prescribed or 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 advisable to return the surplus earning to the Policyholders. The method and timing of the refund is determined by the Company's Board of Directors. To be eligible to participate in the refund, a participating Employer must be a Policyholder at the time the refund is made.

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

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

M. **ENTIRE CONTRACT:** This Plan and all attachments hereto, including the applications of the Policyholder and Insured Employees constitute the entire contract between the parties. All statements made by the Policyholder and the Insured Employees and Dependent(s) shall, in the absence of fraud, be deemed representations and not warranties. No statement made by an Insured Employee or Dependent will 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.

N. **AMENDMENT AND ALTERATION OF CONTRACT:** This Plan may be amended at any time, subject to the laws of the jurisdiction in which it is delivered. The Plan may be amended by written agreement between the Policyholder and the Company without the consent of the Insured Employees or their beneficiaries. This Plan may also be amended on the Plan's renewal date 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 to waive any provision thereof.

O. **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 the 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 so 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.

P. **EXAMINATION:** The Company shall have the right and opportunity to have an independent medical evaluation of the medical, dental or chiropractic care conducted on the person of any individual whose Injury or Illness is the basis of a claim when and so often as it may reasonably require during pendancy of the claim. Such evaluation may only be conducted by a Physician, dentist or chiropractor who is certified to practice in the same field of practice as the primary treating Physician, dentist or chiropractor or who is formally educated in that field. Such evaluation will include a physical examination and a personal review of all x-rays and reports prepared by the primary treating Physician, dentist or chiropractor. A certified copy of all reports of findings will be sent to the primary treating Physician, dentist or chiropractor and the Insured with ten (10) working days after the evaluation. If a dispute arises concerning the findings of an independent medical evaluation, the Insured may submit an appeal for binding arbitration to the Company within thirty (30) days after receiving the findings of the evaluation. The appeal shall be subject to the arbitration rules of the American Arbitration Association.

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.

Q. **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 remains 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 Employee's 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.

R. **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 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.

S. **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.

T. **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 unless brought within three (3) years from the expiration of the time within which proof of loss is required by the Plan.

U. **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.

V. **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.

The Company shall have the sole discretion to construe and interpret the terms and provisions of the Plan and to determine eligibility for benefits. Nothing in the foregoing statement limits the rights of the Insured to protections under the federal law known as ERISA, including, but not limited to, rights of appeal and rights to bring suit in state or federal court.

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 services for a non-preferred provider will be processed according to the usual and customary rate and will be reimbursed at a lower percentage level.

If there is a service which a Preferred Provider of this Plan does not provide, and the Provider who is treating the Insured requests the service, and the Company determines that the use of the service is necessary for the health of the Insured, the service shall be deemed to be provided by a Preferred Provider under the Plan and Benefits will be provided accordingly. If an Insured is confined in a facility which is a Preferred Provider of health care at a time when the facility terminates its agreement with the insurer, or if an Insured obtains confirmation that a Provider is a Preferred Provider and the Provider subsequently terminates its Preferred Provider status, coverage will be provided for the period of confinement at the rate negotiated for that Provider before it terminated its agreement and at no additional cost to the Insured. It is the Insured's responsibility to verify whether a Provider of health care is a Preferred Provider of health care.

X. **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.

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

Z. **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, that 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.

IX. PRIVACY POLICY

We at WMI Mutual Insurance Company respect the privacy 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.

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

- **Disclosure of Information.** We may disclose your personal information to agents, health care providers, or service providers that perform business functions on our behalf. Examples of these types of functions are claims processing and utilization management. We obtain assurances from our service providers that they will also protect the privacy of your information. Personal information regarding a spouse or dependent children will also 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 will not disclose your PHI outside of our normal business functions unless we first obtain a written authorization from you.

- **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, or 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, and must be filed within 180 days of the known date of violation. You will not be retaliated against for filing a complaint.

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