ARIZONA GROUP HEALTH INSURANCE
CERTIFICATE BOOKLET

WMI Mutual Insurance Company

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

"Accident" or **"Accidental Bodily Injury"** means a specific, a sudden, and an unexpected event that occurs by chance and that results in bodily strain or harm.

"Actively at Work" and **"Active Work"** means being in attendance in person at the usual and customary place or places of business and acting in the performance of the duties of the Employee's occupation on a full-time basis devoting full efforts and energies thereto. An Employee shall be deemed to be Actively at Work on each day of a regular paid vacation if he/she was Actively at Work on the last preceding regular work day. An Employee shall also be deemed to be Actively at Work on any day in which he/she is absent from work due to a health factor, for a period not to exceed twelve (12) weeks, if he/she was Actively at Work on the last preceding regular work day.

"Alcohol/Substance Abuse Dependency Treatment Center" means a treatment facility that is licensed or that is 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 any publicly or privately owned ground, water or air vehicle, including a helicopter, that contains a stretcher and necessary medical equipment and supplies, and that is especially designed and constructed or modified and equipped to be used, maintained or operated primarily for transportation of individuals who are sick, injured or wounded or who require medical monitoring or aid. Ambulance does not include a ground vehicle that is owned or operated by a sole proprietor, partnership, private corporation or municipal corporation for the emergency transportation and in-transit care of its employees, or a vehicle that is operated to accommodate an incapacitated person or person with a disability who does not require medical monitoring, care or treatment during transport and that is not advertised as having medical equipment and supplies or Ambulance attendants.

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

"Benefits" means the payments or the application of Eligible Charges towards Deductible and Out-of-Pocket amounts that are provided for Covered Services for the Insured Employee or the Insured Dependent(s) under this Plan.

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

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

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

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

"Company" means the WMI Mutual Insurance Company.

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

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

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

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

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

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

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

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

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

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

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

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

(a) The lawful Spouse of an Insured Employee.

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

(c) An unmarried Child who has reached the limiting age for termination of coverage, who is incapable of self-sustaining employment by reason of intellectual Disability or physical Disability, who became so incapable prior to attainment of the limiting age, and who is chiefly dependent upon the Employee for support and maintenance. Proof of such Disability must be submitted within thirty-one (31) days of such Dependent's attainment of the limiting age and subsequently as may be required, but not more frequently than annually after the two-year period following the Child's attainment of the limiting age.

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

"**Durable Medical Equipment"** is Medical Equipment that meets all of the following requirements listed below.

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

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

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

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

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

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

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

"Emergency" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: 1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

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

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

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

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

"Family Deductible" means two (2) times the individual Deductible amount. Each family member may only contribute his individual Deductible amount to the satisfaction of the Family Deductible amount. An individual will not have to satisfy his Deductible amount once the Family Deductible has been satisfied.

"Family Out-of-Pocket" means two (2) times the individual Out-of-Pocket amount. No individual family member may contribute more than one-half of the Family Out-of-Pocket maximum. Only eligible Deductible and co-insurance amounts that are paid by the Insured during the Calendar Year will be applied toward the satisfaction of the Out-of-Pocket maximum. Amounts that are paid for care or treatment that is not covered do not apply toward the Out-of-Pocket maximums.

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

"Habilitative Services" means health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services include, but are not limited to, physical and occupational

therapy, speech-language pathology and other services for people with disabilities which may be provided in a variety of Inpatient and/or outpatient settings as prescribed by a Physician.

"Home Health Care" means services that are provided by a licensed home health agency to an Insured in his place of residence. These services are prescribed by the attending Physician of the Insured as part of a written plan of care. Services provided by Home Health Care include: nursing, home health aide services, physical therapy, occupational therapy, respiratory therapy, speech therapy, and medical supplies, drugs, medicines, and laboratory services, to the extent that they would have been covered if provided on an inpatient Hospital basis.

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

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

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

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

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

"Hospital" means a facility which is licensed and accredited by the Joint Commission for Accreditation of Hospitals ("JCAH"), which operates within the scope of such license. Such facility must make use of at least clinical, laboratory, diagnostic x-ray services. Such facility must also make use of 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 that results from a disease, a sickness, or a 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 law or occupational disease law.

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

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

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

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

"Medically Necessary" means any services for health care, supplies, or accommodations provided to the Insured for treatment of Illness or Injury. Such services must meet all of the following.

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

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

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

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

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

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

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

"Mental Health Care Practitioner" means an individual who is licensed by the state as a Physician or a surgeon, or an osteopathic Physician and who is engaged in the practice of mental health therapy; a psychiatrist; an advanced practice registered nurse, specializing in psychiatric mental health nursing; a psychologist who is 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 that are listed in the Diagnostic and Statistical Manual, as periodically revised. Refer to the Exclusions section of the Policy for mental conditions or disorders that are not eligible for Benefits.

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

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

"Open Enrollment" means the thirty (30) day period that is chosen by the Employer 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 the first day of the month following the Open Enrollment period. If the Employer fails to choose an Open Enrollment period, the default Open Enrollment period will be the month of December. An Employee or a Dependent who waives insurance coverage during the Open Enrollment period must wait until the next Open Enrollment period to enroll in the insurance Plan.

"Out-of-Pocket" means the maximum dollar amount per year of Eligible Charges that are payable by an Insured to Providers. 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.

"Owner" means an owner, a partner or a proprietor of the Policyholder.

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

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

"Policyholder" means the Employer.

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

"Pre-certification" means the determination that being confined in a Hospital is Medically Necessary and that the proposed length of stay is appropriate. **Pre-certification does not guarantee the payment of claims. Pre-certification also does not determine whether Benefits are eligible.** 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 or which is restricted to prescription dispensing by state law. A Prescription Drug must bear the legend "Caution, Federal Law Prohibits Dispensing Without a Prescription" or other similar type of wording. The term Prescription Drug **does not** include insulin, diabetic testing equipment, supplies for insulin, and Prescription Drugs for genetic inborn errors of metabolism, which are covered elsewhere in the Policy.

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

"Private Room" means a Hospital room containing one bed.

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

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

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

(a) Resident beds or residential units.

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

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

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

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

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

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

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

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

"Special Enrollment" means an enrollment period, other than the initial enrollment period of the Employer or the 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.

"Telemedicine" means the interactive use of audio, video or electronic media for the purpose of diagnosis, consultation or treatment. Telemedicine does not include the sole use of an audio-only telephone, a video-only system, a facsimile machine, instant messages or electronic mail.

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

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

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

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

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

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

B. **Eligibility Date for Newly Hired Employees:** Newly hired Employees are eligible to participate in this Plan on the dates listed below.

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

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

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

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

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

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

1. Employees who declined participation in the Plan when they were first eligible because they maintained other health insurance 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, for whom the application and approval procedures for adoption pursuant to A.R.S. 8-105 and 8-108 have been completed, 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 by a qualified medical child support order ("QMCSO") to have a right to enrollment under a group health plan with respect to such Employee, outside of the Open Enrollment period. If the medical child support order is determined by the Company to be a "qualified" order, the effective date of the coverage for the alternate recipient will be the first day of the first month following

the date of determination. A copy of the QMSCO procedures for this Plan may be obtained free of charge, upon request.

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

G. **Maintenance of Group Eligibility:** The Company requires that 100% of all of the Employees participate if there are three (3) or less Employees that are eligible for the insurance. The Company requires that 75% 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:** Coverage for an Employee will terminate on the earliest of the dates that follow.

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

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

3. The insurance for an Employee under this Plan may terminate immediately if he/she has performed an act or practice that constitutes fraud. The insurance for an Employee under the Plan may also be terminated if he/she has made an intentional misrepresentation of material fact under the terms of the coverage. The Company will give a 30-day advance notice to the Insured prior to such rescission or termination. Any person who knowingly presents a false or fraudulent claim for payment of a loss or a 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 coverage for a Dependent shall automatically terminate on the earliest of the dates that follow.

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

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

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

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

5. The insurance for a Dependent under this Plan may terminate immediately if he/she has performed an act or practice that constitutes fraud. The insurance for a Dependent may also be terminated if he/she has made an intentional misrepresentation of material fact under the terms of the coverage. The Company will give a 30-day advance notice to the Insured prior to such rescission or termination. Any person who knowingly presents a false or fraudulent claim for payment of a loss or a 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 death of the Employee.

2. If an Employee's covered Dependent is incapable of self-support because of intellectual Disability 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 in the Claim and Appeals Procedures section as set forth elsewhere in the Policy.

1. **Inpatient Hospital Services**. A Semi-private Room is eligible for Benefits. A room for intensive care is also eligible. Supplies that are related to the stay are eligible if they are medically necessary. A Private Room and a private duty nurse are covered if they are medically necessary. A long term acute care/subacute care Hospital is eligible for Benefits. A skilled nursing facility may provide the treatment instead of an Inpatient Hospital. Professional services and prescriptions that are filled in the skilled nursing facility pharmacy are eligible. The plan limits skilled nursing facility services to ninety (90) days in each Calendar Year.

2. **Inpatient Mental Illness Care, including residential treatment**. The treatment must be rendered in a licensed facility, such as, but not limited to, a psychiatric special hospital, a Residential Care Facility/Institution or a general Hospital. Mental health care that is rendered must also meet all other criteria for eligibility. The treatment is subject to all of the other terms and provisions of the Policy. The treatment that is eligible includes the following: (a) partial hospitalization/day treatment; (b) psychiatric assessment; (c) psychotherapy and psychotherapeutic counseling; (d) electroshock convulsive therapy; (e) psychological testing and neuropsychological testing; (f) behavioral health treatment; (g) behavioral health counseling and therapy; and (h) management of medication.

3. **Inpatient Alcohol Dependency or Substance Abuse Treatment, including residential treatment**. The treatment must be rendered in a licensed facility, such as, but not limited to, a psychiatric special hospital, a Residential Care Facility/Institution or a general Hospital. The treatment that is rendered must also meet all other criteria for eligibility. The treatment is subject to all of the other terms and provisions of the Policy. The treatment that is eligible includes the following: (a) partial hospitalization/day treatment; (b) psychiatric assessment; (c) psychotherapy and psychotherapeutic counseling; (d) electroshock convulsive therapy; (e) psychological testing and neuropsychological testing; (f) behavioral health treatment; (g) behavioral health counseling and therapy; and (h) management of medication.

4. **Inpatient Detoxification.** Eligible services include detoxification and related medical ancillary services when required for the diagnosis and treatment of addiction to alcohol and/or drugs. Eligible services also include medication management.

5. **Inpatient Extended Care Facility/Rehabilitation Care Facility**. The eligible amount for the daily room charge incurred at an Extended Care or a 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. 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, including a facility fee, will be paid as set forth in the Schedule of Benefits. Outpatient services, supplies and treatment that are provided by an Ambulatory Service Facility, including a facility fee, 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. Eligible treatment includes psychiatric assessment, psychotherapy, psychotherapeutic counseling, electroshock convulsive therapy, psychological and neuropsychological testing, behavioral health treatment, behavioral health counseling and therapy, and medication management.

D. **OUTPATIENT ALCOHOL DEPENDENCY OR SUBSTANCE ABUSE TREATMENT:** Eligible outpatient treatment must be rendered by a Provider, by a 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. **OUTPATIENT DETOXIFICATION.** Eligible services include detoxification and related medical ancillary services when required for the diagnosis and treatment of addiction to alcohol and/or drugs. Eligible services also include medication management.

F. **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 allowance for the primary surgeon. That amount will be split equally between the primary surgeon and the co-surgeon.

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

4. Multiple or Bilateral Surgical Procedures. The value of the major procedure plus 50% of the value of the lesser procedure will be allowed when multiple or bilateral surgical procedures which add significant time or complexity to patient care are performed at the same time and through the same incision. The value of the major procedure plus 75% of the value of the lesser procedure will be allowed when multiple procedures are performed through separate incisions or in separate sites. Incidental procedures are procedures that are considered to be an integral part of another procedure. An additional Benefit is not warranted for those types of procedures.

G. **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. The services of a nurse anesthetist who is not employed by the Hospital and who bills for services that are provided are also covered. The services of a nurse anesthetist are covered only if they are Medically Necessary and if a Hospital employee or a Physician is unavailable.

H. **PHYSICIAN SERVICES:**

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

2. **Physician Consultations:**

   (a) The Plan covers Hospital Visits by a Physician if the Employee or the Dependent is confined in a Hospital. Hospital Visits by a surgeon after a surgical procedure takes place are considered to be an integral part of such procedure. Such Visits do not warrant a separate Benefit.

   (b) Consultations are covered if they are requested by the attending Physician or another appropriate Provider.

   (c) 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 surgical service of the Hospital for the same condition but under the care of another Physician, is entitled to Hospital Physician Benefits from both Physicians prior to a surgical procedure taking place. Hospital Visits by a surgeon after the surgical procedure takes place are considered to be an integral part of such procedure. Such Visits do not warrant a separate Benefit. This does not apply if the surgery performed is diagnostic, is a myelogram, or is 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 services provided by the additional Physician will be covered if they are Medically Necessary.

I. **HOSPICE CARE:** All services that are provided by a Hospice if: (a) the charge is incurred by an Insured person who is diagnosed by a doctor as terminally ill with a prognosis of six months or less to live; and (b) services are provided under an approved program for Hospice care.

Hospice Care includes: (a) services and supplies that are furnished by a Home Health agency or a licensed Hospice, including Custodial Care; (b) palliative and supportive medical and nursing services; and (c) the services of a psychologist, of a social worker or of a family counselor for individual and for family counseling.

Hospice care may be provided in a Hospital, a skilled nursing facility or similar institution, a Home Health care agency, a Hospice facility, or any other licensed facility or agency under a Medicare approved Hospice care program.

J. **ORGAN TRANSPLANTS:**

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

    (a) Heart.
    (b) Arteries.
    (c) Veins.
    (d) Intra-ocular lenses.
    (e) Corneas.
    (f) Kidneys.
    (g) Skin.
    (h) Tissues.
    (i) Heart/lung combined.
    (j) Liver.
    (k) Small bowel/liver.
    (l) Kidney/liver.
    (m) Lung (single or double).
    (n) Pancreas.
    (o) Kidney/pancreas.
    (p) Bone marrow, stem cell rescue, stem cell recovery, any and all other procedures that involve bone marrow or bone marrow components as an adjunct to high dose chemotherapy. This includes services that are related to any evaluation, treatment or therapy 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. "Myeloablative Chemotherapy" means a dose of chemotherapy which is expected to destroy the bone marrow. "Autologous Hematopoietic Stem Cell" means an infusion of primitive cells that are capable of replication and differentiation into mature blood cells which are harvested from the blood stream or bone marrow of the Insured prior to the administration of the myeloablative chemotherapy. "Colony Stimulating Factor" means a substance which increases the reproduction, differentiation, and maturation of blood cellular components.

    All organs for transplants must be natural body organs. Artificial organs or any mechanical or electronic organs of any type are not eligible for Benefits. This exclusion does not apply to intra-ocular lens implants.

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

3. Benefits include travel (to and from the transplant site), daily lodging (while at or while traveling to the transplant site), and daily meals (while at or while traveling to the transplant site). Transportation to and from the transplant site includes charges for a rental car used during a period of care at the transplant facility. Transportation to and from the transplant site in a personal vehicle will be reimbursed at 37.5 cents per mile when the transplant site it more than 60 miles one way from the Insured's home. Travel Benefits are available during evaluation, candidacy, the transplant event and post-transplant care. This Benefit is only for the recipient and for one companion. The term companion includes a spouse, a family member, a legal guardian, or any person who is not related to the recipient but who is actively involved as the caregiver of the recipient. Travel expenses are limited to $10,000.

4. Organ transplant Benefits will apply only to transplants that are not experimental.

K. **JOINT IMPLANTS:**

1. 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 implants may require a second opinion if it is deemed necessary by the Company. All implants may also require a third opinion if it is deemed necessary by the Company because the first opinion and the second opinion differ. If a second opinion or a third opinion is requested by the Company, the Company will be responsible for the cost of such opinion. If the required opinion(s) are not obtained, all Hospital payments will be reduced by 10%. All joints of the body are eligible for implant Benefits.

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

3. Joint implant Benefits will apply only to joint implants for the specific diagnosis for which they are indicated.

L. **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 an Injury or an Illness.

1. Laboratory services, supplies, and tests are covered.

2. Radiology services, including x-ray, MRI/MRA, CT scan, PET scan, ECT, BEAM (Brain Electrical Activity Mapping) and ultrasound imaging are covered.

M. **MATERNITY SERVICES:**

1. Benefits for maternity are paid on a female Insured the same as Benefits are paid on any other Illness. Delivery may occur in a Hospital or in a birthing center. In no circumstance will maternity Benefits be restricted for any Hospital length of stay in connection with childbirth for the mother or the newborn Child to less than forty-eight (48) hours following a normal vaginal delivery or less than ninety-six (96) hours following a cesarean section. It is not necessary for a Provider to obtain authorization from the Company for a length of stay that is within these time limitations. Although it is 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 are covered. Coverage includes screening and ultrasounds.

3. Maternity Benefits apply to the costs of the birth of a Child who is legally adopted by the Insured if all of the following are true:

   (a) The Child is adopted within one year of birth;

   (b) The Insured is legally obligated to pay the costs of birth;

   (c) All Deductibles and copayments have been paid by the Insured;

   (d) The Insured has notified the Company of the Insured's acceptability to adopt Children pursuant to A.R.S. 8-105 within sixty (60) days after this approval or within sixty (60) days after a change in insurance policies, plans or companies.

   This coverage is in excess of any other coverage the natural mother may have for maternity benefits except coverage made available to persons pursuant to A.R.S. Title 36, Chapter 29, but not including coverage made available to persons defined as eligible under A.R.S. 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e).

   If such other coverage exists, the agency, attorney or individual arranging the adoption shall make arrangements for the insurance to pay those costs that may be covered under that policy and shall advise the adopting parent in writing of the existence and extent of the coverage without disclosing any confidential information such as the identity of the natural parent.

   The Insured adopting parents shall notify the Company of the existence and extent of the other coverage.

   The Company is not required to pay any costs in excess of the amounts it would have been obligated to pay to Hospitals and Providers if the natural mother and Child had received the maternity and newborn care directly from or through the Company.

N. **REHABILITATIVE AND HABILITATIVE SERVICES:**

1. Physical therapy, speech therapy, Occupational Therapy, cardiac rehabilitation therapy, and pulmonary rehabilitation 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, Occupational Therapy, cardiac rehabilitation therapy, and pulmonary rehabilitation 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. Braces, splints, prostheses, orthotics, and orthopedic appliances are covered. Internal prosthetics are covered. Internal medical appliances are covered. Supplies or apparatuses used to support, to align or to correct deformities or to improve the function of moving parts are also covered. Prosthetics for artificial limbs are limited to the initial prosthetic device. This limitation does not apply if the initial device is no longer serviceable and it cannot be made serviceable.

   (a) Compression garments for the treatment of lymphedema are limited to one set upon diagnosis. Coverage of up to four (4) replacements each Calendar year are allowed when determined to be Medically Necessary and the compression garment cannot be repaired or when it is required due to a change in an Insured's physical condition.

   (b) External prosthetic devices include artificial arms and legs, terminal devices such as a hand or hook, wigs, and hair pieces. Wigs and hair pieces are limited to one (1) each Calendar Year and are only eligible for a diagnosis of alopecia as a result of chemotherapy, radiation therapy, or second or third degree burns.

   (c) Foot orthotic devices and shoe inserts are only eligible for coverage if they are provided for the treatment of diabetes mellitus and any of the following complications involving the foot: (i) peripheral neuropathy with evidence of callus formation; (ii) history of pre-ulcerative calluses; (iii) history of previous ulceration; (iv) foot deformity; (v) previous amputation of the foot or part of the foot; or (vi) poor circulation.

   Benefits include custom-molded shoes constructed over a positive model of the Insured's foot made from leather or other suitable material of equal quality containing removable inserts that can be altered or replaced as the Insured's condition warrants and that have some sort of shoe closure. This includes a shoe with or without an internally seamless toe.

4. The purchase or the rental (up to the purchase price) of Durable Medical Equipment, as defined in the Policy, is covered. Repair or replacement is covered when it is Medically Necessary.

5. Expenses for the screening for, diagnosis of, and treatment of autism spectrum disorders, for an Insured. Coverage includes the following:

(a) Medically Necessary habilitative or rehabilitative care, including applied behavioral analysis, that is prescribed, provided or ordered by a licensed Physician or licensed psychologist, including but not limited to professional, counseling, and guidance services and treatment programs that are Medically Necessary to develop, maintain, and restore, to the maximum extent practicable, the functioning of the Insured. Outpatient rehabilitative therapy that is part of a rehabilitation program for treatment of autism spectrum disorder, including physical, speech and occupational therapy is subject to the sixty (60) visit limit per Calendar Year as described in Section IV, M, 1.
(b) Medications prescribed by a Physician.
(c) Psychiatric or psychological care.
(d) Behavioral therapy.
(e) Therapeutic care that is provided by licensed or certified speech-language pathologists, occupational therapists, or physical therapists.

Behavioral therapy means interactive therapies that are derived from evidence-based research. These therapies must be medically necessary. The therapies listed below are included in this provision.

(a) Applied behavior analysis.
(b) Discrete trial training.
(c) Pivotal response training.
(d) Programs that have intensive intervention.
(e) Programs that have early intensive intervention for behavior.

Treatment must be prescribed by a licensed Physician or licensed psychologist and 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.

The following services are excluded from Benefits: sensory integration, LOVAAS therapy, and music therapy.

O. **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. Services include, but are not limited to, counseling for the following: (i) unhealthy alcohol use; (ii) healthy diet; (iii) sexually transmitted infections; (iv) skin cancer behavior; (v) BRCA risk assessment and genetic counseling; (vi) tobacco use; and (vii) obesity. Services also include, but are not limited to, screening for the following: (i) depression; and (ii) intimate partner violence. Certain preventive medications are covered. These include, but are not limited to, aspirin, fluoride, vitamin D for adults who are age 65 or older, folic acid for a woman who is planning or who is capable of pregnancy, iron, and tobacco cessation products. These medications must be obtained with a Prescription Order according to the guidelines that are set forth in the U.S. Preventive Services Task Force.

2. Immunizations that are for routine use in children, in adolescents, and in 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, for children, and for 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"). This includes the insertion or the extraction of FDA-approved contraceptive devices. Benefits also include counseling for breastfeeding and for lactation. Benefits also include counseling for family planning. Benefits also include tubal ligation and vasectomy.

5. Other wellness services that are not set forth in the above guidelines are covered. This includes well baby/child visits through 47 months, Routine Physical Examinations and check-ups are covered.

6. Prostate cancer screening and digital rectal examination (DRE) are covered when ordered by the Physician or Practitioner of the Insured. Prostate specific antigen (PSA) and DRE are covered annually if the following criteria are met.

   (a) You are under age 40 and are at high risk because of any of the following.
      (i) Family history (for example, multiple first-degree relatives diagnosed at an early age).
      (ii) African-American race.
      (iii) Previous borderline PSA levels
   (b) You are age 40 or older.

7. 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 (a parent, a sibling, or a child) before the relative's age of 60, or in two or more first-degree relatives at any age.

8. A baseline mammogram for women who are between the ages of 35 and 39 is covered. An annual mammogram for women who are age 40 or older. Mammograms that are not routine are covered as Medically Necessary elsewhere under the general covered services and supplies section of the Plan.

9. Chronic disease management services are covered.

P. **PEDIATRIC VISION SERVICES:** The services that are listed below are covered for Children through the end of the month in which the Child turns nineteen (19).

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

2. One pair of prescription lenses each Calendar Year. Benefits include polycarbonate lenses and scratch resistant coating. Lenses may include single vision, conventional lined bifocal or conventional lined trifocal, or lenticular. Benefits include ultraviolet protective coating, blended segment lenses, intermediate vision lenses, standard and premium progressives, prescription sunglass lenses, photochromic glass lenses, plastic photosensitive lenses, polarized lenses, standard, premium and ultra anti-reflective coating, and hi-index lenses. Two pairs of glasses may not be ordered in place of bifocals.

3. One pair of frames each Calendar Year.

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

   Visual therapy and lenses that do not need a prescription (plano) are ineligible for Benefits.

Q. **PEDIATRIC DENTAL SERVICES:** The services listed below are covered for Children through the end of the month in which the Child turns nineteen (19). Benefits are subject to all other Policy provisions. Benefits are eligible only when they are determined to be necessary for the prevention, the diagnosis, the care or the treatment of a covered condition. Benefits must also meet dental protocols that are generally accepted.

1. **General Services.**

   a. Palliative (emergency) treatment for treatment of dental pain is covered. This benefit does not include debridement.

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

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

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

2. **Diagnostic and Preventive Services.**

a. Periodic oral evaluations are covered. This Benefit includes prophylaxis. This Benefit is limited to one exam every six (6) months. Limited and comprehensive oral evaluations are covered. This Benefit is limited to one exam every six (6) months. A comprehensive periodontal evaluation is covered. This Benefit is limited to one exam every six (6) months.

b. Bitewing x-rays and vertical 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. An intraoral complete series is limited to once every sixty (60) months. Intraoral periapical and occlusal films are covered. Cephalometric films are allowed when necessary. Oral/facial photographic images are allowed.

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

d. Sealants for permanent molars are limited to one sealant per tooth every three (3) years. Preventative resin restorations in a moderate to high caries risk patient are allowed on permanent teeth. This Benefit is limited to one sealant per tooth every (3) years.

e. Fixed or removable space maintainers, unilateral or bilateral, are covered. Recementation of space maintainers is covered.

f. Diagnostic models are covered.

3. **Restorative, Endodontic and Periodontic Services.** The following services are covered.

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

b. Oral surgery is covered. This Benefit includes the following: (1) extraction of an erupted tooth or an exposed root; (2) surgical removal of an erupted tooth that requires elevation of mucoperiosteal flap and removal of bone and/or section of tooth; (3) removal of an impacted tooth; (4) surgical removal of residual tooth roots; (5) coronectomy; (6) tooth reimplantation and/or stabilization of an accidentally evulsed or displaced tooth; (7) surgical access of an unerupted tooth; (7) alveoloplasty; (8) removal of exostosis; (9) incision and drainage of an abscess; (10) suture of recent small wounds up to 5 cm; and (11) excision of pericoronal gingiva. This Benefit also includes general anesthesia and IV sedation.

c. Root canals are covered. Retreatment of a previous root canal therapy is covered. Root amputation, per root, and hemisection, including any root removal, are covered.

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

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

f. Osseous surgery, including flap entry and closure, for four (4) or more continguous teeth or bounded teeth spaces per quadrant is covered. Benefits are limited to one service every thirty-six (36) months.

g. Pedicle soft tissue graft procedures, free soft tissue graft procedures, and subepithelial connective tissue graft procedures are covered.

h. Full mouth debridement to enable comprehensive evaluation and diagnosis is covered. This Benefit is limited to once per lifetime.

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

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

k. Pulpal therapy is covered. Pulpal therapy is covered on primary teeth only and is limited to once per tooth per lifetime. Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration.

l. Periodontal scaling and root planing is limited to once per quadrant every twenty-four (24) month period. Periodontal maintenance following active periodontal therapy is limited to four (4) services in a twelve (12) month period.

m. Prefabricated stainless steel, porcelain/ceramic, porcelain/metal, metal and titanium crowns are covered. They are limited to one per tooth every sixty (60) months. Core buildup, including pins, and prefabricated post and core, in addition to the crown, are covered, and are limited to one per tooth every sixty (60) months. Recementation of crowns, and crown repair, by report, are covered. Clinical crown lengthening-hard tissue is also covered.

n. Metallic and porcelain/ceramic inlays and onlays, including recementing, are covered. Benefits are limited to one per tooth every sixty (60) months.

o. Protective restorations, and pin retention for each tooth in addition to the restoration, are covered.

4. **Prosthodontic Services.** The following services are covered.

a. Resin-based partial dentures, cast metal framework with resin base partial dentures, and complete and immediate upper and lower dentures are covered. A one-piece cast metal removable unilateral partial denture is also covered. Replacements of dentures are eligible once every sixty (60) months. Benefits include adjustments, repair of denture base, repair cast framework, repair or replace broken clasp, replacement of a broken tooth, addition of a tooth to an existing partial denture, addition of a clasp to an existing partial denture, tissue conditioning, recementing of a fixed partial denture, and repair of a fixed partial denture.

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

c. Endosteal implants, surgical placement of interim implant body, eposteal implants, and transosteal implants including hardware are covered if they are determined to be a dental necessity. Benefits are limited to one every sixty (60) months.

d. Implant supported partial and complete dentures are covered. An implant or abutment supported connecting bar is covered once every sixty (60) months.

e. Prefabricated abutment and abutment supported porcelain/ceramic, porcelain/metal, and metal crowns are covered. They and are limited to one per tooth every sixty (60) months. Implant supported porcelain/ceramic, porcelain/metal, and metal crowns are covered. They are limited to one per tooth every sixty (60) months.

f. An abutment/implant supported retainer for porcelain/ceramic, porcelain/metal, and metal fixed partial dentures is covered and is limited to one every sixty (60) months. An abutment/implant supported retainer for fixed partial dentures for a partially or completely edentulous arch is covered. Benefits are limited to one every sixty (60) months.

g. Implant maintenance procedures, repair of an implant prosthesis, replacement of a semi-precision or precision attachment, repair of an implant abutment, implant removal, and an implant index are covered. Benefits are limited to one every sixty (60) months.

h. Metal, titanium, porcelain/metal, and porcelain/ceramic pontics are covered. Benefits are limited to one every sixty (60) months.

i. Cast metal for resin bonded fixed prosthesis retainer and porcelain/ceramic for resin bonded fixed prosthesis retainers are covered. The core buildup, including any pins, for the retainer is also covered. Benefits are limit to one every sixty (60) months.

j. An occlusal guard is covered. Benefits are limited to one every twelve (12) months and are limited to a patient who is age thirteen (13) years or older.

5. **Orthodontic Services.** Orthodontia that is determined to be Medically Necessary is covered. Benefits include fixed or removable appliance therapy. Services to alter the vertical dimension or to restore or to maintain the occlusion are not covered. This includes, but is not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.

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

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

2. A second opinion is covered. A third opinion is also covered when it is requested by the Company.

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

4. A routine eye examination for an adult Insured is eligible once per Calendar Year (this service is eligible under the preventive and wellness services provision as stated elsewhere in the Policy).

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

6. Blood transfusions, including the cost of blood and blood plasma are covered.

7. Radiation therapy and chemotherapy are covered.

8. Back and spine manipulations and modalities are covered.

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

10. Diagnostic mammograms, and a mammogram for any woman desiring a mammogram for medical cause, are covered. Screening mammograms are covered elsewhere under the preventive and wellness services section of the Plan.

11. Home Health Care is covered for an Insured who is homebound. Home Health Care must be provided by a licensed home health agency. Home Health care must also be provided in the place of residence of the Insured and must be prescribed by the attending Physician of the Insured. Services provided for Home Health Care include the following.

    (a) Nursing.

    (b) Home health aide services.

    (c) Physical therapy.

(d) Occupational therapy.

(e) Respiratory therapy.

(d) Speech therapy.

(e) Medical supplies, drugs, medicines, and laboratory services, to the extent that they would have been covered if they were provided on an inpatient Hospital basis.

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.

12. Ambulance is covered if the services are reasonably necessary for an Accident or an Illness. The services must be provided to the nearest Hospital that provides the level of care that is needed. The Usual and Customary amount for air ambulance shall be limited to 250% of the amount that is allowed by Medicare.

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

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

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

16. The Plan covers treatment for genetic inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism and for which medically standard methods of diagnosis, treatment and monitoring exist. Coverage shall include nutritional and medical assessment, including clinical services, biochemical analysis, medical supplies, Prescription Drugs, corrective lenses for conditions related to the genetic inborn error of metabolism, nutritional management and special medical foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.

    The Plan also covers treatment for disorders that are not inherited. Special medical foods are considered to be medically appropriate for disorders that are not inherited when the Insured has: (i) a permanent non-function or a disease of the structures that normally permit food to reach the small bowel; or (ii) a disease of the small bowel which impairs the digestion and the absorption of an oral diet that consists of solid or of semi-solid foods.

    Special medical foods are nutritional substances in any form that are (i) formulated to be consumed or administered enterally under the supervision of a Physician; (ii) specifically processed or formulated to be distinct in one or more nutrients present in natural food; (iii) intended for the medical and nutritional managements of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation; and (iv) essential to optimize growth, health and metabolic homeostasis.

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

18. The Plan covers reconstructive breast surgery resulting from a mastectomy. The Plan covers all stages of reconstructive breast surgery on the non-diseased 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, prosthetic devices incident to a covered mastectomy, mastectomy bras/camisoles, physical complications of a mastectomy, including lymphedemas, and benefits for outpatient chemotherapy following surgical procedures.

19. Drugs and medicines that require a Prescription Order and that are prescribed for the condition(s) for which they are approved for use by the Food and Drug Administration ("FDA") are covered, unless otherwise excluded as set forth elsewhere in the Policy. Generic, Brand and specialty Prescription Drugs that are Eligible are covered. Generic Prescription Drugs must be used whenever a Generic equivalent is available. If a Brand name drug is purchased instead of a Generic equivalent, the Insured is responsible for the price difference. This Benefit includes medication that is prescribed as part of a clinical trial, which is not the subject of the trial. This Benefit also includes specialty and biotech medications that are considered to be self-injectable (such as, but not limited to, Avonex, Betaseron, Enbrel, Fuzeon, Imitrex, Humira, Intron, and Rebif), even if they are administered by a Provider. Eligible Prescription Drugs that are provided for less than the standard refill amount are allowable if the Insured requests enrollment into a medication synchronization program. In accordance with the Policy provisions for determining medical necessity, some Prescription Drugs are subject to maximum dispensing limitations at either a retail pharmacy or through the mail order program. These limits are based on prescribing guidelines that are clinically approved and that are regularly reviewed to ensure the medical necessity and the appropriateness of care. Prescription drugs that exceed the recommended dosage by the manufacturer or the dosage that is established by the FDA are not covered. The Company is entitled to any and all available rebates that are paid by Prescription Drug manufacturers.

    Drugs and medicines that require a Prescription Order that have not been approved for use by the FDA for the specific condition for which they are being prescribed, but have been approved for use by the FDA for another condition, are eligible for Benefits if it is determined that they have been recognized as medically appropriate and effective for the treatment of the specific condition for which they are being prescribed in one or more of the following medical reference publications: the American Hospital Formulary

Services Drug Information; the National Comprehensive Cancer Network Drugs and Biologics Compendium; Thomson Micromedex Compendium DrugDex; Elsevier Gold Standard's Clinical Pharmacology Compendium; and other authoritative compendia as identified by the Secretary of the United States Department of Health and Human Services. Medical literature that has been reviewed by peers may also establish medical appropriateness. Medical literature must meet the requirements listed below to be acceptable.

i. 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.
ii. 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.
iii. The literature meets the uniform requirements for manuscripts subjected to biomedical journals established by the international committee of medical journal editors or is published in a journal specified by the United States Department of Health and Human Services as acceptable medical peer-reviewed medical literature.

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

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

22. Expenses for epidural injections that are for back pain are covered. They are only covered when they are Medically Necessary.

23. Ostomy supplies which are medically appropriate for the care and the cleaning of a temporary or a permanent ostomy are covered. Such supplies include, but are not limited to, pouches, bags and catheters, and skin barriers.

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

(a) Blood glucose monitors. This includes commercially available blood glucose monitors that are designed for patients use and for persons who have been diagnosed with diabetes.
(b) Blood glucose monitors for the legally blind. This includes commercially available blood glucose monitors that are 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. This includes test strips whose performance achieved clearance by the FDA for marketing.

(d) Visual reading and urine testing strips. This 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. This includes those that are adaptable to meet the needs of the legally blind, to assist with insulin injection.
(h) Syringes. This includes insulin syringes, pen-like insulin injection devices, pen needles for pen-like insulin devices and other disposable parts that are required for insulin injection aids.
(i) Insulin pumps. This includes insulin infusion pumps.
(j) Medical supplies for use with insulin pumps and insulin infusion pumps. This includes infusion sets, cartridges, syringes, skin preparation, batteries and other disposable supplies that are needed to maintain insulin pump therapy.
(k) Medical supplies for use with or without insulin pumps and insulin infusion pumps. This includes durable and disposable devices to assist with the injection of insulin and infusion sets.
(l) Prescription oral agents for each class approved by the FDA for the treatment of diabetes, and a variety of drugs, when available, within each class.
(m) Podiatric appliances that are Medically Necessary for the prevention of feet complications that are associated with diabetes. This includes therapeutic molded or depth-inlay shoes and functional orthotics. This also includes custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment.
(n) Glucagon emergency kits.
(o) Any other device, medication, equipment or supply for which coverage is required under Medicare.

25. Self-management training and patient management for diabetes is covered. This includes therapy for medical nutrition. Expenses are only eligible if they are medically necessary and when they are prescribed by an attending Physician.

26. Nutritional evaluation and counseling and chronic disease self-management training is covered. These are only covered when dietary adjustment has a therapeutic role of a diagnosed chronic disease or condition. Such chronic disease or condition includes, but is not limited to: 1) morbid obesity; 2) diabetes; 3) cardiovascular disease; 4) hypertension; 5) kidney disease; 6) eating disorders; 7) gastrointestinal disorders; 8) food allergies; and 9) hyperlipidemia. Benefits do not include intra oral wiring, dietary formulae, hypnosis, cosmetics, and health and beauty aids.

27. Services for the treatment of Temporomandibular Joint Syndrome are covered if they are the result of an Injury, a trauma, a congenital defect, a developmental defect or a pathology. Services for orthognathic treatment and surgery are covered. Dental services that are necessary due to an Accidental Injury are covered.

28. Emergency room services, supplies and treatment. Benefits include psychiatric assessment and stabilization in the emergency room, 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.

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

30. 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.

31. Routine patient costs that are directly associated with a phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition are covered. A life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted. Routine patient costs are only covered if they are otherwise eligible for Benefits under this Plan. Routine patient costs 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 standards of care for a particular diagnosis that are widely accepted and established.

    A) Coverage will be provided **if** the following criteria are met:

        (a) The Insured is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition.

        (b) Either:

            (i) The referring health care professional is a Preferred Provider and has concluded that the Insured's participation in such trial would be appropriate; or

            (ii) The Insured provides medical and scientific information establishing that the Insured's participation in such trial would be appropriate.

    B) The following are defined as approved clinical trials:

        (a) A federally funded trial, in which the study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

            (i) The National Institutes of Health.
            (ii) The Centers for Disease Control and Prevention.
            (iii) The Agency for Health Care Research and Quality.
            (iv) The Centers for Medicare & Medicaid Services.
            (v) Cooperative group or center of any of the entities described in (i) through (iv) above or the Department of Defense or the Department of Veterans Affairs.

(vi) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

(vii) Any of the following if the conditions described in Section C below are met: 1) The Department of Veterans Affairs; 2) The Department of Defense; and 3) The Department of Energy.

(b) A study or investigation that is conducted under an investigational new drug application reviewed by the Food and Drug Administration

(c) A study or investigation that is exempt from having such an investigational new drug application.

The conditions for a study or investigation conducted by a Department are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used the National Institutes of Health; and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

32. The Plan covers amino acid-based formula that is ordered by a Physician provided that 1) the Insured has been diagnosed with an eosinophilic gastrointestinal disorder; 2) the Insured is under the continuous supervision of a Physician; and 3) there is a risk of a mental or a physical impairment without the use of the formula.

33. Bariatric surgery for extreme obesity is covered if certain medical guidelines are met. These guidelines include, but are not limited to, the following.

(a) The Insured has a body mass index (BMI) of greater than or equal to 35.
(b) The Insured has at least one co-morbidity related to obesity.
(c) Documented evidence is provided that dietary attempts at weight control are ineffective. Documentation must include information that the Insured actively participated in a Physician-supervised weight-management program within the last two (2) years for a minimum of six (6) months.
(d) The Insured is at least age eighteen (18), or has reached full expected skeletal growth.

Open vertical banded gastroplasty, laparoscopic vertical banded gastroplasty, open sleeve gastrectomy, and open adjustable gastric banding are ineligible for Benefits.

34. Hearing examinations are covered. Benefits are limited to one (1) hearing examination per Insured per Calendar Year.

35. Hearing aids are covered. Benefits are limited to one (1) hearing aid per ear per Calendar Year. Cochlear implants that are Medically Necessary are covered. Batteries for such cochlear implants are also covered.

36. Allergy testing is covered. The administration of antigens is covered. The administration of allergen extracts is covered.

37. Infusion therapy is covered. IV therapy is covered.

38. Dialysis treatment is covered.

39. Reconstructive surgery for the repair of congenital defects and birth abnormalities for Dependent Children are covered.

40. Biofeedback is covered for pain management only in the treatment of Mental Illness and alcohol/substance abuse.

41. Health care services that are provided through telemedicine are covered. For the purpose of this Benefit, health care services means services that are provided for the following conditions or in the following settings: (a) trauma; (b) burns; (c) cardiology; (d) infectious diseases; (e) mental health disorders; (f) neurologic diseases including stroke; (g) dermatology; (h) pulmonology; (i) substance abuse; (j) pain medicine; and (k) urology. 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. Benefits will be available in all areas of the state.

42. Facility and anesthesia services for a hospitalization that are in connection with dental or with oral surgery are covered. These services are only covered if they are provided due to a hazardous medical condition. Such conditions include heart problems, diabetes, and hemophilia. Such conditions also include dental extractions that are due to cancer related conditions. Such conditions also include the probability of allergic reaction (or of any other condition that could increase the danger of anesthesia). For Insureds who are age nineteen (19) or older, dental procedures are ineligible for Benefits except as stated elsewhere in the Policy.

43. Diagnostic services that are rendered for an evaluation of infertility are covered. Medical treatment and Prescription Drugs that are related to infertility once a diagnosis has been made are ineligible for Benefits.

V. GENERAL LIMITATIONS AND EXCLUSIONS APPLICABLE TO ALL BENEFITS:

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

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

2. Expenses that are covered by any workers' compensation law; an employers' liability law (or legislation of similar purpose); an occupational disease law; or for an Injury arising out of, or in the course of, employment for compensation, wages, or profit.

3. Expenses that are covered by programs that are created by the laws of the United States, by any state, or by any political subdivision of a state

4. Expenses for which payment has been made under automobile or vehicle medical payment provisions when such coverage is in force are not covered. Credit will be applied towards the Deductible and the Out-of-Pocket amounts under this Policy after such expenses have

been paid by the automobile or the vehicle medical payment coverage. The Company must receive proof of such payment before credit will be applied.

5. 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. This exclusion only applies if the Insured is convicted as determined by a legal finding of law.

6. Care or treatment of an Accident, an Illness or an Injury that is caused by, or arises out of the following: riot; war; an act of war while in the military, the naval, or the air services of any country at war; declared or undeclared war; armed aggression; or acts of aggression that are committed by the person who is entitled to Benefits.

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

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

9. 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 is the recipient.

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

11. 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 that are 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. This exclusion also does not include nutritional evaluation, or screenings and counseling as allowed under preventive and wellness services, which are covered as stated elsewhere in the Plan.

12. Expenses in connection with the reversal of a gastric or an intestinal bypass; a balloon implant; gastric stapling; or other similar surgical procedure are not covered.

13. Expenses in connection with genetic studies, genetic testing or genetic counseling are not covered. This exclusion does not apply to amniocentesis, to ultrasound or to any other procedures that are for gender determination of a fetus when they are medically appropriate to determine the existence of a genetic disorder that is related to gender. This exclusion also does not apply to genetic testing and therapy when they are medically appropriate for the purpose of making treatment decisions. This exclusion also does not apply for genetic counseling that is eligible for Benefits under the Preventive and Wellness Services section of the Policy.

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. Marriage counseling is not covered. Counseling for occupational problems and religious counseling are also not covered. This exclusion includes drugs for the same.

16. Expenses that are for milieu therapy; for modification of behavior; for biofeedback (except for pain management in the treatment of Mental Illness or alcohol/substance abuse); or for sensitivity training are not covered.

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

18. Expenses for the care or the treatment of sexual dysfunction or for transsexual 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.

19. Expenses for the care or for the treatment of learning disability and developmental disorder (except as provided for the treatment of autism spectrum disorder); mental retardation; chronic organic brain syndrome; or for the treatment or the care of chronic psychiatric or psychosocial conditions that are not subject to favorable modification according to generally accepted standards of medical practice are not covered. This exclusion does not apply to services that are required to diagnose any of the above.

20. 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.

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

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

23. Expenses for rest cures are not covered.

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

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

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

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

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

    (a) They are Medically Necessary.

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

29. Expenses for training, for educating, or for counseling a patient are not covered. This exclusion does not apply when such services are incidentally provided (without a separate expense) in connection with other Covered Services. This exclusion also does not apply when the services are Medically Necessary and they are specifically prescribed by a Physician. This exclusion also does not apply to the self-management training for diabetes. This exclusion also does not apply to nutritional counseling and to chronic disease self-management counseling. This exclusion also does not apply to eligible preventive services counseling, as stated elsewhere in the Policy.

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

31. Expenses for transportation are not covered. This exclusion does not apply to ambulance services that are Medically Necessary. This exclusion also does not apply to eligible transportation charges that are covered under the Organ Transplants section of the Policy.

32. A cardiac stress test when an Insured has no symptoms and is at low risk for heart disease is not covered. A CT scan to screen for lung cancer is not covered. A full-body PET/CT scan to screen for cancer is not covered. A bone density test for an Insured who is under age 65 and who does not have risk factors for serious bone loss is not covered. This exclusion does not apply when services are required to diagnosis an Illness or Injury.

33. Expenses for (i) Routine Physical Examinations for Insureds which exceed the guidelines set forth in the Preventive and Wellness Services section of the Policy; or (ii) mental examinations or psychological tests when there are no symptoms of Mental Illness, such as I.Q. testing and psychological testing on children that are requested by or for a school system.

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

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

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

37. Expenses for services that are incurred for the drainage of an intraoral alveolar abscess are not covered. This exclusion does not apply to care that is eligible pursuant to the pediatric dental services provisions that are set forth elsewhere in this Plan.

38. Expenses for charges that are incurred with respect to the eye for diagnostic procedures are not covered. This exclusion includes, but is not limited to eye refraction; the fitting of eye glasses or contact lenses; and orthoptic evaluation or training. This exclusion does not apply to one (1) routine eye exam per Calendar Year for an adult, which is eligible as set forth elsewhere in this Plan. This exclusion does not apply to lens implants (either donor or artificial) for cataracts. This exclusion also does not apply when services are required as part of an examination to diagnose an Illness or an Injury (other than refractive errors of vision). 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.

39. 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.

40. Expenses for assistive listening devices are not covered. Assistive listening devices are television amplifiers, telephone amplifiers, remote signaling devices and person FM listening systems. This exclusion does not apply to Eligible hearing examinations, Eligible cochlear implants and Eligible hearing aids, which are covered elsewhere in the Plan.

41. Expenses are not covered for the following.

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

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

42. Expenses for corrective shoes or for special shoe accessories. This exclusion does not apply to foot orthotics and to shoe inserts that are provided for the treatment of diabetes and other complications involving the foot as set forth elsewhere in the Rehabilatative and Habilitative Services section of the Policy.

43. Expenses for acupuncture or for acupressure are not covered.

44. Expenses for preventive medication (except as set forth in the Preventive and Wellness Services section of the Policy), vitamins without a prescription, mineral and nutrient supplements, food supplements, and sports therapy equipment are not covered.

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

46. Expenses for services, supplies, and treatment that are for hair loss. This exclusion includes, but is not limited to, the use of Minoxidil and Rogaine. This exclusion does not apply to wigs and hair pieces that are covered under the Rehabilitative and Habilitative section of the Policy.

47. Expenses for experimental drugs; non-legend drugs; and anti-wrinkle agents are not covered. Tretinoin, all dosage forms (for example, Retin A) for Insureds who are over twenty-five (25) years of age is eligible for Benefits if it is being used for a medical condition, and will be subject to preauthorization through the pharmacy benefit manager.

48. Expenses for autopsy procedures are not covered.

49. Expenses for treatment or services that are rendered in connection with artificial insemination; for invitro fertilization; for all procedures to preserve sperm and ova; for Prescription Drugs to induce fertility; for gamete intrafallopian transfer ("GIFT"); and for any other procedures that are designed to help or to treat infertility. This exclusion does not apply to diagnostic services that are rendered for infertility evaluation.

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

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

52. Expenses for massage therapy are not covered.

53. All shipping, handling, delivery, sales tax, or postage charges are not covered. This exclusion does not apply if the charges are incidentally provided in connection with Covered Services or supplies.

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

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

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

57. Drugs and medicines that are available over the counter, (except as covered elsewhere in the preventive and wellness section of the Policy), or that do not require a Prescription Drug Order are not covered.

VI. COBRA, USERRA, COVERAGE DURING DISABILITY, EXTENSION OF BENEFITS AND CONVERSION:

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.

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

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

2. The Employee or the Dependent(s) ceases to be Totally Disabled.

3. The Disabled person becomes insured or covered under any other group medical benefit or service plan or self-funded plan.

D. **Extension of Benefits:**

1. If the Employer employs fewer than 20 Employees, an Employee and any qualified Dependent whose insurance under the group Policy has been terminated may elect to continue coverage under the group Policy, provided the Employee has been covered under the Employer's health benefit plan for at least three (3) months before a qualifying event. This provision does not apply if continuation coverage benefits are available to Insureds pursuant to 29 United States Code sections 1161 through 1169, or 42 United States Code sections 300bb-1 through 300bb-8, or if the Insured seeking to continue coverage is eligible for Medicare.

   For purposes of this section, qualifying event means:

   (a) Voluntary or involuntary termination of employment for a reason other than gross misconduct or reduction of hours required to qualify for health benefits under the Employer's health benefit plan.
   (b) Divorce or legal separation from the Employee.
   (c) Death of the Employee.
   (d) The Employee becoming eligible for Medicare.
   (e) A Dependent Child ceasing to be eligible for coverage under the terms of the Policy.

   The Employer shall provide the Insured written notification of the Insured's qualifying event and of the right to continue group coverage within thirty (30) days after the qualifying event. A written communication or a notice postmarked within forty-four (44) days after a qualifying event mailed by the Employer to the Insured's last known address satisfies this notice requirement. Notice to the Employee constitutes notice to any

qualified Dependent unless the Employer knows there is a qualified dependent who does not live at the same address and knows the Dependent's address, in which case, a separate notice shall be sent to the qualified Dependent. The notice shall inform the Insured of the following:

(a) The Insured's right to continue coverage at the full cost of the coverage, which includes the Employer's contribution and the Insured's contribution and an administrative fee for the Employer that may not exceed five (5) percent of the premium.
(b) The amount of the full cost of coverage, stated separately for the Employee and qualified Dependent.
(c) The process and deadline for the Insured to elect continuation coverage.
(d) The date and time by which the Insured must submit the initial and ongoing payments to the Employer to continue coverage.
(e) The loss of continuation coverage if the Insured fails to pay the premium and administrative fee in a timely manner.

To continue coverage, the Insured shall elect continuation coverage in writing within sixty (60) days after the date of notice to elect continuation coverage, and submit the first month premium to the Employer within forty-five (45) days after the date of election to continue coverage. If the Insured elects coverage, coverage continues as if there had been no interruption. If the Employer fails to provide complete, accurate and timely notice of the right to continue coverage, the Insured has one hundred twenty (120) days after the date of the notice to elect continuation coverage and pay the required premium and administrative fee.

2. Continuation of coverage ends on the earliest of the following:

(a) Eighteen (18) months after the date the continuation coverage begins.
(b) The date on which coverage ceases under the Policy due to the Insured's failure to timely pay the premium and administrative fee.
(c) The date on which the Insured becomes eligible for Medicare or Medicaid or obtains any other health care coverage, with respect only to that person.
(d) The date on which the Employer terminates coverage under the group health insurance for all Employees.
(e) As to a Dependent Child, the date the Dependent Child would otherwise lose coverage under the terms of the health plan due to attaining a certain age.

3. A qualified Dependent who is determined to have a disability under title II or title XVI of the social security act at the time of a qualifying event may be eligible to continue coverage for an additional eleven (11) months, if the qualified Dependent provides the written determination of disability from the social security administration to the Employer within sixty (60) days after the date of determination and before the end of the eighteen (18) month continuation period. The Plan may charge up to one hundred fifty (150) percent of the group rate during the eleven (11) month disability extension. The qualified Dependent shall notify the Employer within thirty (30) days after the social security administration determines that the qualified Dependent no longer has a disability under title II or title XVI of the social security act.

4. If a qualified event as defined in this section occurs during the eighteen (18) month continuation period, a qualified Dependent may be eligible to continue coverage for an additional eighteen (18) months.

5. If an Employee is in the military reserve or national guard and is called to active duty and the Employee's employment is terminated either after or during the active duty period, the termination is a separate qualifying event, distinct from the qualifying event that may have occurred when the Employee was called to active duty, and the Employee and any qualified Dependents are eligible for a new eighteen (18) month benefit period beginning on the later of the date active duty ends or the date of employment termination.

6. If an Employee is in the military reserve or national guard and is called to active duty, the following event are qualifying events distinct from the qualifying event that may have occurred when the Employee was called to active duty.

   (a) The Employee dies during the period of active duty.
   (b) A divorce or legal separation of the Employee from the Employee's Spouse occurs.
   (c) A Dependent Child ceases to be a Dependent Child to be eligible for coverage under the terms of the Policy.

7. Notwithstanding section 2 above, if an Employee who is in the military reserve or national guard has elected to continue coverage and is thereafter called to active duty and the coverage of the Employer's health benefit plan is terminated due to the Employee becoming eligible for a health care program provided by the United States department of defense, the eighteen (18) month period or any other applicable maximum time period for which the Employee would otherwise be entitled to continuation coverage is tolled during the time that the Employee is covered under the health care program. Within sixty-three (63) days after the federal health care program coverage terminates, the Employee may elect to continue coverage under the Employer's health benefit plan retroactively to the date coverage terminated under the federal health care program for the remainder of the eighteen (18) month period or any other applicable time period, subject to termination of coverage at the earliest of the conditions specified in section 2 above.

E. **Conversion Plan:** All individuals who were covered under the group Policy have the right to continue coverage under a conversion plan of the Company when the group coverage terminates. The conversion plan will be a group insurance plan which provides coverage most similar to that of the terminated coverage. The right to conversion is available under the following circumstances.

1. Upon the termination of the Employee's employment.

2. Upon the death of the Employee. This provision applies to the surviving Spouse and, at the option of the Spouse, the Child(ren) for whom the Spouse has responsibility for care and support.

3. Upon the divorce, annulment, or legal separation of the Employee and Spouse. This provision applies to the surviving Spouse and, at the option of the Spouse, the Child(ren) for whom the Spouse has responsibility for care and support.

4. Upon a Dependent Child ceasing to be a qualified Dependent. This provision applies to the Child.

An individual does not have conversion rights, and the conversion plan will terminate, if any of the following apply.

1. The individual has failed to pay premiums or premiums are not received in a timely manner.

2. The individual is eligible for Medicare or acquires other group health coverage that is comparable to the coverage under the conversion plan;

3. The Individual has performed an act or practice that constitutes fraud, or has made an intentional misrepresentation of material fact under the terms of the coverage.

Written application and the first premium payment for the converted policy shall be made to the Company within thirty-one (31) days following termination of coverage under the existing policy. The effective date of the conversion plan is the day following termination of insurance under the group Policy.

VII. COORDINATION OF BENEFITS AND 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 under another plan such as any of the following.

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

   (b) Coverage under a governmental plan that is required or that is 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 that 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 that establish 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. Benefits are then determined by the health care plan of the Spouse (if any) of the parent with custody of the Child(ren).

   c. Benefits are finally determined 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. If one of the plans is issued out of this state and determines the order of benefits based upon the gender of a parent and, as result, the plans do not agree on the order of benefits, the plan with the gender rule shall determine the order of benefits.

5. The benefits of a plan that covers a person as an Employee (or as that Employee's Dependent) are determined before those of a plan that covers that person as a laid off or retired employee (or as that person's Dependent). 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.

6. 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.

(d) Overpayment: In the event the Company provides Benefit payments to the Insured or on his/her 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 persons it has paid or for whom it has paid, 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. **PERSONS COVERED BY MEDICARE:**

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

   (a) An active Employee who is age sixty-five (65) or older and who is 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 that is 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 is enrolled under a group health Plan provided by the Employer of the Spouse, this Plan shall then be secondary to that coverage and Medicare becomes the third payer.

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

   (a) For all other Insured persons.

(b) After the time period that is 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. The rates that apply are available from the Company upon request.

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

1. On the Plan renewal date. The Company will give written notice to the group Policyholder at least sixty (60) days prior to such premium due date.

2. On the applicable date that the number of persons Insured changes.

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 that immediately precedes the next due date except as otherwise provided herein.

C. **GRACE PERIOD:** A grace period of thirty-one (31) days will be allowed for the payment of any premium due 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 that are then due and are unpaid, including a *pro rata* premium for the grace period. If the Policyholder gives written notice to the Company that this Plan is to be terminated before the end of the grace period, this Plan shall be terminated on the later of the date of receipt of such notice, or the date specified by the Policyholder. The Policyholder shall be liable to the Company for the payment of all premiums that are then due and are unpaid. That amount shall include a *pro rata* premium for the period that commences with the last premium due date and that ends with such date of termination.

This Plan may also terminate immediately if the Employer has performed an act or a 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, and the beneficiary that is designated by each Employee, if any. This record shall also show the date when each Employee became Insured and the Effective Date of any change in coverage. This record shall also show any other information that may be required to administer the insurance. The Company shall furnish a copy of this record to the Policyholder, upon request. The Policyholder shall give the Company any information that is required to administer the insurance. This information shall include, but is not limited to, information for enrolling Employees, changes in coverage, and termination of insurance. Any records of the Employer and/or the Policyholder that may have a bearing on this insurance shall be open for inspection by the Company at a reasonable time.

F. **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 an amendment to, this Plan. If the provisions of this Plan and the Certificates conflict, the terms of this Plan shall govern.

G. **FREE CHOICE OF PROVIDER:** The Employee shall have free choice of any legally qualified Physician or Provider. This Plan will have no affect on the relationship of the patient and the Provider.

H. **CLAIM AND APPEAL PROCEDURES:**

Following is a description of how the Plan processes claims and appeals. At the time of enrollment, each Insured Employee will also be provided with a "Health Care Insurer Appeals Process Information Packet" that describes the procedures to follow to appeal an adverse benefit determination. At the time coverage is renewed, we will also send a separate statement explaining that another copy of the packet may be requested. The packet will also be sent within five (5) business days after we receive a request for an appeal. We will also send a copy of the packet to you or your treating provider at any time upon request. Another copy may be requested by calling the Company at (801) 263-8000 or (800) 748-5340.

A claim is defined as any request for a Plan Benefit, that is made by an Insured or a representative of an Insured and that complies with the Plan's procedures for making a claim. There are two types of claims: pre-service and post-service. The different types of claims are described below. Each type of claim has a specific time period for approval and for request for further information. Each type of claim also has a specific time period for denial. Time periods begin at the time that a claim is file. "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. The Insured will be given at least forty-five (45) days to respond. A notification of the benefit determination will be sent within fifteen (15) days after the receipt of the additional information. If there is an ongoing course of treatment (*i.e.*, concurrent care), a notification of the 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 a termination of the concurrent care benefit that was previously approved before the end of the treatment period, a notification will be sent at least fifteen (15) days prior to the end of the treatment.

Pre-certification for pre-service claims involving Urgent Care is **not** required, although it is recommended. However, once the care is no longer Urgent Care, the Pre-certification requirements will apply. The pre-service claim will be subject to the time periods that are 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 that involve Urgent care.

In the event of a post-service claim, the Insured will receive a notification of the benefit determination within thirty (30) days after the receipt of the request. If additional information is needed, the Insured will be notified within that time. The Insured will be given at least forty-five (45) days to respond. A notification of the benefit determination will be sent within fifteen (15) days after the receipt of the additional information.

Notice to Insured of Adverse Benefit Determination

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

Decisions You Can Appeal

You can appeal the following decisions:

1. We do not approve a service that you or your treating provider has requested.
2. We do not pay for a service that you have already received.

3. We do not pre-certify a service or pay for a claim because we say that it is not "medically necessary.
4. We do not pre-certify a service or pay for a claim because we say that it is not covered under your insurance policy, and you believe it is covered.
5. We do not notify you, within 10 business days of receiving your request, whether or not we will authorize a requested service.
6. We do not authorize a referral to a specialist.

Decisions You Cannot Appeal

You cannot appeal the following decisions:

1. You disagree with our decision as to the amount of "usual and customary" charges.
2. You disagree with how we are coordinating benefits when you have health insurance with more than one insurer.
3. You disagree with how we have applied your claims or services to your plan deductible.
4. You disagree with the amount of coinsurance or copayments that you paid.
5. You disagree with our decision to issue or not issue a policy to you.
6. You are dissatisfied with any rate increases you may receive under your insurance policy.
7. You believe we have violated any other parts of the Arizona Insurance Code.

If you disagree with a decision that is not appealable according to this list, you may still file a complaint with the Arizona Department of Insurance, Consumer Affairs Division, 100 N. 15th Avenue, Suite 102, Phoenix, AZ 85007-2624.

Who Can File An Appeal?

Either you or your treating provider can file an appeal on your behalf. At the end of this packet is a form that you may use for filing your appeal. You are not required to use this form; you may send us a letter instead with the same information, along with any additional supporting documentation. If you decide to appeal the decision to deny a pre-service claim, you should tell your treating provider so the provider can help you with the information you need to present your case.

Description of the Appeals Process

There are two types of appeals: an expedited appeal for urgent matters, and a standard appeal. Each type of appeal has 3 levels. The appeals operate in a similar fashion, except that expedited appeals are processed much faster because of a patient's condition.

	Expedited Appeals (for urgently needed services you have not yet received)	**Standard Appeals** (for non-urgent services or denied claims)
Level 1.	Expedited Medical Review	Informal Reconsideration
Level 2.	Expedited Appeal	Formal Appeal
Level 3.	Expedited External Independent	External Independent Medical Review

MedWatch (refer to page 9) makes the Level 1 and Level 2 decisions for Expedited Appeals. WMI makes the Level 1 and Level 2 decisions for Standard Appeals, unless the appeal 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. In that case, we will consult with an independent health care professional who has appropriate training and expertise in the field of medicine involved in the medical judgment. An outside reviewer, who is completely independent from our company, makes Level 3 decisions. You are not responsible to pay the costs of the external review if you choose to appeal to Level 3.

EXPEDITED APPEALS PROCESS FOR URGENTLY NEEDED SERVICES NOT YET PROVIDED

Level 1. Expedited Medical Review

Your request: You may obtain Expedited Medical Review of your denied pre-service claim for urgently needed services if:

- You have coverage with us,
- We denied your pre-service claim for urgently needed services, and
- Your treating provider certifies in writing and provides supporting documentation that the time to process your request through the Informal Reconsideration and Formal Appeal process (about 30 days) is likely to cause a significant negative change in your medical condition. (At the end of this packet is a form that your provider may use for this purpose. Your provider could also send a letter or make up a form with similar information.) Your treating provider must send the certification and supporting documentation to the entity as shown on page 9 of this document listed as "for pre-service appeals."

Our decision: We have 1 business day after we receive the information from the treating provider to decide whether we should change our decision and pre-certify your requested service. Within that same business day, we must call and tell you and your treating provider our decision, and mail you our decision in writing. The written decision must explain the reasons for our decision and identify the documents on which we based our decision.

If we deny your request: You may immediately appeal to Level 2.

If we grant your request: We will pre-certify the service and the appeal is over.

If we refer your case to Level 3: We may decide to skip Level 1 and Level 2 and send your case straight to an independent reviewer at Level 3.

Level 2. Expedited Appeal

Your request: If we deny your request at Level 1, you may request an Expedited Appeal. After you receive the Level 1 denial, your treating provider must immediately send a written request to the same entity and address listed on page 9 that was used for the Level 1 appeal to tell us you are appealing to Level 2. To help your appeal, your provider should also send any

additional information that hasn't already been sent, to show why you need the requested service.

Our decision: We have 3 business days after we receive the request to make our decision.

If we deny your request: You may immediately appeal to Level 3. If you decide not to appeal to Level 3 you have the right to file suit in court.

If we grant your request: We will pre-certify the service and the appeal is over.

If we refer your case to Level 3: We may decide to skip Level 2 and send your case straight to an independent reviewer at Level 3.

Level 3: Expedited External Independent Review

Your request: You may appeal to Level 3 only after you have appealed through Levels 1 and 2. You only have 5 business days after you receive the Level 2 decision to send your written request for Expedited External Independent Review. Send your request and any additional supporting information to the same entity shown on page 9 that was used for the Levels 1 and 2 appeals.

Neither you nor your treating provider is responsible for the cost of any external independent review.

The process: There are two types of Level 3 appeal depending on the issues in your case.

(1) Medical Necessity

These are cases where we have decided not to pre-certify a service because we think the services that you or your treating provider are asking for are not medically necessary to treat your problem. For medical necessity cases, the independent reviewer is a provider retained by an outside independent review organization ("IRO"), procured by the Arizona Insurance Department, and not connected with our company. The IRO provider must be a provider who typically manages the condition under review.

(2) Contract coverage

These are cases where we have denied coverage because we believe that the service already provided is not a covered benefit under your insurance policy. For contract coverage cases, the Arizona Department of Insurance is the independent reviewer.

Medical Necessity Cases

Within 1 business day of receiving your request, we must:

1. Mail a written acknowledgement of the request to the Insurance Director, you, and your treating provider.

2. Send the Director of Insurance: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to

render our decision; a summary of the applicable issue including a statement of our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

Within 2 business days of receiving our information, the Insurance Director must send all of the submitted information to an external IRO.

Within 72 hours of receiving the information the IRO must make a decision and send the decision to the Insurance Director.

Within 1 business day of receiving the IRO's decision, the Insurance Director must mail a notice of the decision to us, you, and your treating provider.

The decision (medical necessity): If the IRO decides that we should pre-certify the service, we must do so. If the IRO agrees with our decision to deny the pre-certification, the appeal is over. Your only further option is to pursue your claim in Superior Court.

Contract Coverage Cases

Within 1 business day of receiving your request, we must:

1. Mail a written acknowledgement of the request to the Insurance Director, you, and your treating provider.

2. Send the Director of Insurance: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issue including a statement of our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines.

Within 2 business days of receiving this information, the Insurance Director must determine if the service is covered, issue a decision, and send a notice to us, you, and your treating provider.

Referral to the IRO for contract coverage cases: The Insurance Director is sometimes unable to determine issues of coverage. If this occurs, the Insurance Director will forward your case to an IRO. The IRO will have 72 hours to make a decision and send it to the Insurance Director. The Insurance Director will have 1 business day after receiving the IRO's decision to send the decision to us, you, and your treating provider.

The decision (contract coverage): If you disagree with the Insurance Director's final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If we disagree with the Director's final decision, we may also request a hearing before OAH. A hearing must be requested within 30 days of receiving the Director's decision. OAH must promptly schedule and complete a hearing for appeals from expedited Level 3 decisions.

STANDARD APPEAL PROCESS FOR NON-URGENT SERVICES AND DENIED CLAIMS

Level 1. Informal Reconsideration

Your request: You may request an Informal Reconsideration if you receive a denial on your pre-or post-service claim if:

- You have coverage with us,
- We denied your pre-service claim or your post-service claim,
- You do not qualify for an expedited appeal, and
- You or your treating provider asks for an Informal Reconsideration within 2 years of the date we first deny the pre-service claim or the post-service claim by calling, writing or faxing your request to the appropriate entity as shown on page 9.

Our acknowledgment: We have 5 business days after we receive your request for an Informal Reconsideration ("the receipt date") to send you and your treating provider a notice that your request was received.

Our decision: For a denied pre-service claim, we have 15 calendar days after the receipt date to decide whether we should change our decision and pre-certify your requested service. For denied post-service claims, we have 30 calendar days to decide whether we should change our decision. We will send you and your treating provider our decision in writing. The written decision must explain the reasons for our decision and identify the documents on which we based our decision.

If we deny your Level 1 review: You have 60 calendar days to appeal to Level 2.

If we grant your appeal: We will pre-certify the service or pay the claim and the appeal is over.

If we refer your case to Level 3: We may decide to skip Level 1 and Level 2 and send your case straight to an independent reviewer at Level 3.

Level 2. Formal Appeal

Your request: You may request a Formal Appeal if you receive a denial on your Level 1 review. After you receive the Level 1 denial, you or your treating provider must send us a written request within 60 days to advise us that you are appealing to Level 2. To help us make a decision on your appeal, you or your provider should also send us any additional information that you haven't already sent us, to show why we should pre-certify the requested service or pay the claim. Send your appeal request and information to the appropriate entity as shown on page 9.

Our acknowledgment: We have 5 business days after we receive your request for Formal Appeal ("the receipt date") to send you and your treating provider a notice that your request was received.

Our decision: For a denied pre-service claim, we have 15 calendar days after the receipt date to decide whether we should change our decision and pre-certify your requested service. For a denied post-service claim, we have 30 calendar days to decide whether we should change our decision. We will send you and your treating provider our decision in writing. The written decision must explain the reasons for our decision and identify the documents on which we based our decision.

If we deny your Level 2 appeal: You have four months to appeal to Level 3. If you decide not to appeal to Level 3 you have the right to file suit in court.

If we grant your appeal: We will pre-certify the service or pay the claim and the appeal is over.

Level 3: External, Independent Review

(Note: Level 3 appeals cannot be accepted for issues regarding deductible amounts, co-insurance levels, or usual and customary allowed amounts)

Your request: You may appeal to Level 3 only after you have appealed through Levels 1 and 2. You have four months after you receive our Level 2 decision to send us your written request for External, Independent Review. Send your request and any additional supporting information to the appropriate entity as shown on page 9.

Neither you nor your treating provider is responsible for the cost of any external independent review.

The process: There are two types of Level 3 appeals, depending on the issues in your case:

(1) Medical Necessity

These are cases where we have decided not to pre-certify a service or we have denied a claim because we think the services that you or your treating provider are asking for, or the services that you have already received, are not medically necessary to treat your problem. For medical necessity cases, the independent reviewer is a provider retained by an outside independent review organization ("IRO"), procured by the Arizona Insurance Department, and not connected with our company. For medical necessity cases, the provider must be a provider who typically manages the condition under review.

(2) Contract Coverage

These are cases where we have denied coverage because we believe that the requested service or the service already provided is not a covered benefit under your insurance policy. For contract coverage cases, the Arizona Department of Insurance is the independent reviewer.

Medical Necessity Cases

Within 5 business days of receiving your request, we must:

1. Mail a written acknowledgement of the request to the Insurance Director, you, and your treating provider.

2. Send the Director of Insurance: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issue including a statement of our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

Within 5 days of receiving our information, the Insurance Director must send all of the submitted information to an IRO.

Within 21 days of receiving the information the IRO must make a decision and send the decision to the Insurance Director.

Within 5 business days of receiving the IRO's decision, the Insurance Director must mail a notice of the decision to us, you, and your treating provider.

The decision: If the IRO decides that we should pre-certify the service or pay the claim, we must do so. If the IRO agrees with our decision to deny the pre-certification or claim, the appeal is over. Your only further option is to pursue your claim in Superior Court.

Contract Coverage Cases

Within 5 business days of receiving your request, we must:

1. Mail a written acknowledgement of the request to the Insurance Director you, and your treating provider.

2. Send the Director of Insurance: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issue including a statement of our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines.

Within 15 business days of receiving this information, the Insurance Director must determine if the pre-service or post-service claim is covered, issue a decision, and send a notice to us, you, and your treating provider. If the Director decides that we should provide the service or pay the claim, we must do so.

Referral to the IRO for contract coverage cases: The Insurance Director is sometimes unable to determine issues of coverage. If this occurs, the Insurance Director will forward your case to an IRO. The IRO will have 21 days to make a decision and send it to the Insurance Director. The Insurance Director will have 5 business days after receiving the IRO's decision to send the decision to us, you, and your treating provider

The decision: If you disagree with the Insurance Director's final decision on a coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If we disagree with the Insurance Director's final decision on a coverage issue, we may also

request a hearing with OAH. Hearings must be requested within 30 days of receiving the coverage issue determination. OAH has rules that govern the conduct of their hearing proceedings.

Where to Call or Send Appeals

For pre-service claims:

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

For post-service claims:

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

Obtaining Medical Records

Arizona law (A.R.S. §12-2293) permits you to ask for a copy of your medical records. Your request must be in writing and must specify who you want to receive the records. The health care provider who has your records will provide you or the person you specified with a copy of the records.

Designated Decision-Maker: If you have a designated health care decision-maker, that person must send a written request for access to or copies of your medical records. The medical records must be provided to your health care decision-maker or a person designated in writing by your health care decision-maker unless you limit access to your medical records only to yourself or your health care decision-maker.

Confidentiality: Medical records disclosed under A.R.S. §12-2293 remain confidential. If you participate in the appeal process, the relevant portions of your medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose you medical information to any other people.

Documentation for an Appeal

If you decide to file an appeal, you must give us any material justification or documentation for the appeal at the time that the appeal is filed. If you gather new information during the course of your appeal, you should give it to us as soon as you get it. You must also give us the address and phone number where you can be contacted. If the appeal is already at Level 3, you should also send the information to the Department.

The Role of the Director of Insurance

Arizona law (A.R.S. §20-2533(F)) requires "any member who files a complaint with the Department relating to an adverse decision to pursue the review process prescribed" by law. This means, for decisions that can be appealed, you must pursue the health care appeals process before the Insurance Director can investigate a complaint you may have against our company based on the decision at issue in the appeal.

The appeal process requires the Director to:

1. Oversee the appeals process.

2. Maintain copies of each utilization review plan submitted by insurers.

3. Receive, process and act on requests from an insurer for External, Independent Review.

4. Enforce the decisions of insurers.

5. Review decisions of insurers.

6. Send, when necessary, a record of the proceedings of an appeal to Superior Court or to the Office of Administrative Hearings ("OAH").

7. Issue a final administrative decision on coverage issues, including the notice of the right to request a hearing at OAH.

Receipt of Documents

Any written notice, acknowledgement, request, decision or other written document required to be mailed is deemed received by the person to whom the document is properly addressed on the fifth business day after being mailed. "Properly addressed" means your last known address.

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.

REQUEST FOR EXCEPTION FOR PRESCRIPTION DRUGS

Notwithstanding the procedures outlined in the above sections regarding appeals, the following procedures are available for an Insured, the Insured's designee, or the Insured's Physician (or other prescriber) to request and gain access to clinically appropriate drugs that are not otherwise covered by the Plan.

Standard review exception request: A request for a standard review must be submitted in writing to the Company and must set forth the reason that the requested drug is appropriate for the care of the Insured. A determination on the standard review request will be made, and notification will be sent to the Insured or the Insured's designee, and to the prescribing Physician (or other prescriber), no later than 72 hours following receipt of the request. If the

standard exception request is granted, coverage will be provided for the duration of the prescription, including refills.

Expedited review exception request: A request for an expedited review based on exigent circumstances may be submitted orally or in writing to the Company. Exigent circumstances exist when an Insured is suffering from a health condition that may seriously jeopardize the Insured's life, health, or ability to regain maximum function, or when an Insured is undergoing a current course of treatment using a non-formulary drug. A determination on the expedited review request will be made, and notification will be sent to the Insured or the Insured's designee, and to the prescribing Physician (or other prescriber), no later than 24 hours following receipt of the request. If the expedited exception request is granted, coverage will be provided for the duration of the exigency.

External review exception request: If the Plan denies a standard review request or an expedited review request, the Insured, the Insured's designee, or the Insured's Physician (or other prescriber) may request that the original exception request and the subsequent denial of such request be reviewed by an independent review organization. A determination on the request will be made, and notification will be sent to the Insured or the Insured's designee, and to the prescribing Physician (or other prescriber), no later than 72 hours following receipt of the request, if the original request was a standard review request, and no later than 24 hours following receipt of the request, if the original request was an expedited review request. If the external review request of a standard review request is granted, coverage will be provided for the duration of the prescription. If the external review request of an expedited review request is granted, coverage will be provided for the duration of the exigency.

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 to such law.

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 that are required to maintain the minimum compulsory surplus that is required by law. Earnings is defined as earned revenue that is in excess of incurred Benefits and expenses using statutory accounting methods that are prescribed or that are permitted by law.

In any Calendar Year in which there are surplus earnings as a result of favorable claims experience such earnings may be refunded to eligible participating Employers as an experience rating refund. The board of directors will determine in its discretion if it is appropriate and it is advisable to return the surplus earning to the Policyholders. The method and the 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 that 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 to 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 the Insured Employees constitute the entire contract between the parties. All statements that are made by the Policyholder and the Insured Employees and the Dependent(s) shall, in the absence of fraud, be deemed representations and not warranties. No statement made by an Insured Employee or his/her 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 a 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 renewal date of the Plan upon sixty (60) days written notice from the Company to the Policyholder. If an Insured is confined in a Hospital or in an Extended Care Facility on the effective date of the amendment, Benefits shall not be affected until the date of discharge. No change in the Plan shall be valid until it is approved by a duly authorized officer of the Company and unless such approval be endorsed hereon or attached hereto. No agent has the authority to change any Plan or 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 the opportunity to have the person of any individual whose Injury or Illness is the basis of a claim examined when and so often as it may reasonably require during pendancy of the claim. The Company shall also have the right and the 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 to 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 that are made will constitute a complete discharge of the obligations of the Company 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 that relate to the care and the treatment of any Insured who claims Benefits under this Plan. The Company has this right 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 that are 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 that are 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 that is prescribed to them in the Definitions section of this document.

The Company shall have the sole discretion to construe and to interpret the terms and provisions of the Plan and to determine the eligibility for benefits. Nothing in the foregoing statement limits the rights of the Insured to protections under the federal law known as ERISA. This includes, 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. These services 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. These services will be reimbursed at a lower percentage level.

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 that is listed in the telephone directory. The Insured may also contact the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration. Their address is 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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

WMI Mutual Insurance Company

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