WMI MUTUAL INSURANCE COMPANY

Patient Protection and Affordability Care Act ("PPACA") Amendment

This health insurance issuer believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your policy may not include certain consumer protections of the Affordable Care Act that apply to other plans (e.g., the requirement for the provision of preventive health services without any cost sharing). However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act (e.g., the elimination of lifetime limits on benefits).

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to WMI Mutual Insurance Company at 1-800-748-5340 or 801-263-8000. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

The provisions below are required by federal health care reform. These provisions are effective on January 1, 2011. These provisions replace any language in the Certificate to the contrary. Changes or clarifications will be made on a continuing basis in order to comply with federal or state regulations, guidance, or interpretations as they are developed. Benefits that are mandated by state law that are more generous than those required by federal health care reform will continue in force at the current benefit level.

Dependent Age

The limiting age for a non-disabled dependent child is until attainment of twenty-six (26) years, provided the child is not eligible to enroll in his/her own employer-sponsored health plan. This applies regardless of financial dependency, residency with the parent or with any other person, student status, employment, or any combination of those factors. Eligibility for coverage does not include the spouse or child of such dependent child.

Lifetime Limit

The maximum lifetime benefit (per Insured) of $2,000,000 is removed. Any other benefit-specific lifetime dollar limit referenced in the Policy pertains only to those health care services and supplies that are not "Essential Benefits" as defined and interpreted in PPACA.

Annual Limit

This policy has a maximum annual benefit (per Insured) of $2,000,000. This maximum is applicable to the "Essential Benefits" listed below, as they are defined and interpreted in PPACA, provided the services are otherwise eligible according to the terms of the Policy. Any other benefit-specific annual dollar limit referenced in the Policy pertains only to those health care services and supplies that are not "Essential Benefits" as defined in PPACA.

1) Ambulatory patient services.
2) Emergency services.
3) Hospitalization.
4) Maternity and newborn care.
5) Mental health and substance abuse, including behavioral health treatment.
6) Prescription drugs.
7) Rehabilitative and habilitative services and devices.
8) Laboratory services.
9) Preventive and wellness services and chronic disease management.
10) Pediatric services, including oral and vision care.

Preexisting Condition

The preexisting condition exclusion is not applicable for children up to, and including, the age of eighteen (18).

Rescission

Coverage may be rescinded if an Insured performs an act, practice, or omission that constitutes fraud or if an Insured makes an intentional misrepresentation of a material fact. At least thirty (30) days advance written notice will be provided to the Insured prior to the rescission of coverage.

WMI MUTUAL INSURANCE COMPANY

Patient Protection and Affordability Care Act ("PPACA") Amendment 2

This health insurance issuer believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your policy may not include certain consumer protections of the Affordable Care Act that apply to other plans (e.g., the requirement for the provision of preventive health services without any cost sharing). However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act (e.g., the elimination of lifetime limits on benefits).

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to WMI Mutual Insurance Company at 1-800-748-5340 or 801-263-8000. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

The provisions below are required by federal health care reform. These provisions are effective on the plan renewal on or after January 1, 2014. These provisions replace any language in the Certificate or any previous amendments to the contrary. Benefits that are mandated by state law that are more generous than those required by federal health care reform will continue in force at the current benefit level.

Dependent Age

The limiting age for a non-disabled dependent child is until attainment of twenty-six (26) years. This applies regardless of financial dependency, residency with the parent or with any other person, student status, employment, eligibility for the dependent child to enroll in his/her own employer-sponsored health plan, or any combination of those factors. Eligibility for coverage does not include the spouse or child of such dependent child.

Annual Limit

The maximum annual benefit (per Insured) of $2,000,000 for essential benefits is removed. Any other benefit-specific dollar limit referenced in the plan pertains only to those health care services and supplies that are not essential benefits as defined in PPACA. For further information about essential benefits, please contact our Claims & Customer Service Department at 1-800-748-5340 or 801-263-8000.

Preexisting Condition

The preexisting condition exclusion is removed and is not applicable for any insured individual. References to "creditable coverage" are also removed.

Waiting Period

The maximum waiting period for a new employee to be eligible for coverage is 90 days. For a waiting period of 60 days or less, coverage will become effective on the first day of the month following the satisfaction of the waiting period. For a waiting period of 90 days, coverage will become effective on the first day of the month preceding the satisfaction of the waiting period.

Conversion

The conversion provision of the plan is removed. Guarantee-issued individual coverage may be obtained through the Health Insurance Marketplace (the "exchange").

Definitions

The following definition is added to the plan: "Congenital anomaly" means a condition existing at or from birth that is a significant deviation from the common form or function of the body, whether caused by a hereditary or developmental defect or disease. The term "significant deviation" means a deviation which impairs the function of the body and includes, but is not limited to, the conditions of cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism and other conditions that are medically diagnosed to be congenital anomalies.

Insured's Right To An Independent External Review

The following language replaces the current language in the plan:

Please read this notice carefully. It describes a procedure for review of a disputed health claim by a qualified professional who has no affiliation with this health plan. If an Insured requests an independent external review of his claim, the decision made by the independent reviewer will be binding and final on the Company. An Insured will have the right to further review of your claim by a court, arbitrator, mediator or other dispute resolution entity only if the Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), as more fully explained below under "Binding Nature of the External Review Decision".

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

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

An Insured must first exhaust the Company's internal grievance and appeal process. Exhaustion of that process includes completing all levels of appeal, or unless the Insured requested or agreed to a delay, the Company's failure to respond to a standard appeal within 30 days in writing or to an urgent appeal within three business days of the date an appeal was filed. The Company may also agree to waive the exhaustion requirement for an external review request. An Insured may file for an internal urgent appeal with the Company and for an expedited external review with the Idaho Department of Insured at the same time if the request qualifies as and 'urgent care request" as defined below.

An Insured may submit a written request for an external review to:

Idaho Department of Insurance
ATTN: External Review
700 W State St, 3rd Floor
Boise, ID 83720-0043

For more information and for an external review request form:
- See the department's web site, http://www.doi.idaho.gov, or
- Call the department's telephone number, (208) 334-4250, or toll-free in Idaho, 1-800-721-3272.

An Insured may represent himself in his request or he may name another person, including his treating health care provider, to act as his authorized representative for his request. If an Insured wants someone else to represent him, he must include a signed "Appointment of an Authorized Representative" form with his request.

An Insured's written external review request to the Department of Insurance must include a completed form authorizing the release of any of his medical records the independent review organization may require to reach a decision on the external review, including any judicial review of the external review decision pursuant to ERISA, if applicable. The department will not act on an external review request without an Insured's completed authorization form.

If an Insured's request qualifies for external review, the Company's final adverse benefit determination will be reviewed by an independent review organization selected by the department. The Company will pay the costs of the review.

Standard External Review Request: An Insured must file his written external review request with the department within four months after the date the Company issues a final notice of denial.

1. Within seven days after the department receives an Insured's request, the department will send a copy to the Company.
2. Within 14 days after the Company receives the request from the department, it will be reviewed for eligibility. Within five business days after the Company completes that review, the Insured and the department will be notified in writing if the request is eligible or what additional information is needed. If the Company denies the Insured's eligibility for review, he may appeal that determination to the department.
3. If an Insured's request is eligible for review, the department will assign an independent review organization to the review within seven days of receipt of the Company's notice. The department will also notify the Insured in writing.
4. Within seven days of the date the Insured receives the department's notice of assignment to an independent review organization, he may submit any additional information in writing to the independent review organization that he wants the organization to consider in its review.
5. The independent review organization must provide written notice of its decision to the Insured, to the Company and to the department within 42 days after receipt of an external review request.

Expedited External Review Request: An Insured may file a written "urgent care request" with the department for an expedited external review of a pre-service or concurrent service denial. An Insured may file for an internal urgent appeal with the Company and for an expedited external review with the department at the same time.

"Urgent care request" means a claim relating to an admission, availability of care, continued stay or health care service for which the Insured received Emergency services but has not been discharged from a facility, or any pre-service or concurrent care claim for medical care or treatment for which application of the time periods for making a regular external review determination:

1. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function;
2. In the opinion of the treating health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the disputed care or treatment; or
3. The treatment would be significantly less effective if not promptly initiated.

The department will send the Insured's request to the Company. The Company will determine, no later than the second full business day, if the request is eligible for review. The Company will notify the Insured and the department no later than one business day after the decision if the request is eligible. If the Company denies the Insured's eligibility for review, he may appeal that determination to the department.

If an Insured's request is eligible for review, the department will assign an independent review organization to the review upon receipt of the Company's notice. The department will also notify the Insured. The independent review organization must provide notice of its decision to the Insured, to the Company and to the department within 72 hours after the date of receipt of the external review request. The independent review organization must provide written confirmation of its decision within 48 hours of notice of its decision. If the decision reverses the Company's denial, we will notify the Insured and the department of the Company's intent to pay the covered benefit as soon as reasonably practicable, but not later than one business day after receiving notice of the decision.

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

If the Insured's plan is not subject to ERISA requirements, the external review decision by the independent review organization will be final and binding on both the Insured and the Company. **This means that if the Insured elects to request external review, he will be bound by the decision of the independent review organization. The Insured will not have any further opportunity for review of the Company's denial after the independent review organization issues its final decision.** If the Insured chooses not to use the external review process, other options for resolving a disputed claim may include mediation, arbitration or filing an action in court.

Under Idaho law, the independent review organization is immune from any claim relating to its opinion rendered or acts or omissions performed within the scope of its duties unless performed in bad faith or involving gross negligence.

The foregoing is hereby authorized by:

David T. Leo, President