GROUP HEALTH INSURANCE PLAN
CERTIFICATE BOOKLET

IDAHO
Standard Benefit Plan

WMI Mutual Insurance Company

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I. SCHEDULE OF BENEFITS

A. **Preventive Services (Benefit Area "A"):** A Co-payment is required only for adult preventive services. The Co-payment does not apply toward the Deductible or Out-of-Pocket amount.

- Co-payment:
  Adults: $15
  Children: $0
- Benefit Percentage: 100%
- Coinsurance Percentage: 0%
- Annual Benefit Maximum: $500
- Vision Annual Benefit Sub-Cap*: $75

B. **Primary Maternity Services (Benefit Area "B1")**
- Co-payment for initial visit: $15
- Benefit Percentage: 100%
- Coinsurance Percentage: 0%

C. **Other maternity services (Benefit Area "B2")** (following satisfaction of the Deductible and before satisfaction of the Out-of-Pocket amount)**:**
- Benefit Percentage: 80%
- Coinsurance Percentage: 20%

D. **Inpatient Services and Outpatient Services (Benefit Areas "C and D")** (following satisfaction of the Deductible and before satisfaction of the Out-of-Pocket amount)**:**
- Benefit Percentage: 80%
- Coinsurance Percentage: 20%

E. **Ambulance Services and Durable Medical Equipment (Benefit Area "E")** (following satisfaction of the Deductible and before satisfaction of the Out-of-Pocket amount)**:**
- Benefit Percentage: 80%
- Coinsurance Percentage: 20%
- Annual Benefit Maximum for Ambulance Services*: $750
- Annual Benefit Maximum for Durable Medical Equipment*: $15,000

F. **Outpatient Mental Illness and Alcohol/Substance Abuse Treatment (Benefit Area "F")** (following satisfaction of the Deductible and before satisfaction of the Out-of-Pocket amount)**:**
- Benefit Percentage: 80%
- Coinsurance Percentage: 20%
- Annual Combined Benefit Maximum*: $5,000

G. **Prescription Drug Benefit (Benefit Area "G")**

- Co-Payment per prescription: $10
- Benefit Percentage: 100%**
- Coinsurance Percentage: 0%**

*100% of the cost of the generic substitute (when available) is paid. The Insured must pay the difference between the cost of a Brand Drug and the Generic Drug if a Brand Drug is selected when a Generic Drug is available. If a generic substitute is not available, 100% of the cost of the Brand Drug after the co-payment is payable.

H. **Deductible Amounts:**

- Individual Annual Deductible: $500

  Except as specifically set forth in this Schedule of Benefits or the Policy, the Insured and each covered Dependent must satisfy the Individual Annual Deductible before any benefits under this Policy are paid.

- Family Annual Deductible: $1,000

  Once the Annual Family Deductible is satisfied in any Calendar Year, the Individual Deductible is waived for all remaining family members for that Calendar Year.

I. **Annual Out-of-Pocket Amount:**

- Individual Annual Out-of-Pocket Amount: $5,000 (Includes Deductible)

- Family Annual Out-of-Pocket Amount: $10,000 (Includes Deductible)

  The Company will pay Eligible charges at 100% during any Calendar Year in which the applicable Deductible and Out-of-Pocket amounts have been satisfied. Only Deductible and Coinsurance amounts paid by the Insured or Dependent during the Calendar Year will apply toward satisfaction of the Out-of-Pocket amounts. Amounts paid for Co-payments and for non-covered care or treatment are not applicable to Out-of-Pocket amounts for this Policy.

  No individual family member may contribute more than one-half of the Family Out-of-Pocket amount. Each family member must satisfy an Individual Deductible amount (unless the Family Deductible has been satisfied) even if the annual Family Out-of-Pocket amount has been satisfied.

J. **Calendar Year Individual Benefit Maximum:** $100,000

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

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

"Actively at Work" and **"Active Work"** means being in attendance in person at the usual and customary place or places of business acting in the performance of the duties of the Employee's occupation on a full time basis devoting full efforts and energies thereto, except that an Employee shall be deemed Actively at Work on each day of a regular paid vacation; or on any day in which he/she is absent from work due to a health factor, for a period not to exceed twelve (12) weeks; provided he/she was Actively at Work on the last preceding regular work day. In the case of a new enrollee, work must begin before coverage can become effective, however, eligibility will not be denied if the Employee is absent from work due to a health factor on the date that coverage would normally be effective. If this Policy replaces coverage within sixty (60) days of discontinuance of a prior policy, all Employees and Dependents who were validly covered under the previous policy at the date of discontinuance, who are within the definition of eligibility and who would otherwise be eligible for coverage under this Policy, shall be immediately covered under this Policy, regardless of active employment or non-confinement.

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

"Ambulatory Service Facility" means any public or private establishment with an organized medical staff of Physicians, with permanent facilities equipped and operated primarily for the purpose of performing ambulatory surgical procedures and with continuous Physician services whenever an Insured is in the facility, but that does not provide services or other accommodations for Insureds to stay overnight.

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

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

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

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

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

"Coinsurance" means the percentage of the cost of a health care service, paid by the Insured under a health insurance plan, as shown in the Schedule of Benefits.

"Company" means the WMI Mutual Insurance Company.

"Comprehensive Major Medical Expense Benefits" are Covered Expenses subject to an annual Deductible and applicable co-insurance.

"Converted Benefits" means the Benefits provided under the Conversion Plan for that class of Insureds who have been, but are no longer, Employees of the Policyholder and who select Converted Benefits in lieu of or following any state or federal extension of Benefits.

"Cosmetic" or "Cosmetic Surgery" means any surgical procedure performed to improve appearance or to correct a deformity without restoring a physical bodily function. Psychological factors, such as poor body image and difficult peer relations do not constitute a bodily function, nor do they establish medical necessity.

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

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

"Creditable Coverage" means Plan participants will be given "credit" toward the satisfaction of any Preexisting Condition Limitation period for the length of coverage under any of the following plans: (a) group health insurance; (b) Individual health insurance; (c) Medicare and Medicaid; and (d) Government programs such as, public health plans, state high risk pools, or military plans. The exclusion for Preexisting Conditions will be reduced by the number of months that the Employee has remained covered under any of these plans. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after such period and before the Enrollment Date, there was a period of sixty-three (63) days or more during all of which the individual was not covered under any Creditable Coverage. This sixty-three (63) day period shall not include any period that an individual is in a Waiting Period for any coverage under a group health plan (or for group health insurance coverage) or is in an affiliation period.

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

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

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

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

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

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

"Date Incurred" means the date services were provided.

"Deductible" means the cash amount of eligible charges paid per Insured person before insurance Benefits are paid.

"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) unmarried Child(ren), who is under age twenty-five (25) years of age and who receives more than one-half (1/2) of his financial support from the parent; and

(c) A Child who has reached the limiting age for termination of coverage, but who is Disabled and dependent upon the Insured, provided that the Child was enrolled in this Plan at the time of reaching the limiting age.

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

"Durable Medical Equipment" is medical equipment that meets all of the following requirements:

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

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

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

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

Durable Medical Equipment includes, but is not limited to, all types of wheelchairs, crutches, braces, hospital beds, CPAP machines, insulin pumps, pain management

pumps, infusion-type pumps, and pacemakers. Durable Medical Equipment does not include air conditioners, swimming pools, hot tubs, exercise equipment, or similar equipment.

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

"Emergency" means a sudden change in a patient's condition such that immediate medical or surgical intervention is required and the absence of such intervention could be expected to result in imminent deterioration of health, permanent physical harm or death.

"Employee" means any person who is in an Employee/Employer relationship, is Actively at Work in the regular business of an Employer, who works a minimum of eighty (80) hours per month and who receives compensation for his services from the Employer. An Employee of the subsidiaries and affiliates, if any, of the Employer named on the face of this Plan, shall be deemed an Employee of the Employer and service with any such subsidiaries and affiliates shall be deemed service with the Employer, if in compliance with hours worked. For the purpose of this definition, an owner, sole proprietor, partner, officer or director shall be considered an "Employee" provided that he or she is Actively at Work as set forth herein.

"Employer" or **"Participating Employer"** means any corporation or proprietorship operating as a business entity, that is a member of a *bona fide* association that contracts with the Company to provide insurance Benefits to its membership, that has eligible Employees Insured with the Company, who has agreed in writing to become a Policyholder of the Company.

"Enrollment Date" means the earlier of: (a) the first day of coverage; or (b) the first day of the Employer Waiting Period if the Employer applies a Waiting Period before Employees are eligible to participate in the Plan. The Enrollment Date for a Late Enrollee or anyone enrolling as a Special Enrollee is the first day of coverage.

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

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

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

"Family Out-of-Pocket" means two (2) times the individual Out-of-Pocket. No individual family member may contribute more than one-half of the Family Out-of-Pocket maximum and each family member must satisfy an individual Deductible amount (unless the Family Deductible has been satisfied) even if the Family Out-of-Pocket maximum amount has been satisfied. Only eligible Deductible and co-insurance amounts (except co-insurance amounts paid towards Prescription Drugs or for any Benefits which are not eligible to be paid at 100%) that are paid by the Insured or Dependent during the Calendar Year will be applied toward the satisfaction of the Out-of-Pocket maximum. Amounts paid for non-covered care or treatment, and office visit co-payments do not apply toward the Out-of-Pocket maximums.

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

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

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

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

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

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

(d) Qualifies as a reimbursable service under Medicare.

"Hospital" means a facility which: 1) is primarily engaged in providing, by or under the supervision of Physicians, concentrated medical and professional nursing care on a twenty-four (24) hour basis, diagnostic and therapeutic services for medical diagnosis and treatment, mental illness diagnosis and treatment, care of Illness or Injury, rehabilitation services and obstetrical care; and 2) provides for care of two (2) or more individuals for twenty-four or more consecutive hours.

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

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

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

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

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

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

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

"Late Enrollee" means an individual who enrolls under the Plan at a time other than during the period in which the individual was first eligible, including an individual who enrolls during the Open Enrollment period. A Late Enrollee is not an individual who enrolls in accordance with the Special Enrollment provisions of this Plan.

"Maximum Amount of Benefits" means the cumulative Maximum Amount of Benefits payable for services to any Insured Employee or Insured Dependent.

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

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

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

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

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

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

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

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

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

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

"Open Enrollment" means the period between November 1 and December 31 during which an Employee or Dependent who previously waived coverage may enroll in the insurance Plan. An individual who enrolls in the Plan during the Open Enrollment period will become effective on January 1. An Employee or Dependent who waives insurance coverage during the Open Enrollment period must wait until the next Open Enrollment period to enroll in the insurance Plan. The Preexisting Condition Limitation, (reduced by any Creditable Coverage) will apply to any Employee or Dependent enrolling in the Plan during the Open Enrollment period.

"Out-of-Pocket" means the maximum dollar amount per year of eligible charges payable by an Insured to Providers. Co-payment amounts do not apply to the Out-of-Pocket maximum amount and 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. Deductible amounts must be satisfied for each individual family member (unless the Family Deductible has been satisfied) even if the Family Out-of-Pocket maximum amount has been satisfied. The Out-of-Pocket amounts are specified in the Schedule of Benefits section of this booklet.

"Physician" means any of the following licensees duly licensed by the state to practice in any of the following categories of health care professions: 1) chiropractor; 2) dentist; 3) optometrist; 4) pharmacist; 5) physician and surgeon, of either medicine and surgery or of osteopathic medicine and surgery; 6) podiatrist; and 7) any other licensed practitioner who is acting within the scope of that license and who performs a service which is payable under the Policy when performed by any of the previously listed health care practitioners.

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

"Policyholder" means the Employer named on the Certificate.

"Portability" means the transfer of, and credit for, all or a portion of prior Creditable Coverage toward the satisfaction of a Preexisting Condition Limitation period. In order for prior coverage to be portable, the coverage must have existed within the time period allowed by applicable federal or state law excluding any Waiting Period applied by the Employer or the carrier before the Employee or Dependent is eligible to participate in the Plan.

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

"Preexisting Condition" is a physical or mental condition, regardless of the cause of the condition, for which medical advice, care or treatment was recommended or received within the six (6) months prior to the Enrollment Date. The term "Preexisting Condition" does not include pregnancy and does not include genetic information in the absence of a diagnosis of the condition related to such information.

"Prescription Drug" means a drug or medicine which can only be obtained by a Prescription Order and bears the legend "Caution, Federal Law Prohibits Dispensing Without a Prescription" or other similar type of wording, or which is restricted to prescription dispensing by state law. The term Prescription Drug also includes insulin, diabetic testing equipment, and supplies for insulin, excluding supplies meeting the definition of Durable Medical Equipment which are paid in accordance with the Durable Medical Equipment benefit.

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

"Provider" means a Hospital, skilled nursing facility, ambulatory service facility, Physician, Practitioner, or other individual or organization which is licensed by the state to provide medical or surgical services, supplies, and/or accommodations.

"Routine Physical Examination" means a physical examination where an Insured has no symptoms of Illness or Injury. Routine Physical Examination includes the

examination and routine lab procedures required for the physical examination, including, but not limited to, cytologic testing/pap smears, and prostate tests.

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

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

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

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

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

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

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

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

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

"Waiting Period" means the time between the Employee's date of hire and the date the Employee begins participation in the Plan.

III. ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE:

This Plan covers all Employees and Dependents as defined in the Definitions section of this policy.

A. **ELIGIBILITY DATE FOR EMPLOYEES OF NEWLY ENROLLED EMPLOYER GROUPS:** Employees who worked an average of twenty (20) hours

or more per week during the preceding month are eligible to participate in the Plan on the Effective Date of the Employer's Plan, provided that they enroll in the Plan prior to the Employer's Effective Date by submitting a properly completed enrollment card to the Company. Any eligible Employee who does not enroll prior to the Effective Date of the Employer's Plan, is ineligible to enroll in the Plan until the next Open Enrollment period.

B. **ELIGIBILTY DATE FOR NEWLY HIRED EMPLOYEES:** Newly hired Employees are eligible to participate in this Plan on the later of the first day of the month following:

1. The satisfaction of the Employer's eligibility requirements and Waiting Period; or

2. Their date of hire (if they maintained other health insurance coverage as of their date of hire); or

3. Thirty-one (31) days after their date of hire (if they did not maintain other health insurance coverage as of their date of hire); or

4. The date of submission of a properly completed enrollment card and all necessary application and enrollment materials.

Newly hired Employees must submit a properly completed enrollment card to the Company before coverage can become effective. Any eligible Employee who does not submit a properly completed enrollment card to the Company within thirty-one (31) days of the satisfaction of the Employer's Waiting Period is ineligible to enroll in the Plan until the next Open Enrollment period and shall be considered a Late Enrollee.

For purposes of this subsection, a newly eligible Employee or a newly promoted Employee (for example, 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 may enroll in the Plan, by submitting a properly completed enrollment card to the Company, at the time of enrollment of the eligible Employee. Eligible Dependents who enroll at the same time as the Employee are eligible to participate in this Plan on the same day as the Employee. An eligible Dependent who does not enroll at the same time as the eligible Employee, other than a Special Enrollee, is ineligible to enroll in the Plan until the next Open Enrollment period.

D. **SPECIAL ENROLLEES:** The following individuals are eligible to enroll in the Plan outside the Open Enrollment period, provided that a properly completed written enrollment card is submitted to the Company within thirty-one (31) days of eligibility (or within sixty (60) days of eligibility if otherwise specified). Coverage will be effective on the first day of the first calendar month following the date that the enrollment materials are received by the Company.

1. Employees who declined participation in the Plan when they were first eligible because they maintained other health insurance and 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.

2. Employees who marry or acquire a Child through birth, adoption, or placement for the purpose of adoption. The Employee must enroll within the first sixty (60) days of eligibility.

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 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.

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. Enrollment must be within sixty (60) days of eligibility.

    b. Newborn children and adopted newborn children placed for adoption within sixty (60) days of the adopted child's birth are automatically covered from and after the moment of birth for a period of sixty (60) days. Coverage for adopted children placed more than sixty (60) days after the birth of the adopted child shall be from and after the date the child is placed. If the payment of a specific premium is required to provide coverage for a newborn or adopted Child, the Insured Employee must enroll the eligible Child within sixty (60) days from the date of birth or placement for adoption, and must pay all applicable premium within thirty-one days following the receipt of the premium billing, in order for the coverage of a newborn or adopted Child to extend beyond the sixty (60) day period.

    For the purposes of this subsection, "Child" means an individual who has not attained age eighteen (18) years as of the date of the adoption or placement for adoption. For the purposes of this section, "placed" shall mean physical placement in the care of the adoptive Insured, or in those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it shall mean when the adoptive Insured signs an agreement for adoption of such Child and signs an agreement assuming financial responsibility for such Child. Coverage includes that for congenital anomalies and the child is not subject to the Preexisting Condition limitation. Coverage continues until the first to occur of the following events:

1. The date the Child is removed permanently from that placement and the legal obligation terminates; or

2. The date the Insured rescinds, in writing, the agreement of adoption or agreement assuming financial responsibility.

E. **MAINTENANCE OF EMPLOYEE ELIGIBILITY:** Active Employees are eligible to participate in the Plan as long as they are Actively at Work in the regular business of an Employer and they work an average of at least eighty 80 hours per month while receiving compensation for such service from the Employer. Eligibility may also be maintained if the Employee is on paid leave status of not more than six (6) months and if he worked an average of eighty 80 hours during the two (2) months immediately preceding the date he was placed on leave status.

F. **MAINTENANCE OF GROUP ELIGIBILITY:** The Company may terminate the Plan if the number of Employees Insured with WMI Mutual Insurance Company is less than 50% of the number of Employees eligible for insurance. If there are two to five (2-5) Employees eligible for insurance the Company requires 100% participation of all eligible Employees, if there are six to nine (6-9) Employees eligible for insurance the Company requires 80% participation of all eligible Employees, and if there are ten (10) or more Employees eligible for insurance the Company requires 75% participation of all eligible Employees.

IV. TERMINATION OF INSURANCE BENEFITS:

A. TERMINATION OF EMPLOYEES COVERAGE:

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

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

B. **TERMINATION OF DEPENDENT COVERAGE:** The Dependent's coverage shall automatically terminate on the earliest of the following dates:

1. The date the covered Dependent ceases to be eligible as a "Dependent" as defined in the Definitions section of the Policy;

2. The date the Employees coverage under the Plan terminates;

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

C. **EXCEPTIONS TO THE TERMINATION OF DEPENDENT COVERAGE PROVISIONS:**

1. In the event of the Employee's death, the coverage with respect to each of his Dependent(s) shall be continued in force until the last day of the month for which the premium was paid.

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

   (a) The date he ceases to be incapacitated;

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

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

V. COVERED SERVICES:

A. BENEFIT AREA "A": PREVENTIVE CARE BENEFITS

Routine Examinations and Routine Check-ups

Routine Physical Examinations, well baby/well child examinations, routine childhood immunizations, routine adult immunizations, and influenza immunizations are covered under this section at the benefit levels shown in the Schedule of Benefits. Routine Physical Examination includes the examination and routine lab procedures required for the physical examination, including, but not limited to, cytologic testing/pap smears, and prostate tests**.** Routine childhood immunizations and routine adult immunizations shall be determined in accordance with the most recent guidelines of the Centers for Disease Control.

Vision Care

Children under the age of twelve (12) will be provided one preventive care vision exam and eye glasses, as needed, subject to the annual sub-cap per year as shown in the Schedule of Benefits.

B. BENEFIT AREA "B1": PRIMARY MATERNITY SERVICES:

Primary maternity care will be covered at the benefit percentage and subject to the copayment shown in the Schedule of Benefits. Primary maternity care includes

pre-natal, delivery, and post-partum care provided by the primary obstetrician. Other related maternity costs will be covered under the standard provision of the plan, subject to standard Deductible and coinsurance requirements (See Benefit Area "B2".) The copayment for primary maternity services does not apply toward Out-of-Pocket expense limit.

C. BENEFIT AREA "B2": OTHER MATERNITY SERVICES (HOSPITAL/MISCELLANEOUS):

Usual and Customary charges for delivery room and other hospital services, assistant surgeons, anesthesiology, and other services and supplies will be covered as set forth in the Schedule of Benefits on the same basis as any other covered service. Covered Hospital expenses are limited to the Semi-private Room rate.

For purposes of Benefit Areas "B1 and B2", the following applies:

A Dependent spouse or female Employee is eligible for maternity benefits; an Insured's Dependent Child or a Dependent Child's spouse are not eligible for maternity benefits.

In no circumstances will Maternity Benefits be restricted for any Hospital length of stay in connection with Childbirth for the mother or 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 unnecessary for a Provider to obtain pre-authorization from the Company for a length of stay within these time limitations. Although not required, it is recommended that the expectant mother call the Pre-certification company during the first trimester so that a review for a possible high risk pregnancy can be performed.

If a Dependent spouse or female Employee is pregnant at the time of termination of the group Policy, and is not eligible for any replacement group coverage within sixty (60) days of termination, the policy provides that benefits will be payable to the extent as if termination had not occurred for any covered benefits in connection with such pregnancy, childbirth or miscarriage, but not beyond a period of twelve (12) months following such termination.

D. BENEFIT AREAS "C AND D": INPATIENT SERVICES AND OUTPATIENT SERVICES

Benefits for Inpatient Services and outpatient services are subject to the Deductible, coinsurance and Out-of-Pocket amounts shown in the Schedule of Benefits. Benefits for outpatient Mental Illness and alcohol/substance abuse treatment, Prescription Drugs, Ambulance, and Durable Medical Equipment are described elsewhere in the Policy.

Inpatient Facility Services

The Medical Necessity and appropriateness of the length of stay of all Inpatient facility confinements must be Pre-Certified, however, Pre-certification is **not** required for Urgent Care. Once the care is no longer Urgent Care, the Pre-

certification requirements will apply. The company that must be contacted for Pre-certification before all non-Emergency Inpatient facility admissions is shown on the insurance card. Emergency admissions must be reported within twenty-four (24) hours of the admission (or on the next business day if the admission occurs on a weekend or holiday). **Pre-certification of Medical Necessity does not guarantee payment or determine Benefit eligibility.** 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, which will be conducted in accordance with the provisions as established by applicable law.

1. The Plan covers the daily Hospital room rate to the extent that the charge does not exceed the Hospital's most common charge for its standard Semi-private Room accommodations.

2. Inpatient Hospital Intensive Care Unit.

3. Inpatient Ancillary Hospital Services. The Plan covers all necessary Hospital supplies and services. Room charges are covered as a separate expense.

4. Inpatient Mental Illness Care.

5. Inpatient Alcohol or Substance Abuse Treatment.

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

General Surgical Services

1. The Plan covers surgical procedures performed by the primary surgeon.

2. The Plan also covers one surgical assistant per surgery if Medically Necessary and payment is limited to 20% of the amount allowable under the primary surgeon's charges.

3. Multiple or Bilateral Surgical Procedures. When multiple or bilateral surgical procedures which add significant time or complexity to patient care are performed at the same operative session through the same incision, the available Benefits shall be the value of the major procedure plus 50% of the value of the lesser procedure. When multiple procedures are performed through separate incisions or in separate sites, the available Benefit shall be the value of the major procedure plus 75% of the value of the lesser procedure. Incidental procedures such as an incidental appendectomy, incidental scar

excision, puncture of ovarian cysts, and simple lysis of adhesions, are covered under the principal amount payable and no additional Benefit is available.

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

Organ Transplants, Implants and Joint Implants

Services for organ transplants, implants, and joint implants must be pre-authorized by the Company in writing. All transplants or implants require a second opinion (and a third opinion, if deemed necessary by the Company).

All organs for Category I and Category II transplants must be natural body organs. No Benefits are available for any artificial organs or any mechanical-electronic organs of any type other than intra-ocular lens implants and artificial joint implants.

The maximum allowable amount for implantable joint hardware is limited to the invoice cost, plus 25%. An invoice showing the actual cost of the implant must be submitted to the Company. Eligible diagnostic, medical and surgical expenses for a compatible live or cadaveric donor, that are directly related to the implant or transplant, are also eligible, provided that the recipient of the implant or transplant is an Insured under this Policy. Expenses for both the donor and the recipient are only covered under a recipient's coverage (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.

Anesthesia Services

The Plan covers anesthesia service to achieve general or regional (but not local) anesthesia at the request of the attending Physician and performed by a Physician other than the operating Physician or the assistant. Services of a nurse anesthetist who is not employed by the Hospital and who bills for services provided are also covered, but only if a Hospital employee or Physician-anesthesiologist is unavailable.

Physician Medical Services

Hospital visits by a Physician are covered and are limited to one Visit per day, per Physician.

Reconstructive Breast Surgery

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

"Mastectomy" means the surgical removal of all or part of a breast as a result of breast cancer.

"Reconstructive breast surgery" means a surgical procedure performed following a mastectomy on one breast or both breasts to establish symmetry between the breasts. The term includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.

Benefits for reconstructive breast surgery include, but are not limited to, the costs of two prostheses and benefits for outpatient chemotherapy following surgical procedures in connection with the treatment of breast cancer.

Hospice Care

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

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

Speech Therapy

Speech therapy benefits will be provided for children under 12 years of age.

Office Visits

Benefits are provided for Medically Necessary Office Visits.

Outpatient Surgery

Benefits are provided for outpatient services, supplies and treatment provided in an Ambulatory Service Facility.

Mammograms

Coverage for mammograms is subject to the following guidelines:

(1) One (1) baseline mammogram for any woman who is thirty-five (35) through thirty-nine (39) years of age;

(2) A mammogram every two (2) years for any woman who is forty (40) through forty-nine (49) years of age, or more frequently if recommended by the woman's Physician;

(3) A mammogram every year for any woman who is fifty (50) years of age or older.

(4) A mammogram for any woman desiring a mammogram for medical cause.

Colonoscopy

Benefits are subject to the following guidelines in accordance with the American Cancer Society:

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

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

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

Manipulative therapy and related treatment

Manipulative therapy and related treatment, including heat treatments and ultrasound, of the musculoskeletal structure for other than fractures and dislocations of the extremities will be subject to a $1**,000** limit per Calendar Year, subject to the Deductible and coinsurance.

Dental Services

Children who are under the age of twelve (12) will be covered for an annual dental exam, cleaning, fluoride treatment, sealants, and routine care (not caps, crowns, or bridges). Benefits are subject to Usual and Customary allowances.

Dental services that are needed for treatment of a medical condition, such as osteotomies, tumors, or cysts, or that are Medically Necessary by reason of damage to or loss of sound natural teeth due to Accidental Injury (other than from chewing), are covered for any Insured individual. Benefits are subject to Usual and Customary allowances.

Miscellaneous Services

1. Blood transfusions, including the cost of blood and blood plasma.

2. Oxygen and equipment for its administration. Equipment that meets the definition of Durable Medical Equipment will be paid in accordance with the Durable Medical Equipment benefit.

3. X-ray, laboratory, pathological services, and machine diagnostic tests.

4. Physical therapy rendered by a qualified licensed professional physical therapist and if prescribed by an MD or a Physician's assistant as to type and duration.

5. Orthopedic braces (except shoes or related supportive or corrective devices).

6. Prosthetics for natural limbs or eyes lost while the Insured was covered under this Policy as set forth in the Schedule of Benefits. Only the original prosthesis is eligible for payment.

7. Home nursing care by a registered nurse (RN) or licensed practical nurse (LPN) for a period not to exceed ninety (90) Visits in any one Calendar Year. One (1) four (4) hour Visit is allowed per day. Home nursing care is only covered when the care is required in lieu of Hospital confinement and:

   (a) The care is for home Visits rendered outside a Hospital;

   (b) The care is ordered by the attending Physician;

   (c) The care requires the technical proficiency and scientific skills of an RN or LPN; and

   (d) The RN or LPN is not a member of the Employee's immediate family or does not ordinarily reside in the Employee's home.

8. Cardiac rehabilitation therapy, such as, but not limited to, use of common exercise equipment while under a Physician's care in a formal rehabilitation program at an accredited facility, pursuant to a Physician's prescription. Cardiac rehabilitation therapy must be rendered within ninety (90) days following cardiac Illness or surgery.

9. The first lens purchased in conjunction with cataract surgery is covered under Major Medical.

10. Circumcisions.

11. The Plan covers treatment for phenylketonuria ("PKU") including medical services and dietary formula.

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

13. Pulmonary rehabilitation therapy while under a Physician's care in a formal rehabilitation program at an accredited facility pursuant to a Physician's prescription. Pulmonary rehabilitation therapy must be rendered within ninety (90) days following the diagnosis of pulmonary illness or surgery.

14. Expenses for devices for contraception, including treatment or services rendered in connection with placement of such devices.

E. BENEFIT AREA "E": AMBULANCE SERVICE AND DURABLE MEDICAL EQUIPMENT

Eligible expenses for Ambulance and Durable Medical Equipment are covered and subject to the cost sharing amounts shown in the Schedule of Benefits.

Ambulance Service

Eligible expenses are determined according the Policy definition for Ambulance.

Durable Medical Equipment

Eligible expenses are determined according the Policy definition for Durable Medical Equipment

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Eligible expenses for pacemakers are not subject to the Durable Medical Equipment limit and are paid at the levels as for any other major medical expense (refer to Benefit Area "D".)

Items of equipment such as, but not limited to, air conditioners, air purifiers, spas, hot tubs, or exercise equipment, are not considered to be Durable Medical Equipment and are ineligible for Benefits.

F. BENEFIT AREA "F": OUTPATIENT MENTAL ILLNESS AND ALCOHOL/SUBSTANCE ABUSE TREATMENT

Outpatient services for Mental Illness and substance abuse treatment are covered as set forth in the Schedule of benefits.

G. BENEFIT AREA "G": PRESCRIPTION DRUG BENEFIT

This benefit requires a specific copayment from the insured for each prescription filled as shown in the Schedule of Benefits. This copayment does not apply toward the Out-of-Pocket amount.

This area provides coverage for outpatient 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"). Benefits include

contraceptives; prescription vitamins (including prenatal and pediatric vitamins), in single or in combination form; prescription calcium supplements; prescription hematinics; and insulin, testing equipment, and syringes for diabetics. 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 as well as the copayment amount.

In accordance with the Policy provisions for determining medical necessity, some Prescription drugs are subject to maximum dispensing limitations at either a retail pharmacy or through the mail order program. These limits are based on clinically approved prescribing guidelines and are regularly reviewed to ensure medical necessity and appropriateness or care. Prescription drugs that exceed the manufacturer's recommended dosage or the dosage established by the Food and Drug Administration ("FDA") are not covered.

Drugs and medicines that require a Prescription Order that have not been approved for use by the FDA for the specific condition for which they are being prescribed, but have been approved for use by the FDA for another condition, are eligible for Benefits if it is determined that they have been recognized as medically appropriate and effective for the treatment of the specific condition for which they are being prescribed in one or more of the following medical reference publications: the American Medical Association Drug Evaluations; the American Hospital Formulary Services Drug Information; and Drug Information for the Health Care Provider. Medical appropriateness may also be established through major peer-reviewed medical literature. Medical literature must meet the following requirements to be acceptable: a) at least two articles from major peer-reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which the drug has been prescribed; b) no article from a major peer-reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which the drug has been prescribed; and c) the literature meets the uniform requirements for manuscripts subjected to biomedical journals established by the international committee of medical journal editors or is published in a journal specified by the United States Department of Health and Human Services as acceptable medical peer-reviewed medical literature.

VI. GENERAL LIMITATIONS AND EXCLUSIONS APPLICABLE TO ALL BENEFITS:

There are no Benefits available under this Policy for the following:

1. Any service not Medically Necessary or appropriate unless specifically included within the coverage provisions.

2. Custodial, convalescent or intermediate level care or rest cures.

3. Services which are experimental or investigational.

4. Services eligible for coverage by Workers' Compensation, Medicare or CHAMPUS.

5. Services for which no charges are made or for which no charges would be made in the absence of insurance or for which the insured has no legal obligation to pay.

6. Services for weight control, nutrition, and smoking cessation, including self-help and training programs as well as prescription drugs, used in conjunction with such programs and services.

7. Cosmetic surgery and services, except for treatment or surgery for congenital anomaly. Mastectomy reconstruction is covered as described in the Women's Health and Cancer Rights Act.

8. Artificial insemination and infertility treatment and treatment of sexual dysfunction not related to organic disease.

9. Services for reversal of elective, surgically or pharmaceutically induced infertility.

10. Vision therapy, tests, glasses, contact lenses and other vision aids. Radial keratotomy, myopic keratomileusis and any surgery involving corneal tissue to alter or correct myopia, hyperopia or stigmatic error. Vision tests and glasses will be covered for children under the age of twelve (12).

11. Treatment of weak, strained, or flat feet, including orthopedic shoes or other supportive devices, or for cutting, removal, or treatment of corns, calluses, or nails other than corrective surgery, or for metabolic or peripheral vascular disease.

12. Manipulative therapy and related treatment, including heat treatments and ultrasound, of the musculoskeletal structure for other than fractures and dislocations of the extremities will be subject to one thousand dollars ($1,000) per year limit, subject to the Policy deductible, co-insurance, or co-payment.

13. Dental and orthodontic services, except those needed for treatment of a medical condition or Injury or as specifically allowed in the Plan for children under the age of twelve (12).

14. Hearing tests without Illness being suspect.

15. Hearing aids and supplies, tinnitus maskers, cochlear implants and exams for the prescription or fitting of hearing aids.

16. Speech tests and therapy except as specifically allowed in the Plan for children under the age of twelve (12).

17. Private room accommodation charges in excess of the institution's most common semi-private room charge except when prescribed as medically necessary.

18. Services performed by a member of the Insured's family or of the Insured's spouse's family. Family includes parents or grandparents of the insured or spouse and any descendants of such parents or grandparents.

19. Care incurred before the effective date of the person's coverage.

20. Immunizations and medical exams and tests of any kind not related to treatment of covered injury or disease, except as specifically stated in the Plan.

21. Injury or sickness caused by war or armed international conflict.

22. Sex change operations and treatment in connection with transsexualism.

23. Marriage and family and child counseling except as specifically allowed in the Plan.

24. Acupuncture, except when used as anesthesia during a covered surgical procedure.

25. Private duty nursing except as specifically allowed in the Plan.

26. Services received from a medical or dental department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group.

27. Services incurred after the date of termination of a covered person's coverage except as allowed by the extension of benefits provision of the Plan, if any.

28. Expenses for personal hygiene and convenience items such as air conditioners, humidifiers, and physical fitness equipment.

29. Charges for failure to keep a scheduled visit, charges for completion of any form, and charges for medical information.

30. Charges for screening examinations except as otherwise provided in the Plan.

31. Charges for wigs or cranial prostheses, hair analysis, hair loss and baldness.

32. Pre-existing conditions, except as provided specifically in the Plan.

33. Expenses for an elective abortion, including any medications/Prescription Drugs that are for the purpose of inducing 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.

VII. PREEXISTING CONDITIONS:

TWELVE MONTH LIMITATION: During the twelve (12) months following the Enrollment Date, no Benefits will be provided under this agreement for any of the following:

1. A Preexisting Condition as defined in this Policy.

   The Company will not deny, exclude, or limit Benefits for a covered individual for losses incurred more than twelve (12) months following the Enrollment Date of the individual's coverage due to a Preexisting Condition.

   The Company shall waive any time period applicable to a Preexisting Condition exclusion or limitation with respect to particular services in the health Benefit Plan for the period of time an individual was previously covered by public or private health insurance or by any other health Benefit with respect to such services, provided that the previous coverage was continuous to a date not more than sixty-three (63) days prior to the Enrollment Date of the new coverage. The period of continuous coverage shall not include any Waiting Period for the Effective Date of the new coverage applied by the Employer or the carrier.

   The twelve (12) month Preexisting Condition limitation will be reduced by the number of days of Creditable Coverage calculated as of the Enrollment Date of the Insured.

2. Revision or reversal of a surgical procedure which was performed prior to the Enrollment Date.

VIII. COBRA, USERRA, COVERAGE DURING DISABILITY, 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 a period 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 employment.
   2. Reduction of hours.
   3. Death of an employee.
   4. Employee becomes 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 Disability:**

1. Disability related Expenses: In the event that the group Policy terminates for any reason while Benefits are being paid and it is established that:

   (a) The Insured and/or Dependent was totally Disabled when such insurance terminated; and

   (b) Expenses were incurred in connection with the accident or Illness causing such Total Disability; and

   (a) The total maximum amount of Benefits has not been paid,

   Benefits with respect to expenses incurred in connection with the Injury or Illness causing such Disability will be continued during such Total Disability

until the earliest of: (i) twelve months from the date on which insurance terminated; (ii) until the total maximum amount of Benefits have been paid; (iii) the Employee or Dependent ceases to be totally Disabled.

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

D. **Conversion Plan:** An individual whose insurance under the group Policy has been terminated has the right to be covered under the Company's Conversion Plan when group coverage terminates. An individual does not have conversion rights if:

1. Termination of the group coverage occurred because of failure of the Employee to pay any required individual premiums;
2. The Insured acquires other group health coverage that is comparable to the coverage under the conversion plan;
3. The Insured has performed an act or practice that constitutes fraud, or has made an intentional misrepresentation of material fact under the terms of the coverage.

Coverage on the Conversion Plan will terminate when the Insured fails to pay the required premium or obtains other coverage which is comparable to the coverage under the Conversion Plan. However, if other health coverage is obtained that is less than comparable, the Conversion Plan will continue to cover those accidents or Illnesses that the new coverage totally excludes, insofar as they would be covered by the Conversion Plan in the absence of the replacement Policy.

The Insured must notify the Company of the Insured's desire for coverage on the Conversion Plan no later than thirty-one (31) days following the termination of group coverage. This notice must be in writing and must accompany premium to bring insurance premium current with no lapse of coverage.

IX. COORDINATION OF BENEFITS, THIRD PARTY LIABILITY 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:

   (a) Group insurance or group-type coverage, whether insured or uninsured, including prepayment, 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 required or provided by law, except a state plan under Medicaid or under any plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.

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

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

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

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

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

      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. If the parents have the same birthday, the plan that has covered the Child longer determines benefits first.

         Note: If the other health care plan does not have the rule in section (c)(1) and (c)(2) above, 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 the parents are separated or divorced, the following rules apply:

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

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

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

         Note: If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the Child(ren), and the entity obligated to pay or provide the benefits of the health

care plan of that parent has actual knowledge of those terms, the benefits of that health care plan are determined first. This does not apply with respect to any claim determination period or year during which benefits are actually paid and 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 benefits determination rules outlined in the Idaho Code shall apply.

4. When the person (to whom the claim relates) is an Employee who is laid off or retired, or is a Dependent of such an Employee, the benefits of the other health care plan shall be determined before those of this Plan. If the other health care plan does not have this rule, and if, as a result, there is not an agreement between this Plan and the other health care plan on the order of benefits, this rule is ignored.

5. If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan on the basis of their employment, the plan covering the person as an employee, member, subscriber or retiree, or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan, and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan. If the other health care plan does not have this rule, and if, as a result, there is not an agreement between this Plan and the other health care plan on the order of benefits, this rule is ignored. This rule does not apply if the rule in section 2(c)(1) can determine the order of benefits.

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 Insured Employee or the Insured Dependent(s), including from future claim payments due for services incurred by the Insured or any Insured member of the Insured's family, without regard to the identity or nature of the Provider of care, insurance companies, or other organizations.

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

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

1. Recovery Rights: Up to the amount of Benefits paid in connection with the Illness or Injury, the Company shall be entitled to the proceeds of any settlement or judgment which results in a recovery from the third party, but only under the conditions that the Insured is primary, and the Company is secondary.

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

3. The Company shall pay out of such proceeds actually recovered a proportionate share of any reasonable expense incurred in effecting collection from the third party or his insurer.

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

C. **PERSONS COVERED BY MEDICARE:**

1. This Plan will pay its Benefits before Medicare for:

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

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

   (c) The time period required by federal law during which Medicare is the secondary payer to a group health plan and the Insured individual is receiving treatment for end-stage renal disease (ESRD).

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

3. This Plan will pay Benefits only after Medicare has paid its Benefits:

   (a) For all other Insured persons; and

   (b) After the time period required by federal law during which Medicare was the secondary payer to a group health plan and the Insured individual received treatment for end-stage renal disease (ESRD).

X. GENERAL POLICY INFORMATION

A. **COMPUTATION OF EMPLOYER PREMIUMS:** The initial premium due thereafter shall be the sum of:

1. The number of persons then insured for Employee Benefits in each classification multiplied by the applicable rate per person; and

2. The number of persons then insured for Dependent Benefits, if any, in each classification multiplied by the applicable additional rate per person based on the classifications as determined by the premium rates in effect on such premium due date. Applicable rates are available from the Company upon request.

The Company reserves the right to change the rate for any insurance provided under this Plan:

1. On any premium due date provided the rate for such insurance has been in effect for at least three (3) months by giving written notice to the group Policyholder at least thirty-one (31) days prior to such premium due date; or

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

Instead of methods of computation of premiums above provided, premiums may be computed by any method mutually agreeable to the Company and the Policyholder which produces approximately the same total amount.

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

C. **GRACE PERIOD:** A grace period of thirty-one (31) days will be allowed for payment of any premium due, unless the Policyholder gives written notice of discontinuance prior to the premium due date.

D. **TERMINATION OF POLICY:** 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, but the Policyholder shall, nevertheless, be liable to the Company for the payment of all premiums then due and unpaid, including a pro rata premium for the grace period. If, however, written notice is given by the Policyholder to the Company, during the grace period, that this Plan is to be terminated before the expiration of the grace period, this Plan shall be terminated as of the date of receipt of such written notice by the Company or the date specified by the Policyholder for such termination, whichever date is later, and the Policyholder shall be liable to the Company for the payment of all premiums then due and unpaid, including a pro rata premium for the period commencing with the last premium due date and ending with such date of termination.

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

E. **RECORD OF EMPLOYEES INSURED:** The Company shall maintain a record which shall show at all times the names of all Employees insured hereunder, the beneficiary, if any, designated by each Employee, the date when each Employee became Insured and the Effective Date of any change in coverage and such other information as may be required to administer the insurance hereunder. The Company shall furnish the Policyholder, upon its reasonable request, a copy of such record. The Policyholder shall furnish periodically to the Company such information relative to Employees becoming insured, changes in coverage, and termination of insurance as the Company may require for the administration of the insurance hereunder. Any records of the Employer and/or Policyholder that may, in the opinion of the Company, have a bearing on the insurance hereunder shall be open for inspection by the Company at a reasonable time.

F. **EMPLOYEE'S CERTIFICATE:** The Company will issue, as appropriate, directly to the Insured Employee, or to the Policyholder, for delivery to each Insured Employee, an individual Certificate setting forth a statement as to the insurance protection to which he/she is entitled, to whom the Benefits are payable, and such limitations or requirements in this Plan as may pertain to the Insured Employee. The word "Certificate" as used in this Plan shall include Certificate riders and Certificate supplements, if any. Such Certificates shall not constitute a part of this Plan.

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

Pre-Service Claim

A pre-service claim is any claim for a benefit under the plan where the plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care (*i.e.*, claims subject to pre-certification). In the event of a pre-service claim, the Insured will receive a notification of the benefit determination within fifteen (15) days after the receipt of the request. If additional information is needed, the Insured will be notified within that time and will be given at least forty-five (45) days to respond. A notification of the benefit determination will be sent within fifteen (15) days after the receipt of the additional information. If there is an ongoing course of treatment (*i.e.*, concurrent care), a notification of determination as to extending the course of the treatment will be sent within fifteen (15) days after receipt of the request. If there will be a reduction or termination of the previously approved concurrent care benefit before the end of the

treatment period, a notification will be sent at least fifteen (15) days prior to the end of the treatment.

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

Post-Service Claim

A post-service claim is any claim that involves the cost for medical care that has already been provided to the insured. Post-service claims will never be considered to be claims involving urgent care.

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

Notice to Insured of Adverse Benefit Determination

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

Appeals

In the event of an adverse benefit determination, the Insured has 180 days from the receipt of the adverse benefit determination notification in which to file an appeal. An Insured may submit comments, documents, records and other information relating to the claim, and will, upon request, be provided free of charge, access to, and copies of, all documents, records, and other information relevant to the claim that were used in the initial benefit determination. The Company provides two levels of appeal review, which may be performed either internally or independently, as described herein. Both of these levels must be exhausted before an Insured can file suit in court. If an Insured receives an adverse decision on the first level of appeal, he may submit the appeal for a second level of review within sixty (60) days of receipt of the first level decision, along with any additional applicable information. In the case of a pre-service claim, each level of appeal will be responded to within fifteen (15) days after the receipt of the appeal. In the case of a post-service claim, each level of appeal will be responded to within thirty (30) days after the receipt of the appeal.

For pre-service claims, both levels of appeal must be submitted in writing to the utilization review company that performed the Pre-certification and a copy must be

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

Reviews of all appeals of adverse benefit determinations, except those described in the following paragraph, will be conducted internally by a person or a committee of persons who is neither the individual who made the initial adverse benefit determination nor the subordinate of that individual. The time period within which a determination on appeal is required to be made will begin at the time that an appeal is filed.

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

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

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

I. **EXPERIENCE RATING REFUNDS:** This Plan shares in the surplus earnings of the Company. Surplus earnings are defined as the amount of earnings in excess of earnings required to maintain minimum compulsory surplus required by law and the amount required to maintain an appropriate level of financial reserve as determined by the Board of Directors in its sole discretion.

In any Calendar Year in which there are surplus earnings as a result of favorable claims experience, and the Board of Directors in its discretion determines that it is appropriate and advisable to return the surplus earnings to the Policyholder, such surplus earnings will be refundable to eligible Employers as an experience rating refund. The method and timing of the refund is determined by the Company's Board of Directors. To be eligible to participate in the experience rating refund, a participating Employer must be a Policyholder at the time the refund is made.

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

K. **ANNUAL MEETING:** The annual meeting of the Company shall be held on the first Friday in December of each year at the Home Office of the Company.

L. **ENTIRE CONTRACT:** This Plan and all attachments hereto, the application of the Policyholder, and individual applications and the enrollment cards of Insured Employees constitute the entire contract between the parties. All statements made by the Policyholder or by the Insured Employees and their Dependents shall, in the absence of fraud, be deemed representations and not warranties. No statement made by an Insured Employee or his Dependents shall affect the insurance or be used in defense to a claim hereunder unless such statement is formalized in writing and a copy of the instrument containing such statement is, or has been furnished to such Employee or to his beneficiary.

M. **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, without the consent of the Employees insured hereunder or of their beneficiaries, by written agreement between the Policyholder and the Company. This Plan may also be amended on the Plan's renewal date upon sixty (60) days written notice from the Company to the Policyholder. No modification or amendment of this Plan shall affect the right or the extent of Benefits of any Insured Employee or Insured Dependent who is, on the Effective Date of such modification or amendment, Hospital Confined or confined in an Extended Care Facility until the first discharge there from occurring after such Effective Date. No change in the Plan shall be valid until approved by a duly authorized officer of the Company and unless such approval be endorsed hereon or attached hereto. No agent has authority to change any Plan or waive any provision thereof.

N. **NOTICE AND PROOF OF CLAIM:** Written or 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. Notice given by, or on behalf of, the claimant to the Company at its Home Office or to any authorized agent of the Company, with particulars sufficient to identify the Insured Employee or Insured Dependent, 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, written proof covering the occurrence, character, and extent of the loss for which claims are made.

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

concerning an independent medical evaluation, it shall be subject to the Arbitration rule of this Policy.

P. **PAYMENT OF CLAIM:** Upon request of the Insured Employee and subject to due proof of loss, the accrued daily Hospital Benefits will be paid each week during any period for which the Company is liable and any balance remaining unpaid at the termination of such period will be paid promptly upon receipt of due proof. Any other Benefits provided in the Plan will be paid promptly after receipt of due proof. All Benefits are payable to the Employee or his legal assignee. If any such Benefits remain unpaid at the death of the Employee, if the Employee is a minor, or if the Employee is, in the opinion of the Company, legally incapable of giving a valid receipt and discharge for any payment, the Company may, at its option, pay such Benefit to the Employee's legal heirs. Any payments made will constitute a complete discharge of the Company's obligations to the extent of such payment and the Company will not be required to see the application of the money so paid.

Q. **MEDICAL RECORDS:** The Company shall have the right to request and receive, without cost or expense, and as a condition precedent to liability for any Benefits to be provided under this Plan, medical records relating to care and treatment of any Insured who claims Benefits under this Plan. The Insured, by requesting any Benefits hereunder, does fully authorize, empower, and direct his/her Provider to furnish the Company with such complete reports and medical records.

R. **OVERPAYMENTS:** If for any reason the Company pays any amounts to or on behalf of the Insured:

1. For services not covered under this Plan, or

2. Which exceed amounts to be paid as Benefits under this Plan, or

3. On behalf of a person believed to be a Dependent who is not covered under this Plan, the Insured Employee is responsible to reimburse the Company on demand for all and any such amounts.

The Company may, at its discretion recover overpayments to or on behalf of an Insured from future claim payments due for services incurred by the Insured or any Insured Dependent, without regard to the identity or nature of the Provider of care.

S. **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, nor shall such action 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.

T. **TIME LIMITATION:** If any time limitation of the Plan with respect to giving notice of claim or furnishing proof of loss, or the 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.

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

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

V. **SUPERSEDED PLAN:** In the event this Plan is issued to supersede a health care Plan previously issued by the Company, Benefits furnished under the previous health Plan shall apply against the Benefit maximums of this Plan as though such Benefits had been furnished under this Plan.

W. **CANCELLATION OF POLICY:** If the Insured person cancels their health insurance policy with WMI Mutual Insurance for any reason, WMI Mutual Insurance will refund the pro rata portion of the unused collected premium to the beginning of the next monthly billing cycle.

As used in this section "health insurance policy" shall refer to the contract entered into pursuant to this title for which payment or reimbursement is rendered to an Insured or health care provider for the Insured's utilization of health care services which is any service rendered to an individual for diagnosis, relief or treatment of an injury, ailment or bodily condition.

As used in this section "unused collected premium" shall mean that portion of any premium collected which is not used, on a pro rata basis to the beginning of the next monthly billing cycle at the time of cancellation, by WMI Mutual Insurance or other entity regulated pursuant to this title to insure against loss as there is no risk of loss from the Insured, or that portion of any collected premium which would have been collected had the Insured paid monthly.

X. **RIGHTS UNDER ERISA:** If the Insured has any questions about the Plan, he or she should contact the Company. If the Insured has any questions about this statement or his or her rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA), he or she should contact the nearest area office of the Pension and Welfare Benefits Administration, U.S. Department of Labor listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, at 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Y. **QUALIFIED MEDICAL CHILD SUPPORT ORDER ("QMCSO")**: A QMCSO is a court judgment, decree, or order, or a state administrative order that has the force and effect of law, that is typically issued as part of a divorce or as part of a state child support order proceeding. A QMCSO requires that health

plan coverage be provided to a child of the Employee. A copy of the Company's QMSCO procedures may be obtained free of charge, upon request.

Z. **FRAUD:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

XI. 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.