WMI MUTUAL INSURANCE COMPANY

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

The provisions below are required by federal health care reform. The effective date of these provisions is 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. This applies regardless of financial dependency, residency with the parent or with any other person, student status, employment, or any combination of those factors. The spouse or child of such dependent child is not eligible for coverage.

Lifetime Limit

This amendment removes the maximum lifetime benefit of two-million dollars per Insured. Any other lifetime dollar limit in the Policy for a specific benefit in the Policy applies only to health care services and supplies that are not "Essential Benefits". Essential benefits are defined and interpreted in PPACA.

Annual Limit

This amendment adds a maximum annual benefit of two-million dollars per Insured. This maximum applies to "Essential Benefits" as shown in the list below. PPACA defines and interprets the term "Essential Benefits". The services must also otherwise be eligible according to the terms of the Policy. Any other annual dollar limit in the Policy for a specific benefit applies only to those health care services and supplies that are not "Essential Benefits". The definition of "essential benefits" may be changed by the U.S. Department of Health and Human Services.

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 does not apply 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Coverage may be rescinded if an Insured performs an act, practice, or omission that constitutes fraud. Coverage also may be rescinded if an Insured makes an intentional misrepresentation of a material fact. Written notice will be given to the Insured prior to the rescission of coverage. This notice will be given at least thirty (30) days in advance.

Preventive Care

If the following services are provided by a **PPO provider**, benefits are not subject to the Deductible, and are paid with no cost-sharing by the Insured. If the following services are provided by a **non-PPO provider**, benefits are subject to the regular Deductible and regular cost-sharing provisions of the plan. Benefits are also subject to other applicable plan provisions. Additional information is available on the website of the U.S. Department of Health and Human Services at www.healthcare.gov. The Insured may also contact WMI Mutual Insurance Company for additional information.

1) Evidence-based services with a rating of A or B in the US Preventive Services Task Force.
2) Immunizations for routine use in children, adolescents, and adults as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control.
3) Evidence-informed preventive care and screenings for infants, children, and adolescents provided for in the guidelines of the Health Resources and Services Administration.
4) Additional preventive care and screenings for women provided in the guidelines of the Health Resources and Services Administration.
5) Recommendations issued by the US Preventive Services Task Force for women regarding breast cancer screening, mammography, and prevention.

Emergency Services

Emergency services are not subject to the requirement for precertification if they are eligible for benefits. This only applies for services that are performed in an emergency department of a hospital. These services are also paid at the PPO coinsurance level without regard to the status of the provider. The Insured is responsible for any amount that is billed by a non-PPO provider that is over the allowable amount. The Insured is also responsible for any amounts that are ineligible.

Internal Claims and Appeals and External Review

1) Benefit determinations for Urgent care claims will be made within 24 hours of the receipt of the claim. This time limit will not apply if the Insured fails to provide sufficient information to make the determination.

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

3) A third external review level is available. This review level is voluntary. This level is available once the internal appeals process is exhausted. The plan may waive the exhaustion requirement in writing. Exhaustion is also waived if the Plan has failed to comply with any of the requirements of the internal appeals process. The external review level can be used for adverse benefit determinations for medical necessity or for appropriateness of care. This review level can also be used for adverse benefit determinations for services that are experimental or investigational. An Insured must submit a request for an external review within four (4) months from the date of the final adverse benefit determination. It will be reviewed by an independent review organization ("IRO"). The IRO will be assigned by the state. The IRO will provide written notice of its decision for a standard review. This notice will be provided within no more than forty-five (45) days after receipt of the request for the review. The IRO will provide written notice of its decision for an expedited review. This notice will be provided within no more than seventy-two (72) hours after receipt of the request for the review. The Company will accept and comply with the findings made by the IRO. The Company will pay for the reasonable costs of the independent review.

4) There are two options for external review: (a) standard review; and (b) expedited review. The expedited review option is available if: (a) the adverse benefit determination involves a medical condition for which the standard external review timeframe would seriously jeopardize the life or health of the Insured; and (b) the adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which the Insured received emergency services, but has not been discharged from a facility.

WMI MUTUAL INSURANCE COMPANY

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

The provisions below are required by federal health care reform. The effective date of these provisions is the plan renewal date on or after July 1, 2014. These provisions replace any language in the Certificate to the contrary. These provisions also replace any language in 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 dependent child who is not disabled is until attainment of twenty-six (26) years. This applies regardless of the eligibility for the dependent child to enroll in his/her own employer-sponsored health plan.

Annual Limit

The maximum annual benefit (per Insured) of two-million dollars for essential benefits is removed. Any other dollar limit for a specific benefit that is referenced in the plan pertains only to those health care services and supplies that are not essential benefits as defined in PPACA.

Preexisting Condition

This amendment removes the preexisting condition exclusion in the plan. This amendment also removes any references to creditable coverage in the plan.

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. Coverage may be obtained through the Health Insurance Marketplace (the "exchange") on a guarantee-issued basis.